THE ROLE AND RELATIONSHIP OF
CULTURAL COMPETENCE AND PATIENT-CENTEREDNESS
IN HEALTH CARE QUALITY

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ABSTRACT: Patient-centeredness and cultural competence have been promoted extensively in recent years as approaches to improving health care quality. This paper explores the historical evolution of both concepts, demonstrating that early conceptual models focused on how health care providers and patients interact at the interpersonal level, while later models were expanded to consider how patients were treated by the health care system as a whole. The models are compared at both the interpersonal and health care system levels to demonstrate similarities and differences. Although the two concepts have grown out of separate traditions, each with its own focus, many of the core features of patient-centeredness and cultural competence are the same. Each approach holds promise for improving the quality of health care for individual patients, communities, and populations.

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EXECUTIVE SUMMARY

In recent years, patient-centeredness and cultural competence have been promoted as integral components in improving health care quality. Although these two approaches to health care delivery have grown out of separate traditions—each with its own focus—they have many similarities. This paper presents and compares models of patient-centeredness and cultural competence, and discusses their implications for improving health care quality at the level of interpersonal care and at the health-system level.

Patient-centeredness originated in the late 1960s as a way of characterizing how physicians should interact and communicate with patients on a more personal level. Core features include: understanding the patient as a unique person, exploring the patient's experience of illness, finding common ground regarding treatment through shared decision-making, and an emphasis on building the doctor–patient relationship. In essence, patient-centeredness involves perceiving and evaluating health care from the patient's perspective and then adapting care to meet the needs and expectations of patients.

While health care providers play an essential role in delivering patient-centered care, health care systems should also strive to be patient-centered. The Picker–Commonwealth Program for Patient-Centered Care began in 1987 to promote a patient-centered approach to hospital and health services, focusing on patients' needs and concerns. Some of the dimensions emphasized included: respect for patients' values, preferences, and expressed needs; coordination and integration of care; provision of information and education; and involvement of friends and family. In its 2001 report, *Crossing the Quality Chasm,* the Institute of Medicine (IOM) endorsed patient-centered care as one of six aims for health system improvement. Initiatives to promote patient-centered care include efforts to improve relationships between patients and providers, as well as efforts to make systems more responsive to patients' needs and preferences.

The issue of cultural competence in health care emerged later than did patient-centeredness. The term "cultural competence" did not begin to appear consistently in the medical literature until the early 1990s. The primary impetus for this movement in the last decade has been the demonstration of pervasive racial and ethnic disparities in health care, most notably publicized in the 2002 IOM report, *Unequal Treatment.* The report and its underlying research gave rise to an explosion of interest in culturally competent care.

Cultural competence must also be considered in the context of decades-old initiatives to eliminate the cultural and linguistic barriers between health care providers

and patients, which can interfere with the effective delivery of health services. Sometimes described as "cross-cultural," "transcultural," "multicultural," or "culturally sensitive," these efforts were initially targeted at immigrant or refugee populations with limited English proficiency and exposure to Western cultural norms. Some efforts had the potential to emphasize culture-centered, rather than patient-centered care, which proved to be a drawback. That is, these efforts emphasized patients as members of ethnic or cultural groups, rather than as individuals with unique experiences and perspectives, possibly leading providers to stereotype and make inappropriate assumptions. With time, the cultural competence movement tempered this emphasis on specific cultural groups and expanded in scope to include all people of color, particularly those most affected by racial disparities in the quality of health care.

As in the patient-centeredness movement, pioneers of cultural competence recognized that disparities in health care quality may result not only from cultural and other barriers between patients and health care providers but also between entire communities and health care systems. Hence, there was a need not only to train culturally competent providers, but also to design culturally competent health care systems. To this end, efforts have been extended to make health care more accessible to people of color; to make the health care environment more inviting and culturally congruent with preferences of the patient population; to have providers and staff more ethnically similar to the community served; to offer interpreter services for those with limited English proficiency; and to collect data on quality of care stratified by race and ethnicity to track disparities in quality.

Both patient-centeredness and cultural competence aim to improve health care quality, but each emphasizes different aspects of quality. The primary goal of the patient-centeredness movement has been to provide individualized care and restore an emphasis on personal relationships. It aims to elevate quality for all patients. Alternatively, the primary aim of the cultural competence movement has been to increase health equity and reduce disparities by concentrating on people of color and other disadvantaged populations. Nevertheless, there is significant common ground between the two. To deliver individualized care, a provider must take into account the diversity of patients' perspectives, and so—to the extent that patient-centered care is delivered universally—care should become more equitable. Likewise, to the extent cultural competence enhances the ability of health care systems and providers to address individual patients' preferences and goals, care should also become more patient-centered.

At the core of both patient-centeredness and cultural competence is the emphasis on seeing the patient as a unique person. Proponents of cultural competence often make reference to the patient-centered approach when suggesting methods of interaction between patients and physicians. Thus, while not the exclusive focus of cultural competence, the general characteristics of patient-centered care (e.g., building rapport; exploring patient beliefs, values, and the meaning of illness; finding common ground) may be endorsed as aspects of cultural competence. Conversely, because cultural context is relevant to the care of all patients, not only to people of color, cultural competence has the capacity to enhance patient-centeredness and improve quality for all patients.

