PRACTICING CULTURALLY SENSITIVE CARE: WHAT CAN HEALTH CARE PROVIDERS DO?

by

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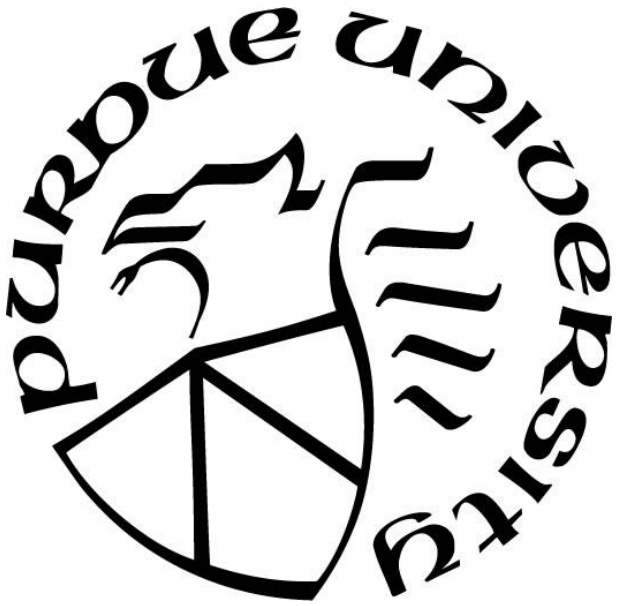

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For my Savior Jesus Christ, my husband Ford, my son Troy and my four-legs children Batsky and Mumu

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ABSTRACT

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Title: Practicing Culturally Sensitive Care: What Can Health Care Providers Do?
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This study investigates health care providers' perceptions and practice in culturally sensitive care. Previous studies mainly focus on patients' perspective, arguing the necessities and influences of having culturally sensitive care (Chau, Yu, & Law, 2014; Watt, Gulati, Shaw, Sung, Dix, Poureslami, & Klassen, 2012). Yet, as the key participants in promoting culturally sensitive care, health care providers' voices should be heard and understood. In order to explore this issue, 8 in-depth interviews were conducted with health care providers, including nurses, nurse practitioners, physicians and physician assistants, that lasted an average of 25 minutes. Interview questions with participants addressed issues in their perceptions of culturally sensitive care and the influential institutional and interpersonal factors of practicing it. The findings first revealed that health care providers tend to understand culturally sensitive care within the patient-centered care perspective. Their practice of culturally sensitive care is partially limited by language barriers, cultural barriers, and limited trainings in cultural sensitivity, while interpreting services, verbal and nonverbal communication strategies, collaborations with colleagues and self-education promote their practice of it. These findings underscore the importance of acknowledging health care providers' influences in promoting culturally sensitive care, and the necessity of offering adequate amount of teachings and trainings in cultural sensitivity at health care programs and hospitals.

CHAPTER 1. INTRODUCTION

The United States has a high number of immigrant populations compared to other countries. As of 2016, 13.5 percent of the United States population are immigrants (cis.org, 2018, September 25). Immigrants contribute not just to the economic development, such as locating their careers in professional fields and service industry, but they also enrich cultural diversity by bringing their culture into this country. At the same time, different cultural backgrounds make them face challenges in adapting to the US culture such as in navigating the health care system. Cultural values influence health seeking behaviors (Gao, Dutta, & Okoror, 2016; Nguyen & Lin, 2015), and compliance to health care treatment (Clegg, 2003; Watt, Gulati, Shaw, Sung, Dix, Poureslami, & Klassen, 2012). Immigrants reported that there are various barriers such as English proficiency, cultural beliefs, and structural factors that keep them from accessing health care services (Gao et al., 2016).

The first barrier is that some immigrants found language limited their ability with health literacy and this has also impacted their communication with their health care providers (Becher & Wieling, 2015; Gao et al., 2016). Cultural belief is the second barrier that influences their trust toward health care providers, and compliance to medical treatment (Clegg, 2003; Nguyen and Lin, 2015; Watt et al., 2012). For instance, Watt et al. (2012) found that Chinese immigrants trust their doctors less if the doctors are not willing to discuss complementary medicine with patients. As a result, immigrants experience health disparities. To find a method to reduce health disparities and guarantee immigrants' health care quality is essential. Researchers advocate that culturally sensitive care is one of the most efficient ways to reduce health disparities, suggesting that culturally appropriate care stands at the belief of patient-centered care (Chau, Yu, & Law, 2014; Spence Cagle & Wells, 2017). In particular, the aim of culturally sensitive care is to focus

on individual needs and respects patients' dignity and spirituality, and eventually help build trust and rapport between patients and health care providers as well as contribute to patients' compliance to providers' medical treatment (Clegg, 2003; Tucker, Wall, Marsiske, Nghiem, & Roncoroni, 2015). Therefore, the necessity and social significances of having culturally sensitive care inspires this study to develop a deeper understanding in making culturally sensitive care more accessible to patients and practical for health care institutions and health care providers.

Whereas current literature looks into patients' needs and positive social outcomes of utilizing culturally sensitive care (Chau et al., 2014; Clegg, 2003), this study explores this topic by standing at the health care providers' angle, understanding their narratives in delivering culturally sensitive care in real practice. Intending to enrich health communication scholars' research spectrum in further analyzing culturally sensitive care, this study looks beyond patients' perspectives and focuses on considering the standards and expectations of offering culturally sensitive care from the perspective of health care providers. Acknowledging the potential scholarly significance and urgent social needs, this study proposes that professionals who work directly with patients should make a daily and standardized module in promoting and improving culturally sensitive care. In the sections that follow, this study addresses this issue by first highlighting the theoretical framework of a culture-centered approach on which this study is based and reviewing previous studies on culturally sensitive care. In greater detail, this study analyzes the narratives from health care providers to investigate the way they deliver culturally sensitive care under the influences of structural and interpersonal factors, and the advantages as well as challenges they face in daily practice. This analysis is concluded by

discussing the necessities of listening to health care providers' voices in promoting culturally sensitive care, and the contributions this study has for institutions (hospitals, for example) as well as health communication research.

Literature Review

In general, three main themes emerged from previous research on culturally sensitive care: the definition of culturally sensitive care, the necessity of having culturally sensitive care, and the advantages of offering culturally sensitive care. Before diving into the discussion of previous research, this study highlights the culture-centered theoretical approach by which this study is informed.

Theoretical Framework

This study adopted a culture-centered theoretical approach to analyze health care providers' understanding of culturally sensitive care. Culture-centered approach (CCA) is a methodological and theoretical framework in health communication which values community members' participation and voices and seeks to break the barriers between the researcher and the participants through dialogue (Dutta & Basnyat, 2008). It suggests that "meanings are socially constructed via dialogue among cultural participants and researchers, and essential to these meanings is the broader context that surrounds them" (Dutta & Basnyat, 2008, p.443). Even though health care providers are the main participants of culturally sensitive care, rarely are their voices been addressed by research. As this study seeks to understand providers' perspectives of practicing culturally sensitive care, it is necessary for the researcher to have deep conversations with them for the sake of accessing their narratives within the context of health care and making meanings of their narratives. In his article of stressing the power of listening in CCA, Dutta

(2014) argued that listening opens up a theoretical entry point for having the community members' voices being heard and being represented in structures. With researchers listening and health care providers sharing, richer narratives about culturally sensitive care will emerge.

Specifically, CCA suggests that community-driven in-depth interviews are the pathway for listening to the marginalized voices in which open-ended questions are formulated initially to lay the ground for identifying the community's key problems and sketching out the scopes of solutions (Dutta, Anaele, & Jones, 2013). CCA proposes that projects grounded in this approach intend to coproduce knowledge in cooperation with local communities (Dutta et al., 2013). Acknowledging that CCA's meaning-making process provides avenues in investigating how "health meanings are constructed and employed in practice" (Dutta, 2008, p.1, as cited in Ross & Bell, 2017, p.731), health care providers' voices are the key in understanding how culturally sensitive care has been adapted in real practice. Having a voice means that people could "speak for themselves, make their own decisions and contest claims that do not resonate with a sense of who they are" (de Souza, 2009, p.696). This study positioned health care providers as the overlooked group whose voices have not been fully addressed by previous research. Within the purpose of addressing this gap, this study strives to provide a chance for providers to share their voices, proposing that health care providers' reflexivity in practicing culturally sensitive care empowered them in the process of constructing meanings with the researcher. As a result, CCA informs this study by listening to health care providers initially, and then construct meanings of practicing culturally sensitive care through the collaborations with participants.

Define Culturally Sensitive Care

The definition of culturally sensitive care varies. Generally, culturally sensitive care is a type of health care delivery that recognizes patients' cultural backgrounds and considers patients' needs, beliefs, and goals as significant indicators in delivering health care services (Lindsay, Tétrault, Desmaris, King, & Piérart, 2014). The definition varies based on how it is used in research. Tucker et al. (2015) specifically defines patient-centered culturally sensitive care as, "health care that embodies the characteristics identified by culturally diverse patients as enabling them to feel comfortable with, trusting of, and respected by their health care providers, office staff, and health care environment" (p.506). Different from Tucker et al.'s (2015) definition which focuses on the nature of the human relationship and advocates the positive interaction between patients and health care providers, Clegg's (2003) study on patient perceptions of culturally appropriate care specifically described culturally sensitive care as respecting individuality, creating "mutual understanding", catering for "spiritual need" and maintaining "dignity" (p.283). Specifically, Clegg (2003) explained that to respect a patient is to accept patients' rights in making decisions and taking actions based on their beliefs. To establish mutual understanding is to acknowledge the patients' unique backgrounds such as cultural beliefs and language preferences. Some patients address the significance of religion in their daily lives as well as hospitalization, and therefore believing meeting spiritual needs means understanding and catering to these specific religious requirements (Clegg, 2003). Finally, for patients to maintain dignity, providers should protect patients' privacy and respect their autonomy.

