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Clinical Pathology & Research Journal
ISSN: 2642-6145

Perceptions, Misconceptions, and Generalizations of Hispanic Populations in Healthcare

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Editorial
Volume 7 Issue 1
Received Date: July 25, 2023
Published Date: August 23, 2023
DOI: 10.23880/cprj-16000166

Keywords: Pew Research Center; Patient-Doctor Communication; Western Medical Model

Editorial

Since 1960, the migration phenomenon has been a crucial part of the challenges of modern medical practice. Notions of what was considered an "effective" patient-doctor communication have been turned upside down by the singularities of an ever-changing society.

Projections of the U. S. population by race and ethnicity from the Pew Research Center (2020) illustrate that the Hispanic population will increase by 29% by 2050. This information is consistent with the data from the U. S. [1], stating that the most significant population increases in the last decade were among non-white ethnic groups and foreign-born populations. According to the Census data, 25% of the U. S. population is comprised of African Americans, Hispanics, Asian/Pacific Islanders, Native Americans, and other racial and ethnic groups.

Von, et al. [2] noted that communication with culturally diverse patients is one of the challenging areas in healthcare. As Ferguson, et al. [3] stated, intercultural doctor-patient interactions are potential sources of misunderstanding which may reduce the quality of the care provided.

Contrary to what some people might believe, everyone has a culture to identify them [4] that Culture is complex and dynamic. It influences people's perceptions of their health, which becomes the building blocks for constructing health beliefs and the actions resulting from those beliefs [5].

Accordingly, Greg [6] comments that individuals from different cultural backgrounds will likely interpret the "same" disease differently. Then, different cultural beliefs and illness interpretations may contribute to health and healthcare disparities. An example of how different cultural beliefs can affect the patient-provider relationship is the following scenario, Juan injured his back in early 1980; he had surgery but re-injured in 1984. He could not return to work, and since 1986 he has received lidocaine treatments at a pain center in New England. Like most Latinos, Juan was very expressive about his pain and displayed pain behaviors, such as wincing, grimacing, and groaning. This sometimes led to misunderstandings with the nurses at the pain center, many of whom are Anglo-Americans; their cultural values probably contributed to their view of Juan's behavior as inappropriate for a man. One nurse said about Juan: "*He starts to yell when I apply the alcohol swab-even before the I.V. He looks so "macho," but he acts like a baby*." In this example, different cultural beliefs about acceptable behavior have led to problems in the patient-nurse relationship Bates, et al. [7].

According to Nakamura [8], although the Western medical model explains illness and disease in terms of pathological agents (cause and effect), Culture provides a culturally diagnostic model by which each individual explains his or her disease and course of treatment. Therefore, health educators must be aware of how Culture influences personal understanding of health and illness and how this affects personal health practices [9].

To alleviate cross-cultural challenges in medical encounters, curricula in Cultural Competence included in Medical Education have been invoked concerning the increasingly multicultural composition of U. S. society and the challenges of caring for diverse populations. The term is mainly applied when there are conspicuous ethnic, racial, and economic disparities in healthcare quality and access [10].

According to Luquis, et al. [9], Cultural Competence includes awareness and acceptance of others and one's cultural values and a commitment to honor and respect the beliefs and values of others. Furthermore, Betancourt [11] commented that Cultural Competence aims to bridge the cultural gap between physicians and patients. The author states,

For some, the distance may be significant, manifested by a patient who has a completely different understanding of hypertension than physicians and thus rejects what he offered as a treatment. For others, the distance may be shorter and based solely on slight but significant mistrust about the physician's intentions and recommendations. (p. 500)

The field of Cultural Competence is not new. However, it has evolved significantly as a strategy to address racial and ethnic disparities in health care. It has become a central tenet of patient-centered care, effective communication, and the need to deliver quality patient care [11].