While patient-centeredness and cultural competence are highly congruent at the provider level, the same is not necessarily true at the level of health care systems. For example, culturally competent health systems may focus on recruitment of a diverse workforce, while patient-centered health systems may emphasize patients' ability to e-mail providers or have access to electronic medical records from home. Many commonalities remain however, such as the general belief that services should be aligned to meet patient needs and preferences; that health care should be available in communities, convenient to patients' homes; that educational materials should be tailored to patients' needs, health literacy, and preferred language; and that information on performance should be publicly available.

Because the cultural competence and patient-centered care movements both aim to improve health care quality in similar ways, it may seem reasonable to combine these efforts into a unified agenda. However, while many features are similar, there are important, disparate aspects of each (see Figure 1 on page 14). Patient-centered physicians and health care systems will benefit people of color and reduce disparities in health care quality, and culturally competent physicians and health care systems will benefit all patients and improve overall quality. As such, the authors recommend that patient-centeredness and cultural competence remain distinct but aligned efforts to both elevate and balance the quality of health care for all patients (Table ES-1).

Table ES-1. Recommendations for the Future

1. Health care organizations should employ principles of patient-centeredness and cultural competence to ensure care is individualized and equitable.

2. Researchers should use and refine measures of cultural competence and patient-centeredness, and explore the impact of their unique and overlapping components on patient outcomes.

3. Educators should develop multidisciplinary programs to improve the patient-centeredness and cultural competence of health professionals.

4. Health care organizations should measure and track patient-centeredness and cultural competence as part of their efforts to deliver high-quality care.

5. Patients should provide feedback to health care systems by participating in surveys and focus groups, for example, to ensure that organizations attend to patients' diverse needs and preferences.

THE ROLE AND RELATIONSHIP OF CULTURAL COMPETENCE AND PATIENT-CENTEREDNESS IN HEALTH CARE QUALITY

INTRODUCTION

In recent years, patient-centeredness and cultural competence have been promoted as integral to improving health care quality (). Although patient-centeredness and cultural competence have grown out of separate traditions—each with its own focus—they have many similarities. Health care that is patient-centered is likely also to be culturally competent, and culturally competent care is likely to be patient-centered. Proponents of patient-centeredness may therefore view cultural competence as within its purview; likewise, proponents of cultural competence may view patient-centeredness as an essential element. This paper presents and compares conceptual models of both patient-centeredness and cultural competence, and discusses their implications for improving health care quality at the individual and health-system levels.

THE EVOLUTION OF PATIENT-CENTEREDNESS

The term "patient-centered medicine" was originally coined by Balint in 1969 to express the belief that each patient "has to be understood as a unique human being."[1] The concept has evolved and expanded, and today, no one would deny that health care should be patient-centered.[2] However, despite universal endorsement of patient-centeredness, there is considerable ambiguity in its definition and use across settings. To understand this variability, it is worthwhile to examine the evolution of the concept.

Early Conceptions of Patient-Centeredness

With its origins in Balint, patient-centeredness began as a descriptive account of how physicians should interact and communicate with patients. In 1984, Lipkin and colleagues described the patient-centered interview as one that "approaches the patient as a unique human being with his own story to tell, promotes trust and confidence, clarifies and characterizes the patient's symptoms and concerns, generates and tests many hypotheses that may include biological and psychosocial dimensions of illness, and creates the basis for an ongoing relationship."[3] According to Lipkin, patient-centered practitioners have specific knowledge (e.g., are able to name various ways to characterize a symptom, can define countertransference, or identify different types of interview questions), attitudes (e.g., has unconditional positive patient regard and respect for patient autonomy and individuality), and skills (e.g., can elicit patients' story of illness, express interest and commitment to patients, and overcome barriers to communication).[4]

Shortly after Lipkin described the patient-centered interview, Stewart and colleagues depicted the patient-centered clinical method as one in which the physician aims to gain an understanding of the patient as well as the disease—as opposed to an approach focusing strictly on the disease—through a process of addressing both the patient's and the physician's agendas, instead of addressing only the physician's agenda.[5] Later, Stewart outlined six dimensions of patient-centered care: exploring the illness experience, understanding the whole person, finding common ground regarding management, incorporating prevention and health promotion, enhancing the doctor–patient relationship, and being realistic about personal limitations.[6]

In 2000, in an effort to summarize the volume of literature that describes the features of patient-centered encounters between patients and practitioners, Mead and Bower developed a conceptual framework similar[7] to Stewart's, which includes five dimensions: adopting the biopsychosocial (i.e., not narrowly biomedical) perspective; understanding the patient as a person in his or her own right, not merely as a body with an illness; sharing power and responsibility between the doctor and the patient; building a therapeutic alliance; and understanding the doctor as a person, not merely as a skilled technician.[8] Noticeably absent from this framework (in contrast to Stewart's account) is any mention of disease prevention or health promotion. Mead and Bower focused their framework on patient-centeredness as a style of interaction and communication with patients, while Stewart delivered a more comprehensive approach to patient care, as within the family medicine arena.