Under the definition of culturally sensitive care, few studies mention the approaches of delivering culturally sensitive care. For instance, Chau et al. (2014) discussed four general approaches to the provision of culturally sensitive health care services. The first is shared

cultural knowledge approach (SCK) which pays special attention to the difference between the minority groups and the general population, explaining that minority groups have their own values of treating health. Health care professionals should meet their needs by understanding their cultural beliefs and promoting health care services through their cultural methods (Chau et al., 2014, Chau, Yu, & Tran, 2011). The diversity-based approach (DB) focuses on the difference among members of one specific minority group, suggesting health care professionals and organizations to use diverse intervention methods such as subsidizing patients to use alternative medicine to provide health care services (Chau et al., 2014; Chau et al., 2011) The other two approaches, mainstream service approach (MS) and knowledge transfer approach (KT), stress "similarities". The MS approach suggests that minority groups also have the same needs as the general population for mainstream health care services. Thus, health care professionals should help these cultural groups overcome structural barriers such as lack of information through providing diverse methods of passing health care information (Chau et al., 2014; Gao et al., 2016; Tran, 2006). The KT approach proposes that minority groups attempt to share their knowledge with other groups, indicating that health care professionals should be encouraged to appreciate and acknowledge each other's cultural beliefs during health care services (Chau et al., 2014).

Ethnic-minority and Cultural-minority Patients Need Culturally Sensitive Care

After discussing culturally sensitive care, it is reasonable to assess how diverse populations in the United States need culturally sensitive care. Cultural beliefs and values influence patients' health seeking behaviors and compliance to medical treatment (Gao et al., 2016; Nguyen and Lin, 2015; Watt et al., 2012; Ye, Mack, Fry-Johnson, & Parker,

2012). Some ethnic-minority patients prefer to use self-medication and traditional treatment that are influenced by their traditional health beliefs (Ye et al., 2012). For instance, Asians and Pacific islanders have their beliefs of wellness, myth, and misconceptions about Hepatitis B (Nguyen & Lin, 2014; Pollack et al., 2011). These values in return influence their behaviors in seeking Hepatitis B screening and medical treatment help. In addition, the study by Watt et al. (2012) on Chinese parents of children with cancer found that cultural beliefs play an important role in complying to medical treatment. They found that these Chinese parents trust conventional western medicine in curing cancer. Yet, they also use food therapy and complementary and alternative medicine (CAM), which is more like traditional Chinese medicine (TCM). Participants in their study mentioned that due to a lack of culturally relevant information, they tend to hide their usage of CAM from their health care providers. However, they state that they would appreciate health care providers' open discussion regarding CAM use, and would comply more to the medical treatment if physicians were more aware of their cultural beliefs. Not only does the Asian populations have cultural concerns in the health seeking process, other ethnic-minority groups consider the factor of cultural beliefs as well. Hispanic patients place value in disease disclosure and acceptance, and they prefer to interact with "godlike" doctors (Spence-Cagle & Wells, 2017). These beliefs may cause misconceptions between them and health care professionals, and thus, culturally sensitive care should be presented.

Culturally sensitive care contributes to patient satisfaction (Tucker et al., 2015). Patient satisfaction is the evaluation patients have toward their healthcare providers based on affective, cognitive, and behavioral perceptions of care providers' behavior (Conlee, Olvera, & Vagim, 1993). Robinson (2008) summarizes two broad dimensions of patients' evaluation toward doctors. The first one is medical-technical, which focuses on professional medical skills and

knowledge. The second one is affective-relational, which involves perceptions of care providers' warmth, concern and trustworthiness. When patients have higher satisfaction, they are more likely to comply with physicians, sue physicians less often, and have better outcomes of health recovery (Conlee et al., 1993; Robinson, 2008). When patients feel comfortable and respected by their health care providers, this contributes to their overall satisfaction. Clegg (2003) pointed out that when patients reported being respected and understood through culturally appropriate care, satisfaction and positive interaction with their health care providers improved. In addition, Tucker et al. (2015) found that patients will be more satisfied if health care providers and staff, such as front desk staff and nurses, show cultural sensitivity toward them. Therefore, within the importance of patient satisfaction, patients and health communication scholars believe that patient-centered culturally sensitive care is effective and necessary in health care service (Tucker et al., 2015; Wanzer, Booth-Butterfield, & Gruber, 2004).

Culturally Sensitive Care Reduces Health Disparities

Besides being patients who need culturally sensitive care, diverse populations also need culturally sensitive medical information to keep healthy and reduce disparities in their access to health care resources. More than 70 percent of Americans believe that inequalities in access and quality of health care are more unfair when compared to the inequalities in health outcomes (Lynch & Gollust, 2011). Health care disparities influence people regardless of their social and cultural group (Wilson, Thorpe, & LaVeist, 2017). Multiple factors caused health disparities. From the economic perspective, the rise of neoliberalism increases economic insecurity and under-employment in high-income regions, enlarging health inequalities in the long term

(Labonté & Stuckler, 2016). One of the most influential results is the widening gap in health insurance coverage that restricts access to health care and increases health disparities (Siddiqi, Wang, Quinn, Nguyen, & Christy, 2016). Besides, Carreon and Baumeister's (2015) study suggests that racial and ethnic residential segregation also influences health care inequalities in terms of access to diagnostic, screening, and preventive services, indicating that segregation is "a fundamental cause of health care disparities" (p. 1451).

In addition to general structural influences on health disparities, studies have summarized specific barriers of appropriate care. Accordingly, groups, influenced by health disparities, have financial challenges, including disproportionately low socioeconomic status, financial instability, and lack of health insurance coverage (Andrew, 2014; Gao et al., 2016; Hong, Holcomb, Bhandari, & Larkin, 2016; Siddiqi et al., 2016). Andrew's (2014) study on Medicaid expansion found that people who are in the 24 states where Medicaid has not been expanded, are not only ineligible for Medicaid, but also are ineligible to receive federal subsidies for purchasing individual health insurance. These low socioeconomic populations will be less likely to have access and resources to appropriate health care. Siddiqi et al.'s (2016) study also reflects this problem, showing that people who have low house-hold income are less likely to have a regular doctor. As for immigrants, non-citizenship is the major trigger that keep them from having health care access. For instance, when compared with US-born Asian Americans, foreign-born Asian Americans have less access to health care, including health insurance, routine care and sick care access (Ye et al. 2012). Also, immigrants who work without citizenship or permanent residency, such as nail salon and restaurant employees, report that since they are undocumented, it is impossible for them to have health insurance. They could not afford it even if when they had access (Fung, 2014; Gao et al., 2016). Finally, language barriers block communicative access

into health care. For some immigrants, their inability to communicate in English to their doctors impeded their motivations to seek health care (Chau et al., 2014). Fung (2014) found that the language barrier and absence of culturally and linguistically appropriate health care services reduces the comfort level immigrant women have when discussing their medical condition. Additionally, language barriers restrain some populations' access of health literacy. Gao et al. (2016) defines these language barriers as communicative inaccess, which is "expressed in the absence of knowledge about health resources, the location of these resources, and the communicative processes through which these resources can be secured and navigated" (p.736). As a result, people with limited English proficiency will be marginalized from mainstream health care services.

For the sake of minimizing these barriers of having appropriate health care, research suggests culturally sensitive care could efficiently reduce health disparities as it offers particular services to people based on their needs (Gao et al., 2016; Lindsay et al., 2014; Ye et al., 2012). For instance, as for people who want culturally and linguistically understandable health care information, it is a good method of providing multiple language medical information on health care websites as well as using bilingual social workers to serve for specific groups (Gao et al., 2016; Lindsay et al., 2014). For patients with limited English proficiency, linguistical servives such as interpreting services could help them in better understanding their health care providers (Hsieh & Kramer, 2012). Scholars also suggest that hospitals' cultural sensitivity training, which includes more culturally sensitive health education about "chronic diseases, medications, available health services, and modes of access" (p. 736), could also help to reduce health disparities within the hospital context (Ye et al., 2012).

Summary and Rationale

Previous literature on culturally sensitive health care mainly comes from the patients' perspective, arguing the necessities of offering culturally sensitive care, and the influence or impact of failing to provide such sensitive care (Chau et al., 2014; Watt et al., 2011). Little is known about how health care providers understand culturally sensitive care, how they practice it, and what they could do to make it easier to utilize in their daily routines. Yet, research on patients' perspectives suggests that health care providers should be aware of the importance of culturally sensitive care and practice this method more in their daily basis (Clegg, 2003; Watt et al., 2012). Since health care providers are the key participants in promoting and practicing culturally sensitive care, research should investigate to understand the barriers and opportunities of utilizing culturally sensitive care. Furthermore, as the definition of culturally sensitive care categorizing patients from all different cultural backgrounds such as different gender, age, and ethnical backgrounds as the group who needs cultural sensitivity, this study specifically considers culturally sensitive care from the intercultural spectrum, exploring how health care providers practice culturally sensitive care with patients from different ethnic and cultural backgrounds. As a result, this project seeks to address this issue and propose the following research questions:

RQ_1: How do health care providers understand culturally sensitive care?