Conversely, Fox [10] argues that the abilities or skills related to patient-centered communication and response to patients' psychological issues and needs should not be seen as professional abilities that can be taught but as virtues associated with moral character. The author points out that Cultural Competence usually does not encompass the distinctive cultural attributes of the U. S. society, which shapes the attitudes and values of healthcare professionals and patients alike. Fox [10] added, "If discussions of Cultural Competence ignore the U. S. culture, they also neglect what psychiatrist and medical anthropologist Arthur Kleinman calls "the culture of biomedicine" and its effects on physicians trained in modern Western medicine" (p. 1316).

Moreover, Von, et al. [2] add that physicians tend to ascribe difficulties primarily to cultural differences when interacting with a patient from a different cultural background. Physicians have their cultural backgrounds, influencing how they interpret their patients' behaviors and medical decisions. As Seeleman [12] states, cultural backgrounds, among other factors such as religion, influence peoples' perceptions of health and health care, their frame of reference, and their expectations.

Along with cultural differences, there are also language differences. Language use and understanding are as dynamic as culture [13]. We should recognize the importance of language when addressing patients with a different cultural background than the physician. A 2002 report funded by the Commonwealth Fund concludes that while many have postulated that Cultural Competence will reduce racial and ethnic disparities in healthcare, only a few studies have found direct links between Cultural Competence and healthcare improvement. The report points out that medical literature that explicitly connects these two focuses on addressing language barriers between providers and patients and training providers to care for diverse patient populations.

Another study by the Latino Community Plan points out that communication difficulties are an essential barrier to health care access for Latinos. Failure to consider a patient's language needs and cultural underpinnings can lead to misdiagnosis, inappropriate medication, and mistrust, resulting in poor medical care. In the U. S. white patients have been shown to receive a higher quality of care than black or Hispanic patients [14,15] argues that Hispanic Spanish-speaking patients are significantly more dissatisfied with provider communication than Hispanic English-speaking patients and white respondents. Even though the reasons for such differences are multifactorial, poor communication is likely the most critical factor. Therefore, effective communication may be impeded by a poor understanding of language and cultural differences Nasreen, et al. [16].

According to Kai [17], patients from all cultural backgrounds highlight the same fundamental aspects of communication as a source of difficulties and dissatisfaction in their health care encounters. However, the ability of patients to communicate effectively during a medical encounter may be particularly compromised. As Kai [17] continues, patients may be afraid, in pain, uncomfortable, embarrassed, and preoccupied with their illness, and these are also contributing factors to misunderstandings.

Patients from minority ethnic groups may also experience stereotyping, prejudice, or racist attitudes and may also find that healthcare services are insensitive to their respective cultural needs. One of the major difficulties in highlighting the role of cultural factors is the danger of cultural determinism. As Helman (1990) points out, "viewing cultures as a thing that causes (and thus explains) the behavior of patients may lead to stereotyping. The effect of stereotyping is detrimental to good healthcare provision as the neglect of cultural factors" (p. 153).

Coupled with this, the reasons for failure and distortions in the communication process have rarely been assessed regarding the impact of ethnic factors. The studies that have taken into account the ethnic dimension have considered the access and utilization of services concerning communication rather than the internal dynamics of ethnicity in the consultation process Nasreen, et al. [16].

Paternotte, et al. [18] identified four significant intercultural communication challenges: language differences, differences in perception of illness and disease,

different perceptions of the social component of health communication, and doctors' and patients' prejudices and assumptions. Seeleman, et al. [12] conclude that illness is culturally determined because how we perceive, experience, and cope with disease is based on our explanations of sickness.

However, being competent in a particular cultural context does not necessarily imply that a person will successfully create meaning between two or more distinct cultural groups, what is called Intercultural Communication Competence, or that he or she will be able to adapt to unfamiliar cultural situations successfully. Thus, the question arises, how to obtain the skills and competencies needed to comply with the demands of a multi-ethnic society? We agree with Fox [10] that such training would entail more than raising awareness about the importance of cultural patterns and intercultural differences, improving communication skills, or role-modeling patient interactions. According to the author, such an endeavor will require "the systematic acquisition of in-depth knowledge and understanding of at least one society other than one's own" (p. 1318).