In a succinct summary of patient-centeredness, McWhinney described the approach as one where the "physician tries to enter the patient's world, to see the illness through the patient's eyes."[9] This notion of "seeing through the patient's eyes" has become the most concise description of patient-centeredness, and has led to further development of the concept of patient-centeredness. By looking through patients' eyes, it may have become clear there is a great deal more to fix in the health care system than the interaction style of practitioners.

Patient-Centeredness as Integral Component of Health Care Quality
The Picker–Commonwealth Program for Patient-Centered Care began in 1987 to promote a patient-centered approach to hospital and health services focusing on the patient's needs and concerns. Seven dimensions of patient-centered care were identified: respect for patients' values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of friends and family; and transition and

continuity.[10] The program clearly went beyond the more narrow interpretation of patient-centeredness as a way for physicians to interact with patients, and moved toward a more comprehensive way of delivering health services. details the key features of patient-centeredness in organizations and in interpersonal interactions between patients and providers.

The shift in focus of patient-centeredness is later reflected in the National Library of Medicine's Medline subject heading definition of patient-centered care, introduced in 1995, which states, "Design of patient care wherein institutional resources and personnel are organized around patients rather than around specialized departments." Most notably, the Institute of Medicine (IOM) endorsed patient-centered care as one of six aims for health system improvement in the groundbreaking 2001 report, *Crossing the Quality Chasm*. The IOM defined patient-centered care as "care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."[2] Further descriptions of patient-centered care in the IOM report draw on the earlier Picker–Commonwealth dimensions, and include the dimensions of coordination and integration, the provision of information and education to patients, attention to physical comfort, emotional support, and involvement of family and friends.[2]

The patient-centeredness movement has generated a number of related terms, including the "patient-centered approach," "patient-centered interview," "patient-centered communication," "patient-centered access," "patient-centered care," and "patient-centered outcomes." The term "patient-centered interview," for instance, describes the original model of interaction and communication between patients and physicians. "Patient-centered communication" is used to describe patient–practitioner interactions, but could include other modes of communication. For example, patients may experience patient-centered communication when interacting with the health system; when using e-mail to contact practitioners; when phone calls are answered by a pleasant and responsive receptionist, and when phone calls are returned in a timely manner. Similarly, written communication, such as signage and patient education materials, may be patient-centered to the extent that they meet patients' needs and are written in a way that enhances participation.

The term "patient-centered care" is not limited to communication and often focuses on other aspects of care such as availability of office hours, ability to get appointments when needed, being seen on time for appointments, and having conveniently located services. The term "patient-centered access" distinctly does not

include the interpersonal aspects of care, and is more clearly focused on the delivery of health services when and where they are needed.[11] "Patient-centered outcomes" typically refer to the measurement or consideration of outcomes that patients might care about, but which have traditionally been ignored by the medical establishment, such as patient satisfaction, quality of life, and functional status.[12]

There are numerous models of care that can be regarded as antithetical to patient-centeredness. Some experts have pointed out that illness-oriented medicine——that is, care that focuses on the disease, rather than the individual—stands in contrast to patient-centered medicine.[1] This has led to a greater focus on the biopsychosocial model, health promotion, attention to physical comfort, and coordinated transition between care settings. Others have argued that patient-centeredness is at one end of a continuum, with "doctor-centeredness" at the opposite end.[13] This has led to a greater focus on the provision of same-day appointments and patient-physician email correspondence. Still others have identified medical paternalism as the opposite of patient-centeredness, because it may fail to acknowledge the preferences, needs, and values of individual patients.[14] This has led to a greater focus on the provision of information and education to patients. In short, it is fair to say that any of these alternative conceptions of patient-physician interactive styles are *not* patient-centered, and that patient-centeredness could be envisioned as a strategy to correct for all of these tendencies in medicine simultaneously.

THE EVOLUTION OF CULTURAL COMPETENCE

The issue of cultural competence in health care emerged later than did patient-centeredness. The term "cultural competence" did not begin to appear consistently in the medical literature until the early 1990s. By October 2005, more than 1,500 articles about cultural competence had been published in medical and nursing journals, over two-thirds of them since 2000. Within the past 10 years, myriad programs addressing cultural competence in health care have been developed,[15] national standards for health care systems have been published,[16] a recurring national conference has been established, and federal mandates to increase cultural competence have been issued.[17] The primary impetus for the cultural competence movement of the past decade has been the demonstration of widespread racial and ethnic disparities in health care, and the consequent publicity surrounding this issue.[18,19] However, the principles of cultural competence are rooted in efforts that precede the high visibility the issue has received in recent years.