RQ_2: How do health care providers practice culturally sensitive care in daily routines?

RQ_3: What structural factors, such as hospital policies, influence their practice of culturally sensitive care?

RQ_4: How do health care providers describe their experiences of practicing or not practicing culturally sensitive care?

CHAPTER 2. METHODS

The techniques from grounded theory were utilized in this study. In greater detail, the purpose of grounded theory is beyond description; instead, it focuses more on interpretation, prediction and explanation (Mellion & Tovin, 2002). It proposes that meaning is created through individual's interpreted experiences (Bodgan & Biklen, 2003) as it could "offer insight, enhance understandings, and provide a meaningful guide to action" (Strauss & Corbin, 1998, p.12, as cited in Jacelon & O'Dell, 2005, p.50). Knowing that this study aims at disclosing and explaining the meanings of health care providers' narratives of practicing culturally sensitive care, it is necessary to comprehensively interpret their experiences and then create deeper meanings from these narratives. Thus, grounded theory is useful in the meaning-making process by offering techniques and guidance in demonstrating explanations of each categorized theme. The specific utilizations of grounded theory were demonstrated in the following sections. In particular, semi-structured interviews were conducted with 8 participants during data collection period, and comparative analysis especially the axial coding was used for data analysis.

Participants

With an exemption obtained from the Institutional Review Board, the researcher started recruiting participants from a regional hospital in a mid-western city. The current study applied criterion sampling, convenience sampling and snowball sampling strategies to recruit potential participants. As Lindlof and Taylor (2017) summarized, criteria are defined in inclusionary terms and a criterion is usually derived from a theoretical

definition or a commonly understood definition. This study intended to listen from health care providers, thus the eligibility of participants must fit the criteria of being 18 years of age or older, must be employed as a health care provider such as a nurse, nurse practitioner, physician assistant or physician, and must have experiences of interacting with patients from different cultures. Moreover, understanding that providers from different cultural backgrounds may have different interpretations about culturally sensitive care, this study purposefully chose Caucasian providers as an entry point for the goal of investigating how providers with the same cultural background interact with patients from other cultures. Convenience sampling, which is composed of the most readily available people who agree to participate (Lindlof & Taylor, 2017), was utilized at the beginning of sampling recruitment. The researcher first reached out to a nurse who works at the Emergency Department of the hospital through the available contact information on the hospital's website. This nurse agreed to be the contact person to recruit other potential participants. The researcher then sent out the recruitment flyer to this nurse, and this person forwarded the recruitment information to colleagues by using their working emails. 4 participants initially responded to participate. The next step involved snowball sampling that "yields a study sample through referrals made among people who share or know of others who possess some characteristics that are of research interest" (Lindlof & Taylor, 2017, p.147). The researcher invited these 4 participants to refer this message to other health care providers who might be interested in this study. As a result, another 4 participants enrolled for this study. These participants are all Caucasians, consisting of 5 females and 3 males (see Appendix A). Among them, there are 3 registered nurses, 2 physician assistants, 1 nurse practitioner and 2 physicians. The years of being a health care provider varies from 4 years to 18 years, with an average of 8 years. Besides one participant who works as an at-home nurse, the other 7 participants currently

work at the Emergency Department. However, all of them have working experiences in other health care departments including acute care, doctors' offices, dialysis clinic and hospitals.

Data Collection

Semi-structured interviews were conducted between January 2019 and February 2019. In order to keep consistency and stimulate discussion, semi-structured questions were developed from the literature review by focusing on three key questions (How do you understand culturally sensitive care? How do you practice it? What influences your ability to practice it?). These questions explored their understanding of culturally sensitive care, their experiences of practicing it, and other factors that limit or encourage them to practice culturally sensitive care (see Appendix B). Other elaborated questions had also been asked during interviews based upon what the participants shared. For example, one participant shared that non-verbal communication is important. The researcher followed this up with 2 questions: what kind of nonverbal communication is important and how does it influence your practice.

Participants were contacted individually to schedule one-on-one interview with the researcher. 5 interviews were conducted in the hospital break room, and 3 were conducted in a coffee shop upon participants' requests. Upon arrival, the researcher explained the purpose of the study to participants. Once participants understood the purpose of this research, they were asked to sign the informed consent form. The researcher made a copy of the signed consent form later and sent it to the participants to keep as a record. The interviews lasted from 11 minutes to 39 minutes with an average of 25 minutes. All interviews were audio-taped and transcribed by the researcher. In total, there were 68 pages double-spaced interview transcripts.

Data Analysis

The current study used techniques from grounded theory such as the constant comparative analysis for the data analysis and codes the dominant categories and themes. Lindlof and Taylor (2017) defined constant comparative analysis as a method that opens up "an impenetrable 'black box'—data analysis—and unpacked a formal, iterative process of coding and conceptualization" (p.321). Guided by the process of open coding: "go through the texts (fieldnotes, transcripts, documents) line by line and 'categorize a chunk of data on the basis of its coherent meaning—its standing on its own—not by an arbitrary designation of grammar'" (Lindlof & Taylor, 2017, p. 322), the researcher first started with going through the transcripts and categorizing data into similar categories. For instance, participants shared language barrier as a challenge of practicing culturally sensitive care, the researcher coded all the words, phrases and sentences that relate to "language" or "language barrier" as a theme – "language challenge." The next step was to compare all the codes and to decide which category each code should belong to. As soon as the researcher noticed participants mentioned many barriers that prevent them from practicing culturally sensitive care, the researcher created a category named "barriers of practicing culturally sensitive care" and put the code "language challenge" into this category. Through the constant comparative method, themes sharing the same meanings were placed into the same category respectively. The last step was integration and dimensionalization. Accordingly, integration is to define and reconfigure the existing categories and to justify two or more categories together as one category, while dimensionalization is the last step in grounded theory to examine each category and tease out the key variations (Lindlof & Taylor, 2017). For example, the researcher initially had separate categories of verbal communication and nonverbal communication, and after integration, recategorized them under "communication strategy in

practicing culturally sensitive care" and identified its dimension as efficient tools to promote culturally sensitive care. As the categories were theoretically saturated, the researcher tested the validity of all emerged themes through internal validity, "in which a research instrument makes only the distinctions that it is intended to make" (Lindlof & Taylor, 2017, p.354). Specifically, the researcher first aligned these saturated themes separately with the narratives that were shared by participants, and then re-tested the validation through thick, rich descriptions of each theme. For instance, under the barriers of practicing culturally sensitive care, the researcher compared this category with all the shared narratives that relate to this theme, and then re-compared these narratives with the thick description of what are the barriers that prevent health care providers from practicing culturally sensitive care. The theme was found valid. All the other themes were deemed valid as well.

CHAPTER 3. FINDINGS

Three categorized themes emerged from participants' narratives: common understanding of culturally sensitive care, barriers to practice culturally sensitive care, and ways that promote the delivery of culturally sensitive care. Explanation and examples from each theme are explored below.

Understanding Culturally Sensitive Care

The first theme to emerge is health care providers' understanding of culturally sensitive care. In this theme, participants described and explained how they perceive culturally sensitive care from their practical experiences. Specifically, health care providers described culturally sensitive care in three parts: to recognize the difference, to adapt to the difference and to offer better treatment. Most health care providers explained that to recognize the difference is the first step to initialize culturally sensitive care, requiring them to have the ability to observe and to be aware of the cultural difference patients may have. For instance, Esther, who has been a nurse for almost 5 years, shared the necessities of recognizing differences in providing culturally sensitive care:

> Knowing what is acceptable and preferred for a client in their culture. What they like eye contact or handshaking or body language, how they interpret different things. Just knowing, knowing how to be culturally sensitive, knowing what things mean to them and being aware of it. Um, traditions and preferences for cultures. (Esther)

Knowing the difference is the most significant part in her experiences of giving culturally sensitive care as it gives her initial ideas in how to give proper care based on certain patients'

needs. In addition to knowing, other health care providers agreed that to recognize is to not only be aware of the differences, but to also acknowledge these differences.

> I would explain culturally sensitive care as being an awareness that other people may have different practices for daily living or rituals as far as their meal planning or their religious preference. They may differ from what we would see as "normal" for what our culture is. So just being receptive to the fact that not everybody does everything the same way, and that's not necessarily wrong, it's just different. (Rachel)

Similar to other participants' opinions, Rachel, a nurse practitioner in the Emergency Department for 10 years, pointed out that being attentive is important in culturally sensitive care, and on the other hand, they should also be "receptive" to different cultures. This means that health care providers have to be open-minded in treating patients from different cultures, accepting their differences and understanding their specific needs. Health care providers expressed that as long as they are able to see these differences as normal, they would have the ability to treat patients equally and properly. As the first layer of understanding culturally sensitive care comprehends the importance of acknowledging cultural difference, it supports the practical applications of shared cultural knowledge approach which requires health care professionals to know patients' cultural beliefs and understand patients' cultural differences in culturally sensitive practice (Chau et al., 2014).

