Cross-Cultural Communication Competency for Health Care Providers
Resource Guide and Toolkit
Human Communication Institute (HCI)

The Human Communication Institute seeks to provide a praxis for community health that reaches beyond quantitative studies and formulas in a manner that listens, engages, understands and includes the health concerns of silenced community members.

The *Cross-Cultural Communication Competency for Health Care Providers toolkit* seeks to broaden the cultural awareness of practitioners and advocates concerning interfacing and providing care for "other". Language as a tool is the primary determinant of how an individual seeks, recognizes and engages in their personal care. It is that same tool that health care providers use to understand and support their patients and communities into their desired wellness. The need to transcend language barriers is not just a matter of differing "tongues" but issues that include social reality, semantics, denotative and connotative uses, cultural paradigms of health and healing, formality, mistrust, gender diversity and many other concerns. Health care providers have a massive job to penetrate the mental residue of patients as well as their own depending on training and practical contact.

Much of "mental residue" of patients and practitioners as they come together, are words, concepts and experiences handed down anecdotally or experientially for generations.

"We are all residents of our residue." HCI

Understanding the need to learn, understand and incorporate cross-cultural messaging and practices into patient-provider relationships is foundational to improving community health.

In the Public Health Liberation Praxis Terms, we introduced concepts that encourage furtherance of cross-cultural communication studies and practices that dig deeper into knowing and serving the community.

Note the following:

Environmental Conditioning – How the environment plays a dominant role in the Public Health conversation and debate as a primary determinant of individual and collective emotional, mental and physical health of marginalized communities. Conditioning mainly occurs through the messages, experiences, behaviors **communicated** to and around them.

Language Legacy™ – Individuals and organizations focused on Public Health and concerns of equity, realize the urgency of addressing the impact of symbol systems on personal and group identity. Language expresses the customs, attitudes, beliefs, and traditions of its people. The cultural imperative of most dominant cultures is to keep in place those traits that maintain power and dominance over the social structures of society. Symbol systems – verbal and nonverbal – are the major mechanisms through which this maintenance occurs. In addition, co-cultures must also adopt and adapt to the "prescriptions" of the dominant cultural language sometimes to their own self-deprecation as well as create their own unique "expressions" that may or may not reflect a consciousness of positive worth. All of this is being passed down generation to generation, and currently under study as generational epigenetic markings. As Tabula rasa speaks to the *blank slate*, *Linguistic Determinism* continues this discussion into how the created and/or imposed *blank slate* generates the behaviors that support a thriving or dying community. Language equals the social reality of the people that live and express within it. This language can of its own creation and usage can be used as an oppressive agent to perpetuate caste systems, as well as be self-reinforced in the absence of critical awareness of its detrimental impact on self, family and community. This is a Public Health alarm particularly relevant for the need to circumvent and reestablish language patterns passed down generationally in caustic and identity-damaging forms and relationship to self and others.

***SPECIAL NOTE TO HEALTH CARE PROFESSIONALS:**

The following *Cultural Competency Toolkit is presented as a general guide to understanding the science of Intercultural Communication. This guide provides effective Intercultural Communication tools to help strengthen healthcare best practices by improving the provider's ability to gain Intercultural Communication tools. It is not limited to any specific area of medical practice but is essential for all practitioners seeking to broaden their cultural competency skills.

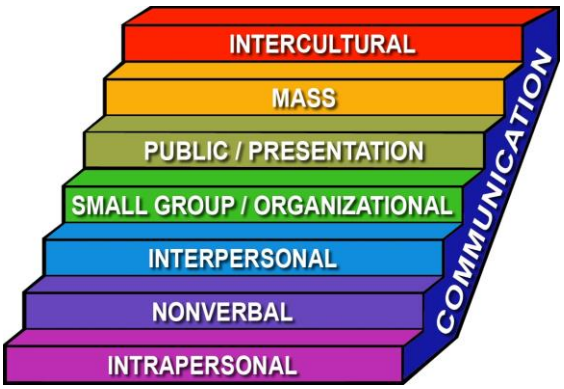
Defining Communication:

"Communication happens whenever meaning is assigned to behavior or the (mental/emotional) residue of behavior."