Early Conceptions of Cultural Competence

For decades, health care leaders and educators have recognized that cultural and linguistic barriers between health care providers and patients can interfere with the effective delivery

of services. Greater attention to these barriers gave rise to programs and curricula bearing the monikers "cross-cultural medicine," "cultural sensitivity," "transcultural nursing," and "multicultural counseling." Programs largely focused on what Berlin and Fowkes refer to as populations "whose health beliefs may be at variance with biomedical models."[20] Although the principles underlying these programs were considered applicable to patients of all backgrounds, they targeted primarily immigrant or refugee populations with limited English proficiency and exposure to Western cultural norms. Programs sought to bridge the substantial distance that existed between health care providers and immigrant patients, focusing on the appropriate use of interpreters and "cultural brokers" (i.e., individuals who serve as liaisons between patients and providers who are from substantially different cultural backgrounds, to mediate interactions, enhance mutual understanding, and reduce conflict) and on learning the history and cultural norms of different minority populations.

Health professionals, educators, and social scientists proposed frameworks and guidelines to help health care practitioners consider patients' cultural context and conduct cultural assessments.[20–23] While offering slightly different approaches, each framework used similar principles. The frameworks valued awareness of and respect for different cultural traditions and perspectives, but also acknowledged that detailed knowledge about all cultural perspectives a health care provider might encounter in clinical practice was impractical. In addition, viewing patients as members of ethnic or cultural groups, rather than individuals with unique experiences and perspectives, might lead providers to stereotype patients and make inappropriate assumptions. To account for these concerns, approaches to cross-cultural health care incorporated a balance between acquiring knowledge of specific cultural groups and developing attitudes and skills not specific to any particular culture. As outlined in the late 1970s and early 1980s by pioneers in cross-cultural medicine including Berlin and Fowkes, Kleinman and colleagues, and Leininger, these generic attitudes and skills included: respecting the legitimacy of patients' health beliefs and recognizing their role in effective health care delivery; shifting from a paradigm of viewing patients' complaints as stemming from a bodily disease to an illness occurring within a biopsychosocial context; eliciting patients' explanations of illness and its perceived causes; explaining the clinician's understanding of illness and its perceived causes in language accessible to patients; and negotiating an understanding within which a safe, effective, and mutually agreeable treatment plan could be implemented.[20,21,24] Essentially, this individualized approach entailed clinicians' seeing the illness experience through patients' eyes, helping patients to see the process through the clinicians' eyes, and reaching common ground.

Inherent in early formulations of cross-cultural health care was the importance of recognizing that both patients and providers brought cultural perspectives to the health care encounter. As such, health care providers were encouraged to acknowledge and explore their own cultural influences, including those acquired through their training in Western biomedicine and entry into the medical profession. They were also invited to reflect on the potential impact of those perspectives—as well as the privilege and power associated with their status as professionals—on their relationships and interactions with patients. Some programs included immersion experiences, where health care trainees were intensively exposed to a cultural environment different from their own, in the hopes of helping them see the world differently. This process of critically questioning and deconstructing the Western biomedical perspective was considered central to effectively delivering care across cultural boundaries.[25]

Many of the principles proposed as ideals for effective cross-cultural care were the same as those for patient-centered care. These included respect for patients as individuals, engagement of patients as partners in problem solving and decision making, effective communication of illness models and treatment goals, holistic consideration of the social and cultural context, and the consequences of patients' experiences with illnesses. Just as patient-centeredness was construed as one end of a continuum (with doctor-centeredness on the other end), cultural competence was similarly characterized, ranging from "ethnocentric" to "ethnosensitive" care,[26] or from "cultural destructiveness" to "cultural proficiency."[27]

Expansion of Cultural Competence as Integral Component of Health Care Quality

From its roots in early models of cross-cultural health care, cultural competence expanded in the late 1980s through the 1990s in three ways. First, the populations expanded from primarily immigrants to all people of color, particularly those most affected by racial disparities in the quality of health care. Second, the conceptual purview expanded to include issues such as prejudice, stereotyping, and social determinants of health. Finally, as with patient-centeredness, the scope of cultural competence expanded beyond the interpersonal domain of cross-cultural care to include health care systems and communities.

The expansion of the scope of cultural competence was driven largely by events that revealed racial disparities both in health status and in the quality of health care in the United States. One of these events was the 1985 publication of the Department of Health and Human Services Secretary's report on black and minority health, which documented

substantial and pervasive disparities in the health of people of color, particularly African Americans, as compared with the white population. During the 1990s, these disparities became a central focus under the Clinton Administration. Surgeon General David Satcher included the elimination of racial disparities in health as one of the two primary objectives of the Healthy People 2010 initiative,[28] while the establishment of the National Center for Minority Health and Health Disparities gave the issue a focal point within the National Institutes of Health.

During this time, a critical mass of research had also begun to accumulate, demonstrating unequivocally that people of color received lower-quality health care than the majority population, even after accounting for differences in access to care.[18,19] This body of research was catalogued and publicized in the IOM report *Unequal Treatment*[18] and included studies suggesting that social and cultural barriers between health care providers and people of color, including immigrants and non-immigrants, might be affecting the quality of health care.[29–32] While proponents of cross-cultural medicine had voiced this concern early, the documentation of racial disparities in health care placed the issue on the forefront. The expansion of the potentially affected population base (with the inclusion of non-immigrant people of color) and the urgency to address the documented racial inequities generated an explosion of new interest and activity in cross-cultural health care, which became known as cultural competence.