The second step is to adapt to the differences. Health care providers shared that once they acknowledged the differences, they would try to adapt themselves into the patients' cultural backgrounds and treat them with unbiased care. Cody, who was an international travel nurse before settling down in the Emergency Department, shared his understanding of culturally sensitive care. He believes that the ability to adapt to the

differences is the essential part of culturally sensitive care, explaining that utilizing culturally sensitive care is a method that equips him to give equal and non-biased care regardless of patients' difference such as "language barriers, cultural differences, religious differences." Bob, a physician assistant, further explained how health care providers acknowledge the difference and then adapt to it:

> I'd say being mindful of different cultures and diversities and treating everyone with the same compassion and care that you would have to any other patients. And I think being sensitive to different cultural backgrounds and understanding that different cultural backgrounds might have different types of interactions. Just recognizing that every culture has their different beliefs, you need to be understanding and sensitive to people's backgrounds and their cultural upbringings and kind of that nature. That's the thing. I try and treat every patient kind of similar. I do as far as my compassion and everything of that nature. It's important to, I think to kind of understand that culturally that we are different. (Bob)

Bob shared that he knows patients may have differences, but he still treats every patient with the same care and compassion. This sharing is similar to the mainstream service approach that suggests minority patients have the same needs as other patients so that they should be treated equally despite of their differences (Chau et al., 2014). To adapt to the difference automatically assists providers to treat patients with the same attitudes. In addition, Sadie, another physician assistant in the Emergency Department, provided an example where she recognizes and adapts to the cultural difference:

> Well, just acknowledging the patient's personal needs. The person's culture. You know, many Middle Eastern people are very modest. We got a lot of Burmese people in, their

> cloth are a lot of layers and they are very uncomfortable of taking off the clothing. You know, you have to be very sensitive to that. You have to be aware of that. You have to be aware who is in the room too, and the religious practices too which is probably the part of the cloth they wear. (Sadie)

As Sadie mentioned, she first tries to understand her Burmese patients' cultural backgrounds and then refines her behaviors while being sensitive to the patient's needs. Her behavior established mutual understandings where she acknowledged patients' religion differences and adapted to it naturally (Clegg, 2003). It is obvious that health care providers' efforts in adapting the differences facilitates the efficiency of culturally sensitive care in terms of treating patients with un-biased attitudes.

Their attitudes and abilities of recognizing difference and offering unbiased care gradually contribute to their ultimate goal of practicing culturally sensitive care: to provide the best treatment to patients regardless of their cultural differences. This is the third layer of understanding culturally sensitive care. As observed in the following remarks, participants believed that the common goal of giving culturally sensitive care is to improve a patient's health seeking experiences and give them the best care they deserve:

> To provide the best care for your clients. (Esther)
>
> I think it's just all-encompassing trying to figure out how to best treat the patient and take into account all those extenuating circumstances. (David)
>
> Obviously, the goal of any kind of care is just to provide the best medical care for that specific patient. Whether it be bridging disabilities or health aging and disabilities or whether it be providing optimal communication so that they understand the plan. I guess doing whatever we can, and whatever is in our power to limit stereotypes and to bridge

> those gaps. Those walls that will be built by different cultures, to break down those walls and to bridge the gaps to ultimately provide the best care for the patient. (Wendy)

What these quotations highlight is that culturally sensitive care serves to provide the best care to patients. No matter how health care providers acknowledge and adapt the differences, their purpose of culturally sensitive practice is to make sure patients receive what they expect, and to improve the health outcomes. Specifically, to provide the best care requires health care providers to be flexible to their treatments based on patients' cultural needs:

> Culturally sensitive care, in my mind means that you are using the education you have about a culture to customize the treatment and take care of them better as a whole. Be able to take care of them and educate them effectively. Get what they need and to be better, and they won't come back hopefully for a year standpoint. (Emma)

As Emma, a nurse in the Emergency Department for 7 years, mentioned, "to customize the treatment" is to provide care based on certain patients' specific cultural needs. Providers have to choose treatments that fit properly to patients' cultural concerns. For instance, some participants shared that when patients refuse blood transfusions, they would try their best to provide alternative treatments for the sake of giving the best care to the patients. This also aligns with shared cultural knowledge approach as it suggests health care providers facilitate health care services through patients' cultural methods (Chau et al., 2011). Moreover, some participants agreed that to give better treatment also means that health care providers should make patients feel comfortable and be understood so that they could open up to and trust their health care providers. For instance, Sadie pointed out the importance of easing patients' fear and making them feel comfortable through providing culturally sensitive care. She explained that the goal of providing culturally sensitive care is to know patients' cultural needs and to make them feel as comfortable as possible

especially when patients are sick or in difficult situations. By saying this, she implies that when patients feel comfortable, they would be willing to trust and share their illness information to their providers. Once the rapport is built up, it is easier for providers to know more about the patient and to give appropriate care accordingly. Likely, Rachel further explained that to make patients feel comfortable is to ensure patients that they are being respected and well cared for so that patients trust the health care environment as well as their health care providers to determine which better treatment could be delivered efficiently:

> I think the goal of culturally sensitive care would be to make sure the patient feels like they are understood, they are safe, and they are practicing to what they are used to doing and not to feel inappropriate or wrong. And to make sure the patient was well cared in their comfort zone, and what their beliefs are. So like somebody who doesn't take blood products or whatever you do everything you can to avoid that for their religious belief. (Rachel)

As culturally sensitive care expects health care professionals to help patients feel comfortable and being respected (Tucker et al., 2015), both examples suggest that culturally sensitive care could provide a comfortable atmosphere for patients to express their health needs without doubt, and to trust and comply to their health care providers' medical decisions that eventually would help in offering the best care that patients are warranted.

Barriers of Practicing Culturally Sensitive Care

The second theme focuses on the barriers of practicing culturally sensitive care in which health care providers demonstrated that there are some limitations that restrict their practice. In general, three barriers emerged limiting health care providers' practice: language barrier, cultural barrier, and limited trainings.

Language Barrier

Health care providers repeatedly discussed how language barriers stop them from practicing culturally sensitive care due to the absence of direct communication between them and their patients. For health care providers, direct communication with patients is essential as it enables providers to get the first-handed and most accurate illness information from the patients. However, for patients with limited English proficiency, it is very hard for both patients and providers to understand each other and exchange necessary information (Becher & Wieling, 2015). Language barriers sometimes could even threaten patients' safety since patients cannot understand medical treatments correctly and are not able to follow medical instructions (van Rosse, de Bruijne, Suurmond, Essink-Bot, & Wagner, 2016). As the participants stated, if they cannot interact with patients directly through verbal communication, it is challenging for them to not only provide culturally sensitive care, but any care to their patients. Rachel stated, "If they can communicate that (cultural needs) to me so I understand that this is a cultural thing." By saying this, she means that if patients are able to express their cultural needs and concerns clearly and directly to health care providers, they could give proper treatments based on patients' requests. For the sake of providing the best care, health care providers shared that sometimes language barriers put them in a situation where they have to do unnecessary tests for patients:

> It's very hard with people speaking different languages to translate for them. I feel terrible for that because sometimes you don't get the whole story, so you have the tendency to order everything. If you don't know if anything is wrong, but it doesn't mean they don't have something going on, and that's very frustrating. (Sadie)

From Sadie's example, language barriers limits information flow in hindering providers in securing full medical history as well as patients' cultural concerns. Within this situation,

providers cannot give culturally sensitive care since there was not enough information exchanged, and they have to do unnecessary exams to make sure patients have been well-cared for. Similar to Sadie's experiences, David, a physician in the Emergency Department, shared a story where he had to do more tests on a patient, who is deaf and cannot understand English, to figure out her illness problems. He explained that within the language barrier, it takes more time to communicate information and decide treatment plans by trying different medical approaches even if the treatments turned out as unnecessary.

Though providers do these unnecessary tests for the sake of fulfilling culturally sensitive care's goal of providing the best treatment to patients regardless of cultural differences, this practice may cause misunderstandings between patients and providers merely due to the limited information flow with language barriers. Participants articulated that sometimes patients would understand that their health care providers are doing things for their benefit, while other patients would not understand their treatments and would doubt and not trust their providers:

> I have seen more people think that you think they don't understand, or you think they are stupid because they have a different language or they understand your language differently, and they will say that, 'You just think I'm stupid.' No. I'm trying to explain to you so we are all on the same page because I don't think that. Sometimes, I think despite all of your best efforts, if they, they have that preconceived, they had bad experience before, or who knows what they told her when they put the pacemaker in, so he has to have it or he is going to die. I don't know her preconceive. Because of language barrier, I was not being able to pass it to find out. I think we are really sensitive to their culture. They think nobody listens to them, nobody believes them. And I think that creates barriers as well. So despite every effort to try to overcome those, sometimes you just can't. (Rachel)

Rachel's experience articulated that with the language barrier, health care providers cannot convey and receive information sufficiently, and the lack of information flow eventually makes patients refuse the communication with their health care providers by blocking health care providers' channels of giving culturally sensitive care. Thus, if misunderstandings happen, it is difficult to offer culturally sensitive care or to accomplish the goal of it.