Defining Intercultural Communication (Cross-cultural Communication):

"Communication between two or more people where differing symbol systems, customs, norms, traditions, and worldview (behavior and residue) can potentially alter the communication experience"

Cross-cultural Communication is one of the most complex communication experiences a doctor and patient can have. It involves a number of **Communication Arenas** working interdependently: **(1)** from an individuals self-talk**, (2)** to patterns of nonverbal communication **(3)** to interpersonal communication involving a complex process of exchange that includes verbal, nonverbal, psychological and sociological interplay **(4)** to small group experiences such as a physician's office **(5)** to communicating before diverse audiences, **(6)** to the power and purpose of mass messages (persuasion) **(7)** culminating into experiencing ever increasing diversity everywhere we go, especially U.S. health care institutions. The communication experiences within the health care organization are numerous, complex, and fluid. It is important to understand these Communication Arenas impact on the organizational communication climate and resultant outcomes. Intercultural Communication is the most complex of all communication systems and thus at the top of the **Communication Staircase Model™**.



Communication Staircase Model™
Human Communication Institute

Communicating effectively across cultures takes time and commitment to understand and consider the worldview of other cultures. It is important to understand how perception shapes the communication between provider and patient of a different culture.

Cultural Competency is defined as the ability to interact effectively with people of different cultures.

Potential cross-cultural barriers between physicians and patients

BARRIER → **COMMUNICATION CONSIDERATION** (see concept list below)

Language → Verbal and Nonverbal

Prejudice → Ethnocentrism (mutual stereotyping – social and historical factors)

Family involvement → Individualism vs Collectivism

Self-disclosure → Belief Systems, high context vs low context cultures

Formality → Uncertainty Avoidance/Power Distance

Female modesty/privacy → Religious beliefs and practices, Masculine versus Feminine cultures

Time allotted → Monochronic versus Polychronic cultures

Cost factors → Masculine versus Feminine Worldviews of health care responsibility

There are varieties of approaches to learning cultural competency skills**. Intercultural Communication** is one approach that brings effective communication to the forefront of the skill set. Providers, patients and families communicate throughout the process of diagnosis to treatment to recovery. When communicating with different cultures about healthcare concerns and needs, the provider and patient must navigate through a complex web of cultural conditioning. This toolkit provides a two-prong framework for examining, learning and utilizing cultural competency to deliver services that result in applicable competency.
Culture-General Information and **Culture-Specific Traits** is shared to help providers understand why patients respond and engage with illness, disease and the health care industry in the manner that they do. This toolkit provides information that is both **Cultural-General** (that which is true of all cultures with unique variations) and **Culture-Specific** traits that identify unique attitudes, beliefs, and values that result in a specific behavior.

The information provided has been principally compiled and formatted to support the needs of Health Care Professionals. The information is presented in a manner that can be supportive of all levels and areas of health care, pediatric and beyond because it is presented in a Culture

General format with a macro approach to examining worldviews as they affect the health care context and the cross-cultural relationships between providers and patients.

Cross-cultural Communication Concepts:

Culture-General Information:

Communication – happens whenever meaning is assigned to behavior or the residue of behavior. Special Note: Residue (past experiences) is the primary factor influencing a patient's relationship with the healthcare organization and its staff.

Cross-Cultural Communication – exchange of messages that must transcend differing worldviews and symbol systems, both verbal and nonverbal

Dualistic versus Non-dualistic Worldviews:

> **Dualistic** sees the world of medicine as separate from supernatural practices that encourage intervention; sees the body as machine to be fixed (Mechanistic)
>
> **Non-dualistic** sees body and soul (spirit) as both equally involved in the health of an individual or collective (non-mechanistic)

Ethnocentrism – Believes one's own culture is better than others; can translate into as attitude that one's own health care perspective may be considered more relevant, valuable or better than other approaches. This can include stereotyping patients and patient care.

Formality versus Informality – the extent to which patients are "open or closed-off" to discussions concerning personal health; how they interact with the physician and her environment. Includes modesty issues that are cultural.

High vs. Low Context – The degree to which a culture operates more analytically or intuitively; also includes value placed on silence vs. verbal skills; context holds a lot or a little tradition built in over time – including how a patient views and interacts with the Health Care Institution

Individualism vs. Collectivism – Either the individual or the in-group (versus out-group) is the most valuable unit of the society – determines the level of family involvement

Masculinity vs. Femininity – The degree to which a culture creates a societal "safety nets" for its citizens – Universal versus privatized Health Care systems

Perception – How an individual makes sense of their personal, social and physical world – includes view about illness, disease, death

Power Distance (**Low vs. High)** – The degree to which a culture believes in governing hierarchies based in position, class, family, tribe – determines the relationship of provider to patient

Self-Disclosure – The amount of personal information a patient feels comfortable sharing with health care staff

Time Orientation (Chronemics), – the patient's outlook on the concept and application of time such as: (1) keeping appointments, (2) life expectancy, (3) duration of illness, taking medicines, etc.