With its expanded audience and new mission, cultural competence snowballed into a growing movement aimed at reducing racial and ethnic disparities in the quality of health care. Proponents of cultural competence, however, acknowledged that the principles and approaches of cross-cultural health care were necessary but not sufficient to address these disparities. The observed inequities were not yet fully explicated, but were thought to have many origins. While cultural barriers might be contributing factors, other factors also needed to be considered. For instance, some people of color might harbor distrust of health care providers or institutions, possibly related to historical or ongoing experiences of discrimination. Providers might harbor either overt or unconscious biases about people of color that influence their interactions and decision-making. Acknowledging the importance of these issues, champions of the cultural competence movement took them on, incorporating into their training programs a wide-ranging set of issues: the concepts of race and class and their impact on health and health care experiences; the relevance of trust in patient-provider relationships and the historical contributors to potential distrust among people of color; the importance of social factors, such as support systems and literacy; and reflection on trainees' own racial attitudes and stereotypes, and the impact they might have on health care encounters.

Some critics believe addressing these issues under the rubric of cultural competence is dangerously dismissive of personal and institutional racism.[33] Nevertheless, all these efforts to address potential sources of racial disparities in patient-provider relationships were generally folded into cultural competence programs. Cultural competence, therefore, grew from a relatively focused set of principles into a broader array of topics relevant to racial and ethnic disparities in the quality of health care.

Several different models have been proposed to describe cultural competence in health care. Nearly all include dimensions of knowledge, attitudes, skills, and behaviors addressing the range of topics previously described. These include appreciating the meaning of culture and its importance to health care delivery; understanding and eliciting information on the social and cultural contexts in which patients' illnesses occur; being aware of and having respect for variations in cultural norms; being aware of one's own cultural influences, biases, and stereotypes; being aware of racial and ethnic disparities in health and health care and promotion of social justice in clinical care; eliciting patients' explanatory models of illness, explaining the biomedical model of illness, and integrating these models to negotiate mutually agreeable diagnostic and treatment plans; maintaining a patient-centered orientation; fostering patient-provider partnership; and communicating effectively, with particular attention to language and literacy.[34] These last few aspects of the cultural competence formulation are also central aspects of patient-centeredness; some have consequently argued that the essence of cultural competence is a "patient-centered approach."[35]

Pioneers of the cultural competence movement recognized that disparities in health care quality may result from barriers not only between patients and providers but also between communities and systems. Most of the health care infrastructure was developed in the pre-Civil Rights era and is, therefore, at risk of propagating institutionalized discrimination against people of color. Even modern health care systems were largely designed with the majority (i.e., white) population in mind. These realities, coupled with the rapid increase in the racial and ethnic diversity of the population during the last three decades, have made it clear that changing health care systems to accommodate the preferences and values of diverse populations is an essential part of the cultural competence agenda.

One of the earliest proposals for more culturally competent systems of care was outlined in a monograph by Cross and colleagues.[27] They defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to

work effectively in cross-cultural situations." They described the culturally competent system as: valuing diversity, having the capacity for cultural self-assessment, being conscious of the dynamics inherent when cultures interact, having institutionalized cultural knowledge, and being able to adapt to the needs and preferences of a culturally diverse clientele.

Efforts to put these principles of "system-level" cultural competence into practice have included initiatives such as the National Standards on Culturally and Linguistically Appropriate Services in Health Care.[14] The goals of these initiatives include making health care environments more accessible to and reflective of the communities they serve; providing high-quality interpreter services and cultural competence training for staff; and tracking quality of care across racial, ethnic, and cultural subgroups. Many proponents believe that making these changes not only serves a moral imperative to reduce health care disparities, but makes business sense in terms of catering to an expanding segment of the health care market.[36] Key features of cultural competence within health care organizations and patient-provider interactions are detailed in .

OVERLAPPING APPROACHES TO IMPROVE HEALTH CARE QUALITY
Patient-centeredness and cultural competence have each had their own focus and agenda. Both aim to improve health care quality, but with emphases on different aspects of quality. The primary aim of the patient-centeredness movement has been to create an individualized approach to quality, to complement the increased focus on process measures and performance benchmarks with a focus on personal relationships and customer service. As such, patient-centeredness aims to elevate quality for all patients. The primary aim of the cultural competence movement has been to balance quality, to improve equity, and reduce disparities by specifically improving care for people of color and other disadvantaged populations. Because of these distinct focuses, patient-centeredness and cultural competence have emphasized different aspects of health care delivery. There is much overlap, however, in how patient-centeredness and cultural competence are put into practice, and consequently in what they have the potential to achieve. Individualizing care must take into account the diversity of patient values and perspectives. To the extent that patient-centered care is delivered universally, care should become more equitable. Conversely, to the extent that cultural competence enhances the ability of health care systems and providers to address individual patients' preferences and goals, care should become more patient-centered.

Both patient-centeredness and cultural competence began as guides for personal interaction. That is, each addressed how individual health care providers should communicate with patients and was later expanded to include the activities of health care

systems. This report considers each framework—i.e., interpersonal communication and health care systems—separately while comparing patient-centeredness and cultural competence at both levels.