Cultural Barrier

Another obstacle is the "cultural barrier". This obstacle captures the unfamiliarity with different cultures due to the vast amount of cultures and variations within these cultures. Esther explained that every culture has its broad spectrum, and it also contains various types of subcultures such as different dialects, religions, and expectations. It is easier to know the general rules of a culture, but difficult to know the specifics. The health care providers, though, are willing to provide culturally sensitive care, but all the different cultures and subcultures make them feel unsure about what behaviors are acceptable and what behaviors are not. They shared that they could not assume patients' beliefs or daily practices solely based on their general cultural backgrounds. For instance, Sadie shared that she has Burmese patients who have different dialects and different cultural beliefs even though they are all under the big umbrella of the Burmese culture. She could not treat all her Burmese patients in the same way; instead, she has to learn to interact with these patients differently.

Additionally, health care providers pinpointed different interpretations of a culture also challenging their knowledge and understanding of cultures, saying that for cultures which they think they are already confident with, differences and misunderstandings still impact daily encounters:

> I would say sometimes hearing different things about a culture, like someone might think they understand the culture, 'I've lived here 20 years or whatever it is, this is how the culture operates,' and then another person who is from that culture says, 'No, this is how the culture operates,' but my experience with the patient is they tell me they don't care. I feel like that's the hardest part for me sometimes balancing different ideas about what a culture may want or may operate, and then my personal interaction with a patient, individuals might just feel differently about things. So that, that would be what I would say the most difficult thing is the complexity of it. (Cody)

Cody's experiences highlight how culture is complicated and various on the context of different perspectives. Participants expressed that it is unreasonable to require them to be familiar with all the cultures. While having these ambiguities, providers are restricted in giving culturally sensitive care as they could not determine what is appreciable and what is not in certain cultures. The constant changing nature of a culture also exerts challenges in knowing cultures:

> Every day we go to work and we work in the ER where you get such a melting pot of people, I'm learning still, you know. So there's never, I don't think there's ever going to be a day where I feel 100% comfortable recognizing and treating. There's always going to be some level of questioning, there's just always going to be that learning curve. And times change too, you know, like trends and things are popping up all the time. I'll never get to a point where I feel like I'm an expert in culture or you know, an expert in knowing about everyone's different cultures. It's just too, there's too much. I mean, before moving to town, I don't think I ever had a Burmese patient. And now we have a large Burmese population here. So I mean it's just, there's always going to be some new learning curve. (Wendy)

Wendy, a physician in the Emergency Department for 5 years, interacts with new cultures on daily basis as part of her daily routine, and she also meets the same culture with different dynamics. Within the constant changing environment that leads to cultural changes, health care providers have to learn different cultures and update their understandings of cultures from daily practices, it is thus unrealistic to expect health care providers to be fully confident in handling patients from different cultures in their daily routines. These cultural challenges include different types of cultures, multiple subcultures, and different interpretations of one culture from different perspectives. The changing nature of cultures also results in health care providers' unfamiliarity and uncertainties of cultures, which prevents providers from practicing culturally sensitive care.

Limited Trainings in Providing Culturally Sensitive Care

Limited cultural sensitivity training is the last barrier to emerge from the data. None of the participants have received specific and targeted cultural sensitivity trainings at work. Hospital "training" includes a little bit of information about cultural sensitivity at new employee orientation, and yearly computer trainings focuses more on cultural-sense topics such as how to take care of geriatric and bariatric patients and less on international cultures.

What stands out is the lack of continuous training on how to communicate sensitively with other cultures. When the researcher asked, "Do hospitals have any cultural sensitivity trainings?" responses included:

> They only do it in orientations. I don't think they ever do it again. (Rachel)
>
> I think there might've been a session, when I was first hired on, when we went through training, there was a little about it. (Bob)
>
> No, absolutely not. I didn't get any training for that when I came to the job. (Sadie)

These answers demonstrated that hospitals are failing at providing an adequate amount of cultural sensitivity trainings. This is further supported by the lack of guidelines or policies hospitals have about practicing culturally sensitive care. Without guidelines and training, health care providers lack the knowledge of specific methods on how to practice culturally sensitive care while still remaining true to hospital's policies. Thus, this situation limited their culturally sensitive practice, and they could only rely on their experiences and exposures to different cultures to explore the right way of providing culturally sensitive care.

Despite the hospital's failure of giving related trainings, the participants recalled the training they had about culturally sensitive care was during their schooling, such as nursing school, physician assistant or nurse practitioner programs and their doctor residency. However, these school trainings were not specifically designed for culturally sensitive care as they lack systematic curriculums and detailed content about cultural sensitivity. As participants described, these school trainings were one or a few class sessions under one particular course which requires students to discuss the general daily practices and common beliefs that different cultures and ethnicities may have. Bob, on recalling his school days, said he only had a little bit of cultural sensitivity trainings in his clinical rotations class and he never had a dedicated course for culturally sensitive care in his physician assistant program. Unsurprisingly, Sadie shared a similar experience:

> We did have like a discussion one day. It was ethnic class. We did one day discussion about different people, ethnicity, and how to handle different situation, how to handle family. Things like that. So yeah, we very lightly covered it, but not to any extent. We talked a little bit about Middle Eastern culture, how they vary, the women don't speak to men, typically speak for the women, and just how to be sensitive to that because you have the

> tendency to talk when you want to get good history of the patient, you want to talk to the patient themselves. We talked about people who don't take blood products, and just how to handle that. Things like that, I'm not remembering all of that because it was so long ago. (Sadie)

Cultural sensitivity training occurred during a one-day class where they only lightly covered related topics, and these discussed contents faded away after few years. When further asked about how these classes teach them to handle cultural differences, participants responded with "just being sensitive" without remembering any details. They shared that these class discussions only gave them a brief overview of cultures, they still rely on themselves to figure out how to give culturally sensitive care. Without a dedicated course or systematic trainings or teaching, health care providers lack a solid understanding of culturally sensitive care.

Ways of Promoting Culturally Sensitive Care

Even though there are barriers of practicing culturally sensitive care, participants suggested that there still are many ways that aid them in practicing culturally sensitive care. These aids help providers in better understanding patients' cultural concerns and choosing proper treatments which promote the efficiency of culturally sensitive care. Specifically, these methods are interpreter services, communication strategies, collaborations with colleagues, and self-education.

Interpreter Services

Language is perceived as the main vehicle in the health care process, and when providers and patients do not share proficiency in the same language, interpreters are involved as the solution to bridge the differences (Becher & Wieling, 2015; Hsieh, 2009). With language serving

as a challenge health care providers face in communicating with patients, interpreting services are one way to address this problem. Hospitals have translation services available where health care providers could plug in the translation phone and the translator will start interpreting between the patient and the health care provider. Emma explained:

> A lot of times, with the language barrier, we have a translator phone we can use. And that is credible, because that is the service we have. It basically makes sure that these translators pass certain tests, they can work for that company that does translation. (Emma)

Like other participants, Emma believed that the translation services provided by hospitals are credible and reliable, ensuring them that the interpreting services could help them to break the language barriers. Besides hospital's translation service, other interpreting methods are also used. Since family are the most convenient and comfortable source of interpreters whom patients consider as more trustworthy and helpful (Hsieh, 2006; Rosenberg, Leanza & Seller, 2007), health care providers prefer to use them to bridge the language gap:

> I will do a lot of things to try to bring family members that may understand English better. Sometimes especially with people who have children here, but they were from another country. The children might be a little bit of mixed culture. But they can bridge the gap better, depending on their age of course. If there are family numbers maybe they can help with some of these things. If there is a staff member that has a similar background they can help as well. We will get an interpreter phone or anything like that. If I have the opportunity, so let me have someone else who can talk to you, I could pull off my physicians or someone else. (Rachel)

Accordingly, Rachel prefers to use family as they have advantages in speaking two languages and knowing the patient's medical history as well as the cultural concerns. Similarly, participants agreed that family members sometimes could be a good resource to bridge the gap between patient and health care providers through offering explanations in language-related and culture-related problems. Bilingual health care professionals are another good source for interpreting services. These interpreters have a level of interpretation, and they are also credible and reliable of having familiarity with medical knowledge and patients' cultural needs. This knowledge enables them to give medical suggestions to their colleagues (Hsieh, 2006). For instance, David recalled that during his doctor residency, there were Hispanic physicians who assisted their coworkers by translating and sharing cultural information of Hispanic patients with the provider. Even though interpreting services are available for most of the time, participants mentioned that Google translation or other translation apps also assist them in their work. Esther explained:

> The hospitals provide translators and they also, we have a translator phone. Um, I'm even in a pinch. I have used Google translate on an iPad before, whatever I need to do. I know that Google translate is not 100% and I get a lot of giggles sometimes because it does translate words or sentences kind of funny, but they get the idea of what's being said. So, um, making, uh, making it an attempt in any way that I could. (Esther)

Though some of these translating sources are not as reliable as professional interpreting services, Esther would try these "ready" technologies, which helps her a little bit in understanding the patients, to break the language barriers with patients. Wendy also acknowledges the usefulness of auto-translation services where she finds Google translation is very user-friendly and patients appreciate her try in bridging the language gap. Therefore, while Google translation is not as accurate as the professional interpreting services, health care providers still value its

convenience, and use it as an alternative option to weaken the language barriers for the sake of providing culturally sensitive care.