Uncertainty Avoidance (High or Low) – The extent to which a culture accepts what is new, different (Homogeneous versus heterogeneous cultures) – familiar or unfamiliar health care practices

Values, Attitudes, Beliefs – Enculturated/Socialized patterns of living that become habitual thoughts and actions

Worldview – What a person or culture understands about the world around them; how they process and create information then turn it into behavior. Includes beliefs such as: fatalism

(some Asian cultures), resignation, *four humors of the body* (some Mexican/Puerto Rican), will to live, and belief in spiritual intervention, etc.

One vital point to make here is that when differing worldviews come together, there is the high probability for misunderstanding or miscommunication to ensue. These worldviews include perspectives on questions that can influence the Health Care experience. Consider G. Hofstede's discussion on issues that explore values that "provide rules for making choices and for resolving conflicts":

- Evil versus good
- Dirty versus clean
- Dangerous versus safe
- Decent versus indecent
- Ugly versus beautiful
- Unnatural versus natural
- Normal versus abnormal
- Paradoxical versus logical
- Rational versus irrational
- Moral versus immoral

Culture-General and Culture-Specific Health Care Considerations:

***Global Health Care Belief Systems**

Scientific/Biomedical Approach to Health Care – Medical practices that treat the body as a machine to be analyzed and fixed; seeing the healthcare as an analysis and scientific rationalization; seeing the body and soul as separate (Duality); medical practices of the body and mind are treated based in biology, chemistry and evidenced based psychology.

Holistic/Naturalistic Approach to Health Care – Health of the body is a condition of balancing mental, physical and spiritual energies. Seeks to use a variety of practices that release tensions and cure disharmony within, such as: acupuncture, acupressure, herbal potent, warm rock therapy, etc.

Supernatural/Religious/Personalistic Approach to Health Care – Sees health as a condition of birth and relationship to the spiritual and supernatural world around them, not just for self but also family, community and ancestors. Belief in spirit interference/intervention in physical conditions. Good and bad spirits that interfere/intervene in illness. Medical practices may include belief in and reliance on community practitioners and holistic, traditional medicines.

Figure 1.1 **Global Health Care Belief Systems (M. M. Andrews)**

Health Care Approach	Examples of Belief System in Practice	Treatments	Cultures that may have this perspective
Scientific/Biomedical Approach	Biological diagnosis/prognosis and scientific/theoretically based care and treatments	Scientific diagnosis, biological prognosis, biomedical remedies that fix the "part" that is broken	SOME: U.S. (excluding co-cultures that maintain all or part of their traditional and spiritual belief systems), Western Europe and parts of Eastern Europe, Australia, Canada, large areas of other large cosmopolitan (westernized) cities/countries in the world such as Harare, Zimbabwe, Cape Town, South Africa, Mexico City
Holistic/Naturalistic Traditions	Seek harmony of natural laws; diagnosis seeks to ascertain what part of the body, mind, spirit is out of balance	Food combining, acupuncture, acupressure, folk healers seek balance, Chinese herbalists and Practitioners	SOME: Native Americans, Mexicans, African Americans, Mexican American folk healers = Curanderos = supernatural healers (most common) Yerberos = herbalists

			Sobadors = Masseuses. Some Asians; growing number of Westerners
Supernatural/ Religious/ Personalistic Traditions	Belief that God and other supernatural forces may cause and intervene in health concerns; Seek believing Practitioners.	Support of Shamans, Tribal doctors, Animist, practices such as cupping, , spell casting, personal offerings to deities or representatives, medicine men, includes praying to Supernatural Deity	SOME: Roman Catholics and other Christian sects; Some Asians including Hmong, Laotians, Vietnamese, Latinos – Cubans, Puerto Ricans, Brazilians, Africans, Haitians, Jamaicans

PHYSICIAN CONSIDERATION: While patients may understand that the U.S. health care system is different than their culturally based systems, this does not mean that there will be automatic compliance with their U.S. practitioner's diagnosis or treatment. Some patients combine Biomedical with their Personalistic or Holistic medical practices. Practitioners may want to work in connection with enculturated health practices when doing so will not bring harm or delay in patient care. This is often a sensitive area with children, i.e., those that do not vaccinate kids for religious reasons or want to take a family member to see a Shaman. If alternative belief practices are shared, the physician can suggest that they add the physician's treatments to their cultural ones to increase chances of healing. Do not negate or put down practices that are not harmful to the patient. The above chart is not meant to generalize cultures but be a guide to possible understanding of medical belief systems that may affect current care.