Interpersonal Communication in Health Care

Quality in interpersonal communication can be viewed as the extent to which providers and patients engage in meaningful dialogue and form effective relationships. The ability or preparedness of health care providers to engage in such interactions depends largely on their knowledge, attitudes, skills, and behaviors (see Figure 4 on page 17). The features of patient-centeredness and cultural competence included in Figure 4 are not intended to be a comprehensive account of all important facets. Instead, they are a representative sample of the two traditions.

At the core of both patient-centeredness and cultural competence is the ability of health care providers to see patients as unique individuals; to maintain unconditional positive regard; to build effective rapport; to use the biopsychosocial model; to explore patient beliefs, values, and meaning of illness; and to find common ground regarding treatment plans. The patient-centered model for patient–physician interactions, in addition, includes a detailed set of knowledge and skills that health care providers should possess. Proponents of cultural competence often make reference to the patient-centered approach when suggesting methods of interaction between patients and physicians. Thus, while these characteristics are not explicitly the focus of cultural competence, most can be endorsed as being aspects of cultural competence.

It is not surprising that the essential elements of patient-centeredness are similar to cultural competence at the personal level. Though patient-centeredness has not been directly responsive to racial and ethnic disparities in health care, it has the potential to reduce disparities because it addresses several of the mechanisms by which patients' race and ethnicity affect health care providers.[37] For example, physicians have been shown to stereotype patients based on race or ethnicity.[37] Although this behavior may be unconscious, patient-centered care has always embraced the goal that each person should be viewed as "a unique human being"[1] and has encouraged physicians to maintain awareness of their own stereotypes and biases. In addition, physicians have been shown to make medical decisions based on patients' race.[37,38] Since patient-centered care aims to equalize power between patients and physicians, it is possible that disparities in clinical decisions would be reduced by increasing patient involvement. Finally, physicians' personal behavior can vary, characterized by more affective distance (less warmth, empathy, respect) when interacting with people of color.[37,39] Patient-centeredness could provide a solution here, too, by fostering positive qualities within the patient–physician encounter.

Alternatively, because of its specific emphasis, cultural competence has more thoroughly described the sort of knowledge, attitudes, and skills required of health care providers in order to provide high-quality care to people of color. In addition to the core features that cultural competence shares with patient-centeredness, the culturally competent health care provider is thoughtful about the meaning of culture, knowledgeable about the customs and traditions of the cultural groups encountered in clinical practice, avoids stereotyping based on knowledge of cultural norms, works to understand the priorities of the local community and patient population, appreciates diversity, is aware of disparities in health and health care and other disadvantages experienced by people of color, and effectively uses interpreter services when needed. Again, as proponents of cultural competence would embrace most aspects of patient-centeredness, it is likely that proponents of patient-centeredness would also embrace these additional features of cultural competence. Because cultural context is relevant to the care of patients in general, not only people of color, cultural competence has the capacity to enhance patient-centeredness and improve quality for all patients.

Health Care Quality at a Systems Level
In the health care system, quality can be can be considered the degree to which the system promotes the health and well-being of the population it serves. Donebedian has described three categories of quality of care: structure (the settings in which health care is delivered), process (giving and receiving health care), and outcome (the effects of care on the health status of patients and populations).[40,41] The structures, processes, and outcomes that are considered part of patient-centered and culturally competent health care systems are illustrated in Figure 5 on page 18. These features are not intended as an exhaustive catalog, but rather as representative facets of the respective traditions.

The overlap between patient-centeredness and cultural competence is not as substantial on the health systems level as it is on the personal level. The overlap features services that are aligned to meet patients' needs and preferences; care that is available in communities, convenient to patients' homes; educational materials tailored to patients' needs, health literacy, and preferred language; and publicly available performance information. (In the case of this last aspect, there is slight variation. Patient-centeredness calls for the availability of general information, while cultural competence standards call for race- and ethnicity-specific data.)

In addition to these overlapping features, patient-centered health care systems offer convenient office hours, provide patients with the ability to get same-day appointments, allow for telephone appointments or e-mail contact with providers, maintain continuity and a secure transition between health care settings, coordinate care between different

providers, solicit patient feedback, attend to the physical comfort of patients, and focus on health promotion and disease prevention. It is likely that a health care system with these features would also improve the care of people of color.

Nevertheless, because of the lack of focus on the specific needs of people of color, there are features of culturally competent health care systems not included in accounts of patient-centeredness. For example, the emphasis on a diverse workforce that reflects the patient population has been proposed as an essential part of cultural competence but has not been mentioned in the patient-centered care literature. In addition, cultural competence for health care systems involves partnering with the communities served, offering language assistance for patients with limited English proficiency, providing ongoing training of staff regarding the delivery of culturally and linguistically appropriate services, and employing community health workers to provide outreach to underserved groups and enhance the cultural acceptability and convenience of care provided within communities of color.