As part of the training in one particular ethnic group, we argue that it will also be necessary to train in that particular ethnicity's language skills. For example, in a pilot study conducted by Barkin, et al. [19], where physicians participated in a 2-week language immersion program, the authors found that the program helped improve their language skills, family perceptions of doctor-patient communication, and patient trust. The authors also commented, however, that the study had a small sample size and that the findings may not be generalizable to other programs. Nevertheless, despite the sample size, Barking, et al. [19] observed a significant positive effect with a short-term intervention focused on building language skills. Therefore, learning the language of a particular ethnic group is important, as well as its nuances and singularities. Still, the literature has overlooked language training that addresses ethnic differences relating to patient-doctor communication.

Weinick, et al. [20] state that Hispanics are a heterogeneous group; thus, language preference might be a more sensitive measure than ethnic sub-group designation for determining the preferences and needs of this population when interacting with healthcare providers. A recent study by Weinick, et al. [21] states that misconceptions of Hispanics as a monolithic population lacking within-group diversity could function as a barrier to efforts aimed at providing appropriate care to Hispanic persons and could be 1 factor contributing to inequalities in the availability, use, and quality of healthcare services in this population. The Hispanic population of the United States includes individuals from a wide range of backgrounds-from different countries with different cultures, different language abilities, citizenship status, and varying degrees of acculturation. To eliminate disparities and effectively and equitably provide healthcare services, the medical, public health, and health services research communities need to challenge their thinking and recognize the considerable heterogeneity within the Hispanic population of the United States. The authors concluded that recognizing significant intra- and inter-population differences allows healthcare policymakers at the local, state, and national levels to target services more appropriately to Hispanic subgroups at greater risk of healthcare disparities.

Furthermore, Roberts, et al. [22] emphasize the "language barrier" effect. The authors argue that patients who do not speak English may have a continuum of ability in terms of accuracy, fluency, and structuring of explanations and presentations of symptoms. Ross, et al. [23] explain that patients' explanations reflect how they want the doctor to perceive them as a patient and person: they reveal patients' identities. However, interpretations are complex when language and cultural background influences patients' English-speaking style. Misunderstandings arise from various linguistic and cultural factors, including stress and intonation patterns, vocabulary, how patients sequence their narratives, and patients and physicians pursuing different agendas.

Also, we need to address how we speak and conduct ourselves while talking, which pragmatic studies identified as politeness. For example, how direct to be, how much background detail to give before the main point, whether interrupting someone is rude or friendly, or what topics are permissible to discuss. The Politeness Theory Levison, et al. [24] assumes that we have two types of faces: positive and negative. A positive face is an individual's desire to be liked and appreciated by others. In contrast, a negative face is an individual's desire to protect their rights, such as their freedom of speech and action. For example, a Spanish-speaking patient interacting with a non-Spanish-speaking physician can protect their positive face concealing actions that may damage their self-image because of the language barriers. In Sociology, this is referred to as "saving face." Saving face is a strategy for avoiding humiliation or embarrassment, maintaining dignity, or preserving one's reputation.

The above exemplifies how these communication strategies can also impact the quality of health care services minorities receive. [25] argues that outcomes in health care, such as Compliance, satisfaction, etc., are directly related to the degree of cognitive disparity between the explanatory models of practitioner and patient and the effectiveness of clinical communication. According to the author, the physician must explore the patient's explanatory model

for the illness during the consultation and try to bridge the distance between the patient and the physician's conception of the health problem [27].

All things considered, it is often difficult for doctors to process what patients say if they have limited competence in the patient's dominant language(s) [28]. No matter how patient-centered a practitioner is or how determined to achieve a collaborative outcome, the crucial starting point is grasping the literal meaning of patients' talk. We cannot stress enough cultural and language differences are present in any particular ethnic group and within a single group [29,30]. It represents a challenge for modern practice and physicians to tackle these critical considerations while interacting with different ethnic groups during medical encounters.

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