The Impact of Nonverbal Communication from a Cross-cultural Perspective

Nonverbal Communication: The conscious and/or subconscious giving and receiving unspoken messages. This factor can account for as much as 93% of what is shared between the physician, staff, patient and family. (Mehrabian, UCLA) Factors include:

- **Appearance** = Cultural and societal dressing habits
- **Chronemics** = Time perception and its relationship to rules/norms

- **Haptics** –Touching Mores
- **Kinesics** – Body movement, including eye contact, facial expressions, posture, walk, gestures, involuntary micro-expressions
- **Olfactory** – Perception and Relationship to Smells
- **Paralanguage** – the noise that surrounds your words including: volume, pitch, tone, clarity, emotion, pacing, inflection (monotone?), interrupters…
- **Proxemics** – Space (along with objects and artifacts) and Spatial Relationships

Figure 1.2 **Nonverbal Patterns as they appear in the Health Care Organization,** HCI, LLC

Nonverbal Behavior/Arena	Patient Considerations	Physician Considerations	Staff Considerations	Environmental Considerations
Appearance	(1) Use of clothing in modesty (2) Are clothes tight or loose fitting used as a cover up for weight insecurities? (3) Have not necessarily adopted Euro-American concerns with weight, and other appearance factors	(1) Understanding cultural implications of the formality of wearing medical attire (2) Color implications on some cultures, i.e., white garment or not (3) the physician's appearance in connection to her dogma	(1) Personal appearance (2) Hospital wear	(1) Austerity of space (2) Friendly or sterile appearance (3) Cleanliness of environment
Chronemics (Time)	(1) Social relationship to time and time mores (2) Time in relationship to communal commitments (monochronic versus polychronic cultures)	(1) How much time is given to individual patient care (2) How physician handles time – seem relaxed or impatient (3) Do time constraints create a lack of rapport and eye contact with patients?	(1) Does staff appear to be rushing? (2) Do time constraints create a lack of rapport and eye contact with patients?	(1) Does the "climate" of the institution feel rushed, impersonal?

Haptics (Touching)	(1) Cultural, particularly religious considerations to patient-doctor contact and vice versa. (2) The degree to which cultural modesty affects doctor-patient relationship (3) Make sure you understand how to approach coming into the personal space of patients and touching them	(1) The degree to which cultural modesty affects doctor-patient relationship (2) Need for attending physician to make sure they are aware of the need to have other practitioners, husband and/or other family member present	(1) Make sure questions of modesty are a part of in-take (2) Be attuned to "shyness" that may be an issue of formality modesty	(1) Make sure institutional awareness includes the possible ways that patients might respond to levels of touching during care
Kinesics (Eye Contact, Movement)	(1) Eye Contact is a prime area of cultural relativity; patient's share either a lot or a little in the way they use eye contact (2) Consider subordinate eye contact norms (3) Facial expressions differ concerning self-disclosure	(1) Our culture has imbedded within it the expectation that eye contact conveys trust, believability and credibility. Cross-cultural health care requires a concerted effort towards inclusive eye contact (2) Understand how gestures, posture, facial expression help create or trust	(1) See the patient with eyes of caring and concern. (2) Use facial expressions that show individual concern	
Olfactory (Smell)	(1) Hygiene can be a concern especially with obese patients; thus feelings of "uncleanness" can be a part of the experience; this can be brought on by depression (2) Some cultures	(1) Attending physicians must feel comfortable expressing concerns about cleanliness when they are obvious and the connection between healthy weight, exercise and proper hygiene	(1) Be sensitive to patients that may have hygiene problems and bring them to the attention of patient and/or family	(1) Smells have a way of affecting the environment in a manner that can create calm or stress; make sure the waiting areas are pleasant smelling; music and running water also creates a peaceful