IMPLICATIONS

Because the cultural competence and patient-centered care movements both aim to improve health care quality in similar ways, there has been debate about whether it is better to keep the movements separate or combine efforts into a single agenda. While many features are similar, important aspects of each remain that have not been formally adopted by the other. Since these non-overlapping features also have the potential to improve health care quality, the authors suggest that the concepts remain distinct, at least in the short-term. To that end, they make a variety of specific recommendations (Table 1). Health care organizations and providers should adopt principles of both patient-centeredness and cultural competence so that health care services are aligned to meet the needs of all patients, including people of color and other disadvantaged groups, whose needs and preferences may be overshadowed by those of the majority. Health services researchers should develop measures of cultural competence and patient-centeredness and explore the impact of their unique and overlapping components on patient outcomes. Medical educators should partner with social scientists, anthropologists and researchers to develop and evaluate educational programs which may improve the patient-centeredness and cultural competence of health professionals. Those interested in ensuring the quality of the health care system should measure both patient-centeredness and cultural competence as part of the process of delivering high-quality care. Finally, all patients should take advantage of every opportunity to provide feedback, through forums like surveys and focus groups, to improve the design and evaluation of health care systems that reflect patients' diverse needs and preferences.

Table 1. Recommendations for the Future

1. Health care organizations should employ principles of patient-centeredness and cultural competence to ensure care is individualized and equitable.

2. Researchers should use and refine measures of cultural competence and patient-centeredness, and explore the impact of their unique and overlapping components on patient outcomes.

3. Educators should develop multidisciplinary programs to improve the patient-centeredness and cultural competence of health professionals.

4. Health care organizations should measure and track patient-centeredness and cultural competence as part of their efforts to deliver high-quality care.

5. Patients should provide feedback to health care systems by participating in surveys and focus groups, for example, to ensure that organizations attend to patients' diverse needs and preferences.

CONCLUSIONS

Cultural competence and patient-centeredness are both important considerations when thinking about high-quality relationships in health care and health care delivery systems. Patient-centered care has broadly focused on the needs of individual patients, while cultural competence has historically focused on the specific needs of people and communities of color. Although separate movements with separate focuses, both patient-centeredness and cultural competence may look fairly similar in practice.

Furthermore, although the patient-centeredness and cultural competence movements were motivated by different forces and evolved separately, many of the principles are overlapping, meeting the aims of both movements. In addition, some of the non-overlapping principles of patient-centeredness have the potential to reduce racial and ethnic disparities in health care quality, and some of the non-overlapping principles of cultural competence have the potential to improve the quality of care for all individuals. Therefore, the authors suggest a more sophisticated understanding: patient-centered physicians and health care systems will benefit people of color and reduce disparities in health care quality, and culturally competent physicians and health care systems will benefit all patients and improve overall quality. As such, they recommend that patient-centeredness and cultural competence remain distinct but aligned efforts to both elevate and balance the quality of health care for all patients.