Verbal and Nonverbal Communication Strategies

The second way to facilitate culturally sensitive care is through using verbal and nonverbal communication strategies. Physicians' verbal and nonverbal communication behaviors influence patients' compliance, patients' satisfaction and ratings of physicians' rapport and medical-technical skills (Robinson, 2006; Wrench & Booth-Butterfield, 2003). Utilizing proper communication strategies in doctor-patient interactions would significantly improve health outcomes. Specifically, verbal communication strategies include asking open-ended questions and clarifying information. Health care providers shared that sometimes patients did not understand their treatments or disagreed with the care plan due to the cultural differences. When this situation happened, they would use verbal communication strategies to explain to patients. For instance, they would keep asking patients questions to try to find answers:

> Usually I'll say 'are you saying no because of this or are you saying no because…' 'Are you saying no because you don't have time? Like do you need to go, do you need to leave?' 'Are you saying no because you personally just don't believe that? You don't believe in this you have like a cultural sensitivity to it.' 'Are you saying no because you're afraid it might be painful or you're afraid because you don't understand it? Can I help explain it more?' So yeah, I'll try again. That's just more communication, right? Just answering, you know, or analyzing like where there's a lack of understanding. I do ask those questions like, 'so why, what is it about this recommendation that you aren't in agreement with?' A lot of times there's different answers, and you'll be surprised. (Wendy)

As indicated by Wendy's example, she would not stop asking clarifying and open-ended questions until she and the patients mutually understand each other. This helps her in understanding patients' needs better contributing to her abilities in offering culturally proper care. Like Wendy's way on conveying information, other health care providers also prefer to ask questions until they understand patients' concerns. As they explained, the more information they get from patients, the easier they could offer proper care. Besides, they would also clarify things as clear and easy to understand as possible for the sake of helping patients to understand the purpose of certain treatment:

> I try and just, I guess sometimes speak more slowly and put it in more generalized terms and um, a lot of times I put it back on them and I just asked them, 'okay, what is it that you want me to help you with?' Or 'what am I missing?' and just try and go back to the basics, I guess. (David)

David's remark shows that he uses the language that patients could easily understand and explained things from the basic knowledge to the deeper meanings. While Bob shared that as medical information seems more reliable and trustworthy to patients, he would explain and clarify everything from the medical aspect by explaining why medically he is doing certain tests. In addition to clearly describe treatment, clarifying is also being used when health care providers need to explain alternative treatments:

> I really just explain exactly. I explain. I tried to be open minded and coming up with multiple options for things. I think that we're lucky enough here in the United States, we have the resources to always have more than just one option for a particular problem. So I tried to say, you know, here's all of our options. Let's see, kind of what option fits best for you. And sometimes the decision is none of them, you know, sometimes the decision is 'I

> don't want any of this', and that's ok too, because usually 99% of the time the patient has that right to make those decisions for themselves. I always just try. I try to over communicate with the patient that, you know, here's all of our options here and let's try together. (Wendy)

Wendy shared that she is "over communicating" with patients as she repeatedly clarifies and explains treatment plans by using different words and phrases. This method has been brought up by most participants, stating that they would patiently repeat their explanation multiple times until patients understand and could make a decision. These verbal communication strategies not only assist them in better understanding patients' needs, but also help patients to better make decisions, it ultimately support them in administrating culturally sensitive care.

In addition to verbal communication, nonverbal communication, especially nonverbal immediacy cues, also has significant influence on delivering culturally sensitive care. Nonverbal immediacy cues are behaviors such as smiles, close distances, touch, forward lean, eye contact, head nods, and gaze that reflect interpersonal warmth, liking, and lessening the degree of psychological distance between people (Bodie & Jones, 2012; Guerrero, Hecht, & DeVito, 2008; Jones, 2004; Jones & Wirtz, 2007; McCroskey & Richmond, 1992). As the primary way people use to communicate closeness, patients who have lower English proficiency, nonverbal immediacy cues would ease their fear, and weaken their uncertainty toward health care providers (Guerrero et al., 2008):

> I always do, just because I don't want them to feel afraid. I know the little girl was there by herself, she was crying, she spoke English, and I was kind of patting her with smile to her family, so they kind of nod if they were understanding. Just to make sure they were understanding. You can tell some of the family understood a little bit of English, I think

> the grandmother did. And I, yeah, I always made eye-contact with smiling and nod because it makes them feel a lot better. I can't imagine what would it be like, going to a foreign country and having people speak to you and having no idea what they are saying. (Sadie)

Sadie's nonverbal immediacy cues are a universal language which she uses to convey favor and caring. Once her patients feel her warmth and caring, they would feel comfortable to interact with her and trust her. Health care providers agreed that to make patients feel comfortable, especially when cultural differences are presented, is vital in encouraging patients to open up their concerns. As nonverbal immediacy cues adequately equip them with the ability to earn patients' trust and satisfaction, providers who use appropriate nonverbal immediacy cues found it is earlier for them to encourage patients to share illness information. Other than smiling, nodding and making eye contact, health care providers acknowledged other helpful nonverbal immediacy cues, including sitting down on their stool and getting closer to patients while talking to them. They would try to avoid any power positions such as crossing arms while talking and avoid standing over patients. All these nonverbal immediacy cues significantly improved the relationship between health care providers and patients. One possible explanation of nonverbal immediacy cues' function in earning trust and efficiently delivering culturally sensitive care is that it can serve as emotional support in which providers use these immediacy cues to comfort patients with empathy and involvement (Jones, 2004; Jones & Guerrero, 2001).

Collaborations with Colleagues

The third method that helps practicing culturally sensitive care is collaboration with colleagues. The environment of the hospital requires health care providers to engage in teamwork, assisting each other in providing the best care to patients. It is necessary for them to

collaborate with coworkers to better understand patients' needs and concerns and then choose the best suitable treatment plan for patients. Participants expressed that they always share their knowledge about different cultures with each other:

> I had a coworker that was Haitian, he taught me a lot about just the Haitian culture, about their preferences, um, languages, things like that, that would, that would definitely help me out with cultural care. (Esther)

Esther's colleague shared his cultural experience with her, helping her in learning the Haitian culture more and better preparing her in dealing with patients from this culture in the future. Health care providers would also voluntarily ask coworkers for suggestions in dealing with patients from certain cultural backgrounds:

> If I have a patient with something like that, sometimes if I know that my physician, my nurse or whoever is the same culture, I will ask questions like, 'if there is something I should be doing different or whatever.' If something is different that I'm not supposed to, I know there is a staff number then I would ask. Sometimes volunteers, they know things, there is struggle there with something that is weird or whatever. So yeah, we do work together on some of those. (Rachel)

Rachel reached out to coworkers for cooperation in treating patients from different cultures through asking questions directly and to requesting colleagues to check whether she is giving care in a proper way. Her willingness of seeking cooperation advanced her ability in better knowing her patients and giving proper care. Similar to Rachel's recall, health care providers said that they would remind their colleagues about some behaviors that they should pay attention to when patients have specific cultural concerns. For example, Emma shared that she once had a patient who is deaf but can read lips. She kindly reminded her colleagues to make sure they look

at this patients' eyes so that this patient could understand what they are saying. As Emma knew this patient's special condition, reminding other coworkers the appropriate way in interacting with this patient helped her colleagues in giving the appreciable care.

Other than these situations, collaborations also emerged when health care providers need to work out alternative treatments upon patients' cultural requests. For instance, Sadie recalled a story where she had a patient who refused to take blood transfusion. In order to save this patient's life, Sadie paged other health care providers including a nurse, a physician and a pharmacist to work together to find out the alternative treatment for this patient. Luckily, they saved this patient. The same kind of collaboration also happens when health care providers have to give their patients to another provider who is more suitable for the patients' cultural concerns:

> I had a Muslim patient a little while ago and it just got assigned to my name. It was a female Muslim. I walked in and she had like a head covering and I just walked out and asked if one of my female coworkers would switch with me because she's a female. Um, it's going to be a lot more comfortable for her if she's got a female nurse. And so, and there was some pushback and I had to do some explaining like of my experience working with, with Muslim women. Then the female coworkers switched with me. (Cody)

Without his colleague's collaboration, it is very likely that Cody would fail to give culturally sensitive care to this patient. Thus, collaborations are beneficial in advancing culturally sensitive care as teamwork with coworkers boost providers' insights into patients' cultural beliefs and improve providers' efficiencies in interacting with patients from various cultural backgrounds.

Self-education

Self-education is a valuable method for health care providers to improve their cultural sensitivity and behavior before encounter (Core, 2008). Health care providers in this study found

that self-education helps them in giving culturally sensitive care, explaining that the more culture they learned by themselves, the better care they can provide. Specifically, there are two main approaches that participants use to educate themselves of different cultures. The first is through personal exposure and experiences to different cultures, including learning from patients with diverse backgrounds. Sadie shared that she initially did not know the cultural practices of her Burmese patients. Yet, as she encounters more Burmese patients, she updated her knowledge of the Burmese culture from her daily interaction with these patients. For instance, she said she would never treat their yellowish makeup as jaundice again as she knew it is one of their unique cultural practices. The more cultural information she learned from these patients, the more confident and comfortable she is with these patients. Besides, learning from personal experiences of exposure to a diverse culture is also helpful.

> Even if I don't understand their culture, I can like more be ok if there's something that I don't understand about their culture and if I need to adapt to them in some way. So cause I've seen differences and what not. (Cody)

As an international nurse who worked in some African and Middle Eastern countries for four years, Cody's experiences of being exposed to many different cultures and religions helped him develop more confidence and comfortable feelings in treating patients with different cultural backgrounds. He could comfortably offer culturally sensitive care to patients without fears and hesitation.