	do not consider body odors unpleasant (3) Type and level of hygiene is cultural and sometimes socio-economic	(2) Need to be sensitive to cultural variations concerning hygiene practices		environment bridging cultures
Paralanguage (Vocal noise)	(1) A patient's paralanguage conveys the level of comfort, control or anxiety they are experiencing (2) Silence and/or low level of self-disclosure is not uncommon from cultures with high formality and modesty	(1) Attending Staff should listen intently for messages within the words spoken that convey emotion (2) Attending Staff should be very careful about their paralanguage and how it carries a lot of influence over the patient's level of stress as well as receptivity (3) Try hard not to let the stress of the job and its time constraints show in your voice	(1) During the entire process of in-take through out-take, allow your voice to convey welcome, professional care and concern (2)) Try hard not to let the stress of the job and its time constraints show in your voice	(1) Think about the "background" noise in the environment; how can it be more inviting? Calming? Culturally inclusive?
Proxemics (Space, Objects Artifacts, Spatial Distance)	(1) Spatial relationships are very cultural in terms of people's proximity to each other; many cultures are comfortable with being close to those they know; they also tend to share space more comfortably (2) Spatial proximity is a concern with modesty issues	(1) Attending physician should be clear about patient's cultural "spatial" norms (2) Make sure you know how to approach coming into the personal space of a patient and touching mores	(1) Patient response to Medical objects on person and in the room (2) Pictures, charts on the wall	(1) Artifacts and objects in a space can create a sense of comfort; keep magazines updated and a cultural variety (2) How can the waiting and patient care rooms be more culturally inclusive

PHYSICIAN CONSIDERATION: The Nonverbal Patterns Chart is introduced to broaden learners understanding of the vast nature of Nonverbal Communication and all the varying ways it can affect the practitioner-patient communication experience. There are multiple examples and cultural considerations that can be added to this chart based on specific cross-cultural experiences. It is not meant to generalize cultures but be a guide to possible understanding of patterns of communication and perspectives.

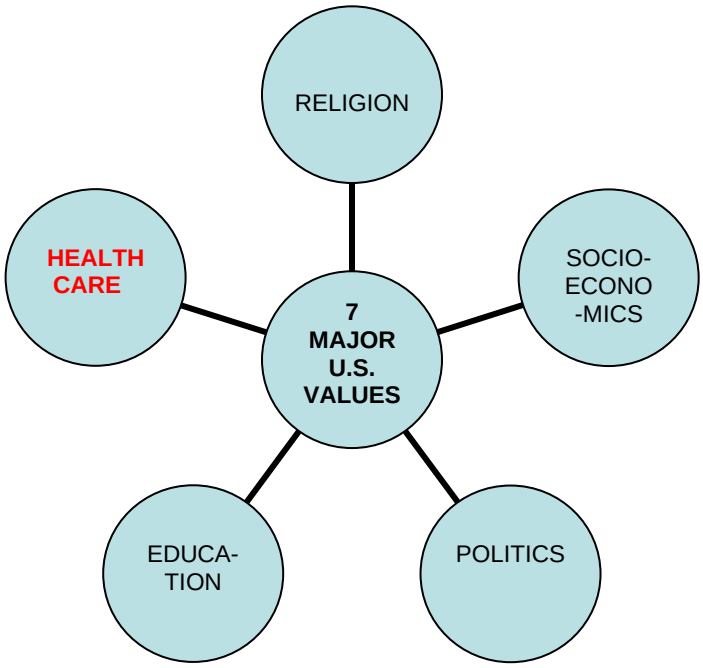
Culture-Specific Information:

American Cultural Patterns/Values are imbedded into all areas of societal paradigms and policy creation, including the Health Care Industry. The basic *U.S. Cultural Patterns/Values of the dominant culture have been socially identified as:

1. **Individualism**
2. **Materialism**
3. **Competition**
4. **Equality**
5. **Science and Technology**
6. **Progress and Change**
7. **Work and Leisure**

The “Four Dynasties” of Politics, Religion, Socioeconomics, and Education are joined by Health Care to assist learners in understanding how our values, attitudes, beliefs create the paradigms for institutional rules, mores, customs

Figure 1.3 **7 Major U.S. American Cultural Values and the Systems they Impact,** HCI



Do U.S. Values affect Healthcare Management? (HCI)