**Figure 1. Patient-Centeredness and Cultural Competence
Integral to Health Care Quality**

Patient-Centered
Health Care
Systems

Culturally Competent
Health Care
Systems

Patient-
Centered
Health Care
Interactions

Culturally
Competent
Health Care
Interactions

Individualized
(Patient-Centered)
Care

Equitable
Care

Safety

Effectiveness

Efficiency

Timeliness

Quality of Care

**Improved
Health
Outcomes**
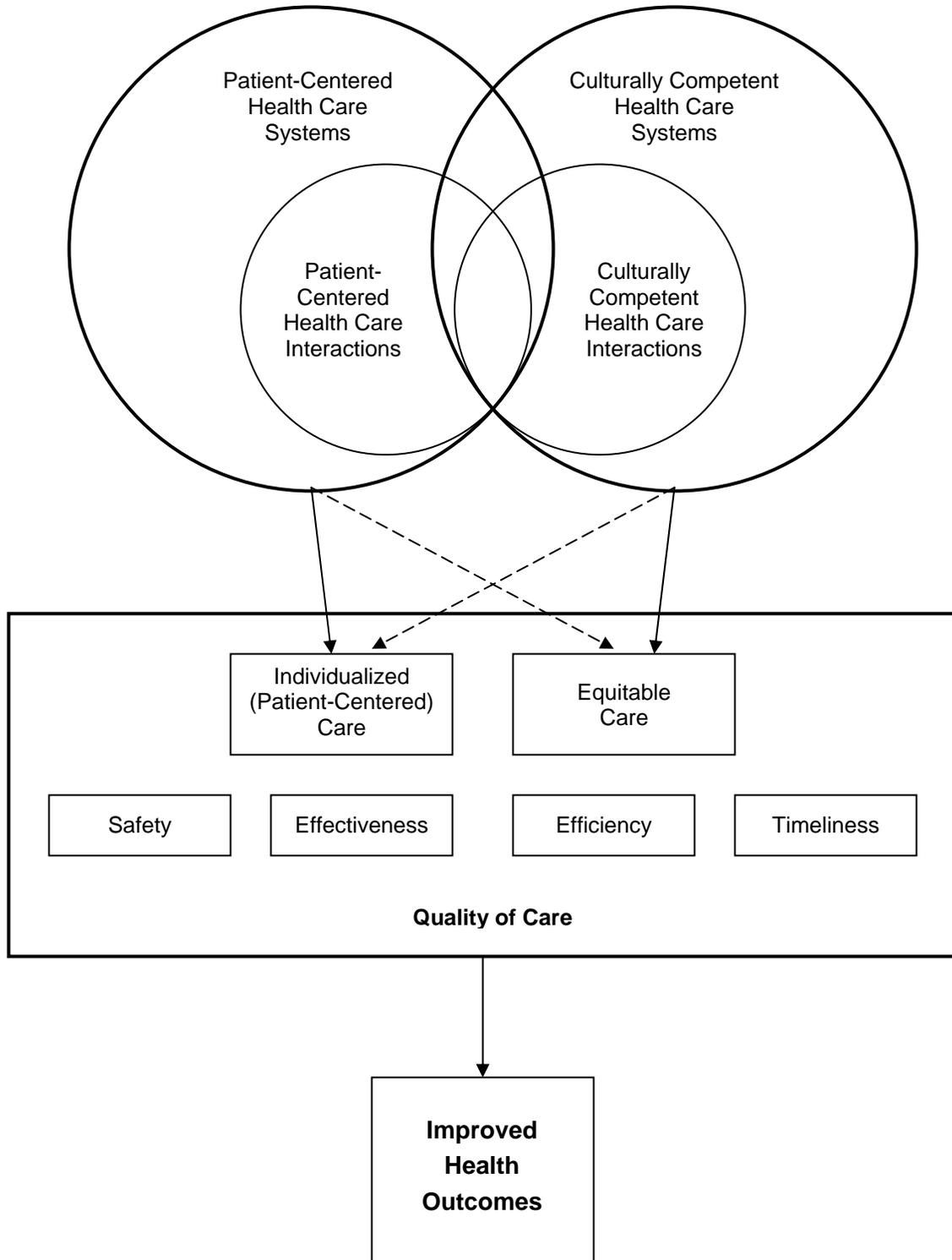
Figure 2. Key Features of Patient-Centeredness

Within Health Care Organizations
Services aligned to meet patient needs and
preferences, as follows:

1. coordinated, integrated, continuous;
2. convenient/easily accessible;
3. geared toward health promotion,
   physical comfort.

Within Interpersonal Communication
Provider understands each patient as a unique
human being, as follows:

1. uses biopsychosocial model;
2. views patient as person;
3. shares power and responsibility;
4. builds effective relationship;
5. is aware of the doctor as a person.

Figure 3. Key Features of Cultural Competence

Within Health Care Organizations
Ability of the health care organization to meet needs of diverse groups of patients, as follows:

1. diverse workforce reflecting patient population;
2. health care facilities convenient to community;
3. language assistance available for patients with limited English proficiency;
4. ongoing staff training regarding delivery of culturally and linguistically appropriate services;
5. tracking quality of care across racial, ethnic, and cultural subgroups;
6. including community in priority setting, planning, delivery, and coordination of care.

Within Interpersonal Communication
Ability of a provider to bridge cultural differences to build an effective relationship with a patient, as follows:

1. explores and respects patient beliefs, values, meaning of illness, preferences and needs;
2. builds rapport and trust;
3. finds common ground;
4. is aware of own biases or assumptions;
5. maintains and is able to convey unconditional positive regard;
6. is knowledgeable about different cultures;
7. is aware of health disparities and discrimination affecting minority groups;
8. effectively uses interpreter services when needed.

Figure 4. Overlap Between Patient-Centered Care and Cultural Competence at the Interpersonal Level

Patient-Centered Care

Cultural Competence

- Curbs obstructive behavior such as using technical language, frequent interruptions, or false reassurance
- Understands transference and countertransference
- Understands the stages and functions of a medical interview
- Attends to health promotion and disease prevention
- Attends to physical comfort

- Understands and is interested in the patient as unique person
- Uses a biopsychosocial model
- Explores and respects patient beliefs, values, meaning of illness, preferences, and needs
- Builds rapport and trust
- Finds common ground
- Is aware of own biases and assumptions
- Maintains and is able to convey unconditional positive regard
- Allows involvement of friends or family when desired
- Provides information and education tailored to patient level of understanding

- Understands the meaning of culture
- Is knowledgeable about different cultures
- Works with local community
- Appreciates diversity
- Is aware of health disparities and discrimination affecting minority groups
- Effectively uses interpreter services when needed

Figure 5. Overlap Between Patient-Centered Care and Cultural Competence at the Health Care System Level

Patient-Centered Care

Cultural Competence

- Convenient office hours, ability to get same-day, appointments, short wait times
- Availability of telephone appointments or e-mail contact with providers
- Continuity, secure transition between healthcare settings
- Coordination of care
- Ongoing patient feedback to providers
- Attention to physical comfort of patients
- Focus on health promotion and disease prevention

- Services aligned to meet patient needs and preferences
- Health care facilities convenient to community
- Documents tailored to patient needs, literacy, language
- Data on performance available to consumers

- Workforce diversity reflecting patient population
- Availability and offering of language assistance for patients with limited English proficiency
- Ongoing training of staff regarding the delivery of culturally and linguistically appropriate services
- Partnering with communities
- Use of community health workers
- Stratification of performance data by race/ethnicity

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