Another self-education approach that is defined by participants is voluntarily self-education such as self-research and attending related educational courses. Esther shared that she always does research by herself to seek out more cultural information about the possible patients she would have. This equipped her with more confidence and assurance in meeting with different

patients and giving culturally sensitive care. Other participants would do the same as Esther does, sharing that when they have patients from a specific culture that they are not familiar with, they would do research by themselves to be better prepared for the future. In addition, some health care providers would even take intercultural courses if available online or in other continuing education conferences.

As participants articulated, either through actively self-learning, or through experiencing different cultures, self-education is significantly helpful for them to update their medical and cultural knowledge, benefiting them in becoming a more competitive and considerable health care provider:

> I just think if you put yourself out there to learn about different cultures and educate yourself. It's just something I'm kind of interested in. so I do it myself. I don't feel you can mandate it necessarily, but I just feel like, you know, as a nurse, any better information or education I could get to help myself to help my patients would be advantageous. (Emma)

This quote from Emma echoes other participants' points of view, implying that health care providers value the necessity of having continuing education on culture-related information that advance them as a better health care professional, as well as aid them in promoting culturally sensitive care properly.

CHAPTER 4. DISCUSSION

This study intends to explore health care providers' understandings of culturally sensitive care, aiming to answer how they perceive it and what influence their practices. The findings from this study highlight health care providers' common belief on patient-centered culturally sensitive care and considers the structural and personal factors that influence their practices critically. The findings are further analyzed to respond to the initial research questions through their connections to previous research. Practical implications and limitations are also offered.

The findings provide answers for the first research question: *how do health care providers understand culturally sensitive care*, suggesting that health care providers view and practice culturally sensitivity within the patient-centered care spectrum. Health care providers believe that culturally sensitive care is presented through acknowledging patients' cultural needs and providing proper care with respect and consideration. They stressed that their ultimate goal of practicing culturally sensitive care is to give the best treatment to patients with patients' compliance to it, believing that patients' concerns and health is the priority. Accordingly, patient-centered communication treats the patient as a whole person considering patient's psychological, physiological, and social background, and it reduces patients' anxiety of diagnostic tests, improves patients' health status, and increases efficiency of care (Sparks, Villagran, Parker-Raley, & Cunningham, 2007; Stewart et al., 2000). Providers thus consider patient-centered communication as the most efficient way to fulfill this goal, implanting this belief into their daily practice of culturally sensitive care through constantly listening to patients' needs and choosing medical treatment correspondingly.

Their belief of patient-centered care leads to the answer of the second research question: *how do health care providers practice culturally sensitive care in daily routines*. Specifically,

health care providers always engage in recognizing patients' cultural concerns in the first place, and then they adapt patients' cultural differences into their decisions of offering appropriate treatment. Instead of considering their own convenience, this process of practicing culturally sensitive care demonstrates that health care providers place patients as the center. This is consistent with previous research, which suggested that culturally sensitive care is patient-centered care in which providers should recognize and consider patients' cultural needs, and patients should feel comfortable with and respected by the provider (Lindsay et al., 2014; Tucker et al., 2015). Furthermore, culturally sensitive care advocates respect, implying that patients have the right to make decisions, to keep their spiritual needs as well as speaking the language they prefer (Clegg, 2003). This claim also has been supported in this study. The participants revealed that they choose treatment for their patients by being aware of patients' spiritual prohibitions, explaining the treatment to their best ability through using interpreting services, and leaving the patients to make the final decisions. All these practices further support that health care professionals value patient-centered care in their daily practice of offering culturally sensitive care.

In terms of the third research question: *what structural factors, such as hospital policies, influence their practice of culturally sensitive care*, findings suggest that structural factors are the indicators of health care providers' practice of culturally sensitive care, meaning that the more structural resources they receive, the more efficient they could deliver culturally sensitive care. This study considers two structural factors including hospital support and school curriculums. First, Real (2007) suggests that health care organizations' policies influence the quality of communication between health care providers and patients. These hospitals' policies are usually the guidelines and principles for health care professionals, directing health care providers' daily

practice through trainings and mandatory policies. Health care providers recall that the hospital did not provide any cultural sensitivity trainings at work, nor did they offer specific guidelines or instructions on how to give culturally sensitive care. The lack of an organization's directions and guidelines limit health care providers' abilities in giving culturally sensitive care in a way that health care providers have uncertainties about to what extent their cultural sensitivity is acceptable by both patients and hospitals. Nevertheless, despite insufficient cultural sensitivity trainings and policies, hospitals' support such as interpreting services assists health care providers' practices. Language is perceived as the main vehicle between patients and health care providers, enabling them to communicate concerns and share medical information (Becher & Wieling, 2015). If patients and providers do not share proficiency in the same language, interpreters must be involved as the solution to bridge the differences (Hsieh, 2009). Participants in this study acknowledged language barriers as one of the most difficult aspects of practicing culturally sensitive care, stating that language difference results in information loss and miscommunication. Luckily, with the hospital's translation service, this issue has been significantly improved. From this perspective, hospitals' support is essentially helpful to health care provider's daily practice. Without available interpreting services, it is almost impossible for health care professionals to give culturally sensitive care. Thus, this study suggests that if hospitals fail to address culturally sensitive issues through providing trainings or detailed policies and fail to provide proper services such interpreters, it is unlikely to expect health care providers to perform acceptable culturally sensitive practices in their daily routines. On the contrary, if hospitals could give the proper amount of support, health care providers' practice of culturally sensitive care could be advanced.

The second structural factor this study wants to stress is school curriculums, which are designed to prepare future health care providers to be culturally sensitive in their future careers. Previous scholarships suggested that schools and hospitals must require current or future health care professionals to undergo cultural trainings so that they will be more aware of the importance of cultural factors in treatment and outcomes (Gonzalez, 2008). Participants shared similar experiences that their cultural sensitivity trainings mainly took place during their school years either through few class sessions or focused lecturing. As health care providers showed decent and considerable insights about culturally sensitive care, this study assumes that school curriculums on cultural sensitivity could help providers to gain knowledge and develop abilities in giving proper care so that health care providers' competence of giving culturally sensitive care could be predicted by how much cultural trainings they received from school.

The finding of personal influences lays the foundation to the last question: *how do health care providers describe their experiences of practicing or not practicing culturally sensitive care*, proposing that power and privilege were presented through health care providers' descriptions of their daily practice of culturally sensitive care. Providers held power in the medical exam room, they have the autonomy to decide whether they would give culturally sensitive care or not, to control what assistance they want to use to deliver proper care, and to decide what options of treatments they could offer to patients (Apker, 2012; Street, 2003). Participants reported that they are the person who initiated the cultural sensitivity practice, choosing translation services when they think patients could not understand and selecting certain communication strategies when they notice patients may misunderstand. When in need of collaborations, participants reported that they would collaborate with their colleagues instead of collaborating with patients. They would consider their own education on cultures as vital so that

they could better persuade patients to comply to their treatments and properly educate patients with more medical information. Even though they believe in patient-centered care, it seems that health care providers consider themselves as playing the dominant role in practicing culturally sensitive care, while patients passively receive what they provide. This belief aligns with the dominant culture that values formal education, professional hierarchy, and professional ethics, attributing health care providers with authority and prestige (Becher & Wieling, 2015). Yet, culturally sensitive care is two-way communication in which health care providers could show cultural sensitivity initially and patients could request cultural sensitivity as well. Within the context of providers' desire to take up the dominant role, it is very likely that patients' desire and voices cannot be fully expressed and heard. It also takes more time for providers to get medical information if patients are not allowed to actively express themselves first. Culturally sensitive care will function better if health care providers would share their authorities with patients, enabling patients to have more chances in expressing themselves and requesting the care they want.

Practical Implications

From the findings, this study suggests that although health care providers are the most important part in giving culturally sensitive care to patients, institutional support from hospitals and schools is also important. This study proposes that institutional support is mainly cultural education for both health care students and practicing professionals. These educational opportunities could be different educational modules such as peer-mentoring, training programs and case problem solving (Core, 2008). The participants reported that they received limited trainings in cultural sensitivity from the hospital, and they expect hospitals would give them more educational support and organizational policies in practicing culturally sensitive care.

Within this in mind, this study advocates that hospitals should offer regular trainings that target cultural sensitivity specifically to their providers. As recommended by the participants, these trainings could be included as one part of the medical educational modules that are mandatory for health care providers, or it could be focused lecturing that is offered regularly. Knowing that there is vast amount of different cultures, hospitals do not have to introduce all the cultures; instead, prominent cultures in certain regions should be educated. For instance, Burmese culture is prevalent in the area where this study has been conducted; thus, the regional hospital of this study should offer related cultural training about this culture to their providers. Besides regular training and education, hospitals could also choose other convenient educational methods such as hanging flyers about different cultures in hospital break rooms and sending out weekly educational emails. Finally, the findings indicate that providers have uncertainties of practicing culturally sensitive care within hospitals' expectations, this study also advise that hospitals should prepare health care providers to be able to decide when and to what extent they could give culturally sensitive care. These could be realized through providing culturally sensitive care guidelines and having specific cultural sensitivity policies available. For instance, recalled that providers have the intention in ordering unnecessary tests for patients due to the language barriers, hospitals could set up instructions on how many tests providers should request to reduce potential misunderstandings or conflicts between providers and patients.

From the participants' narratives, their schools failed to offer adequate number of classes in teaching them how to practice culturally sensitive care, and their memories of the limited leanings also faded away due to the lack of systematic learning process. As a result, this study proposes that school is the first place where health care providers are exposed to related knowledge about culturally sensitive care, it is necessary for schools to improve curriculums and

to have systematic courses to teach future health care providers the proper skills in delivering culturally sensitive care. As Core (2008) suggested that student-oriented educational models should be interdisciplinary, multi-cultural and community-oriented, schools could offer intercultural classes from the medical perspective, teaching how different cultures influence patients' understanding of disease, and their compliance to treatments. In addition, specific strategies should also be covered in such courses. These strategies include interpersonal strategies such as communication strategies in getting information about patients' cultural concerns and medical histories, and abilities in recognizing cultural differences. If possible, certain mock conversations regarding how to treat patients from different cultures should also be provided.

Furthermore, in acknowledging health care providers' authority in the exam room, health care providers should also use their advantages to involve patients into collaborations for the sake of getting patients' medical history and hearing patients' desires on how much cultural sensitivity they expect. Specifically, the findings from this study suggest that verbal and nonverbal communication strategies help providers in better understanding patients' needs, other health care practitioner could also encourage their patients to talk through verbal strategies such as asking questions and nonverbal immediacy cues such as nodding and eye-contact. Furthermore, as self-education is being largely valued by the health care providers in this study as well as other researches (Core, 2008), providers should equip themselves with more cultural knowledge through self-education such as voluntarily seeking and learning cultural information by attending intercultural trainings and doing self-research.

For health communication scholars, the findings from this study provide them new opportunities to further explore the practical utilization of culturally sensitive care. First, the

participants shared that interpreting services helped them in better practicing culturally sensitive care. Yet, the function and efficiency of each interpreting service is not the same. Thus, health communication scholars could investigate this issue deeper to find out what influence providers' choices of interpreting services under the goal of efficiently providing culturally sensitive care. Communication strategies also have been valued by participants, health communication scholars therefore could consider the specific applications and potential limitations of verbal and nonverbal communication strategies in promoting culturally sensitive care, sketching out instructions in directing providers use effective communication strategies in interacting with patients.

Limitations and Future Studies

Like many studies, this study has limitations in terms of participants selection and research scope. The first limitation focuses on the parts of the hospital represented. The researcher recruited all but one participant from the same department of one regional hospital. Thus, the homogeneity of our participants limited the findings, meaning that our participants could have similar experiences including having the same practice environment and the same hospital policies of practicing culturally sensitive care. In addition, as all the participants are Caucasians, the findings of this study may have higher homogeneity in which the participants might have the same perspectives in interacting with patients from other cultures. Yet, providers from different cultural backgrounds may have different interpretations and understandings in giving culturally sensitive care. Different health care environment would also influence providers' practice such as the time they would spend with patients (Lammers, Barbour, & Duggan, 2003).). Thus, this study suggests that future studies can address these limitations by choosing health care providers from different departments, hospitals, regions, and different

ethnicity groups, expanding the sample size and comparing different perspectives from different types and different ethnicity of health care professionals. The second limitation is that this study did not test how a large scale of structural factors such as health insurance and the US health care system influence providers' practice of culturally sensitive care. For instance, as fee-for-service and managed care are the major financing forms of healthcare, some physicians get paid by each medical service they provide (Apker, 2012; Real & Street, 2009). The more medical services such as X-ray, physical exams and immunizations physicians order, the more they would get paid. Besides, health care providers also have to take insurance companies' approvals into consideration when ordering tests, their practice of culturally sensitive care might be limited by the insurance policy (Apker, 2012). Hence, future studies should investigate these issues to consider how these structural factors influence providers' purpose and practice of culturally sensitive care, and to further develop a comprehensive understanding of the challenges, advantages and outcomes of providing culturally sensitive care in a broader context.

CHAPTER 5. CONCLUSION

Listening to health care providers' narratives of practicing culturally sensitive care in their daily basis offers a new lens in investigating the practical applications of culturally sensitive care. Considering the fact that scholars have been continually stressing patients' voices in arguing the necessities of having culturally sensitive care while overlooked health care providers' voices about its practical utilizations, the absence of health care providers' input in previous studies silenced their voices. As marginalization indicates "one discourse being voiced while another discourse is silenced," having health care providers' voice being heard assures them to have a space to "break marginalizing practices through reflexivity" (Koenig, Dutta, Kandula, & Palaniappan, 2012, p.820). Even though health care providers are not considered as marginalized group, directed by the culture-centered approach, this study provided a space for providers to express their concerns through their identity, experiences and standpoint. As a result, this analysis finds that providers' narratives mirror their belief of patient-centered care. Although the findings of this study agree with other studies that health care providers hold power over patients in the health care settings, the researcher argues that under the context of practicing culturally sensitive care, they only demonstrate their privilege when deciding the ways of offering culturally sensitive care. Rather, the value of patient-centered care is still implanted in providers' daily practice, urging them to make medical decisions with primarily considering patients' needs. The findings of this study also show the unfolded problems (the limited trainings at work, for example) as well as the possible opportunities (such as collaborations with colleagues) that culturally sensitive care has.

Looking beyond health care providers' importance in further understanding culturally sensitive care, recognizing the challenges and opportunities that health care providers face in the

real world of practicing culturally sensitive care benefits medical practitioners and scholars in the same level. Specifically, this study contributes to practitioners in two levels. For health care providers, this study gives them references in rethinking their daily practice of treating patients from different cultures. As narratives are shared by the same community members, it serves to provide deeper insights into providers' practice, enabling them to critique the status quo they have in offering such care. Culture-centered approach enables the marginalized voices to be heard by stakeholders such as policymakers through the partnership of academic researcher and community members, together identifying structure barriers and having conversations with community members to establish influence (Dutta et al., 2013). By situating health care providers as an overlooked group in previous studies, this study provides a space for them to voice their concerns of culturally sensitive care so that stakeholders, such as hospital policymakers and school curriculum designers, can obtain practical knowledge from them and would take their narratives into considerations when (re)considering the practical utilization of culturally sensitive care. Thus, acknowledging that health care providers play a significant role in offering culturally sensitive care, this study is constructive for hospitals to reconsider their training programs and policies of culturally sensitive care and is helpful for schools to redesign their curriculums in offering cultural sensitivity classes.

On the other hand, this study also benefits the health communication research. First, through using culture-centered approach, this study fills the gap where previous studies failed to address health care providers' voices in considering the practical utilization of culturally sensitive care. This study was able to listen to unrevealed narratives from providers about practicing culturally sensitive care, providing a different angle in understanding its practical usefulness. From what the study have found, health communication scholars can conduct further

research in exploring influential factors and practical guidelines for providing culturally sensitive care. Their potential findings (advancing interpreting services, for example) could benefit policymakers in improving the detailed instructions of culturally sensitive care. Future health communication scholars could also consider using culture-centered approach as a way to create equal chances to let marginalized groups' concerns (such as minority patients) and overlooked groups' voices (such as policymakers) to be heard by more communication research as well as health care practitioners. The effort in listening to various types of voices would offer different aspects and interpretations in advancing current knowledge of culturally sensitive care.

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APPENDIX A. PARTICIPANTS DEMOGRAPHIC INFORMATION

Name (Pseudonyms)	Race	Gender	Provider Type	Length of Practice
Emma	Caucasian	Female	Nurse	7.5 years
Rachel	Caucasian	Female	Nurse Practitioner/Nurse	18 years
Sadie	Caucasian	Female	Physician Assistant	10 years
Cody	Caucasian	Male	Nurse	8 years
Esther	Caucasian	Female	Nurse	4.5 years
Wendy	Caucasian	Female	Physician	5 years
Bob	Caucasian	Male	Physician Assistant	4 years
David	Caucasian	Male	Physician	5 years

APPENDIX B. INTERVIEW QUESTIONS

1. Have you ever taken trainings that teach you how to practice culturally sensitive care? If you need to explain what is culturally sensitive care, what would you say?
2. Do hospitals/doctor's offices have guidelines for you for how to give culturally sensitive care? Do you think these guidelines/expectations are realistic or appropriate?
3. Do hospitals/doctor's offices or any other colleagues ever tell you what to do to practice culturally sensitive care? Do you follow their instructions? Why?
4. What do you think is the goal of culturally sensitive care?
5. Do you feel that it's easier to practice culturally sensitive care for some patients but not others? Why?
6. Were you ever in a situation that a patient was not satisfied to your treatment due to the lack of shared cultural knowledge? How do you handle such a situation?
7. If you notice that you and the patient misunderstood each other or seem confused, what do you do?
8. Were you ever in a situation that you and a patient had significant cultural differences or have significant differences in their way of handling illness information? Why is that? How do you resolve the situation?
9. Do you try to educate doctors/nurses/patients about how to interact with each other? Why? Why not?
10. What is the most difficult aspect of practicing culturally sensitive care?
11. What is the most important skill for practicing culturally sensitive care?
12. Do you think doctors/nurses and other health care providers should learn the skills to deliver culturally sensitive care? What kinds of skills are important?