U.S. Cultural Patterns vs. other Worldviews (*U.S. Cultural Patterns as cited by Samovar, Porter and McDaniel)	**IMPACT ON ROLE OF HEALTH CARE**
Individualism vs. Collectivism	Affects the role of Family involvement critical to many cultures during health crisis; individual vs. family involvement
Competition vs. Cooperation	The Healthcare Providers, Insurance Companies, Pharmaceutical Companies on the quality and quantity of services vs. community healers, affordable care
Equality vs. Hierarchy (High vs Low Power Distance)	Availability of services and quality of services. Additionally, *power distance* between patient and provider
Materialism vs. Basic needs	Affordable for some versus bankruptcy for others. Additionally, healthcare not viewed as a basic need
Progress and Change vs. Allegiance to the Past/History	Futuristic focus on medicine; change is good "Out with the old, in with the new"
Science and Technology vs. Subsistence Agriculture and Industries	Biomedical System versus Personalistic and Naturalistic Systems; biological machine vs. fate of man

Work and Leisure vs. Family & Societal Needs, and relaxation/play as a part of everyday existence	Healthcare has primarily been for the working, able-bodied. Work harder for more leisure that only a few receive the benefit of vs. huge attempt to balance family and work with family taking priority

How do Global Cultural General Patterns affect U.S. Health Care Delivery?

Based on the work of ***Hofstede's Value Dimensions and E.T. Hall***

***Cultural Patterns**	**Possible Cross-cultural Competency Concerns,** HCI
Individualism versus Collectivism	Who is responsible and who gets involved in patient care?
Power Distance	Is the patient "socialized" with an attitude of "quiet acceptance" without questioning, clarifying, engaging?
Uncertainty Avoidance	If a patient has fear and distrust of the unknown, how does this impact seeking help, accepting prognosis and treatment? Formality vs informality?
Masculinity versus Femininity	Determines the role of the "provider" and the outlook of patient expectations
High versus Low Context	Cultures that are more intuitive, holistic and homogeneous versus those that are more analytical
Dualistic versus Holistic Worldview	Does a culture see man as separate from God or the creation?
Mechanistic versus Non-Mechanistic Worldviews	Is the body a machine or governed by a supernatural force

PHYSICIAN CONSIDERATION: The Cultural Patterns Charts are introduced to help broaden the awareness of the "lens" through which some patients may be looking and experiencing the world, thus greatly affecting their outlook on illness/disease – prevention/treatment as well as the openness to a physician's involvement. The charts are not intended to generalize but be a guide to possibly understanding cultural patterns of communication and perception.

Health Care Communication Approaches to Cross-cultural Competency

(Summarized from Communication Between Cultures, Samovar, Porter and McDaniel and HCI)

1. **Do not assume your views and feelings concerning patient care are shared by your patients from different cultural backgrounds (Do not treat them the way YOU want to be treated)**
2. **Make sure there is a culturally diverse staff that reflects the patient population**

3. **Create intake forms that are user friendly, language and cognitively clear, inclusive of cross-cultural questions that do not only support biomedical approach**
4. **Provide necessary language interpreters**
5. **Use formality that is culturally accepted by patient/family**
6. **Allow patients to be open and honest**
7. **Do not discount beliefs that include the intervention or involvement of the supernatural**
8. **Tactfully inquire into patients' belief and/or use of nontraditional cures**
9. **Do not try to force change or compliance; create understanding and awareness of serious nature**
10. **Employ empathy when creating and delivering messages**
11. **Be restrained and compassionate in sharing bad news**
12. **Follow the patient's lead in Communication style verbal (interpreter) and nonverbal, eye contact, touching mores, modesty**
13. **Provide Cultural Competency training for providers**
14. **All Health Provider programs should include intensive studies and practicums in HealthCare Communication**
15. **Make use of the LEARN Model (J. Luckman)**
    a. **Listen and ask questions**
    b. **Explain using simple terms**
    c. **Acknowledge the validity of differing views**
    d. **Recommend what patient should do**
    e. **Negotiate with patient and adapt your recommendations where you can**

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PROVIDER TOOLKIT HANDOUT #1

Communication Effectiveness for Health Care Providers

Defining Effective Communication for Health Care Providers:

"Communication happens whenever meaning is assigned to behavior or the residue of behavior."

Within the Health Care Provider purview is the consistent need to be clear, helpful, and accurate in its dissemination of information. The level of clarity necessary to meet these goals is only achieved by creating an organizational climate where effective Communication is brought to the forefront of all provider services.

Critically evaluating the definition provides important keys concerning the impact communication has on desired outcomes:

(1) Communication is something that "happens". It is not the biological function of talking; the voiceless communicate but do not talk. Just as the deaf listen but do not hear. Communication requires intellectual processing effectively utilizing a variety of skill sets.
(2) "Behavior" is a broader term than *words*, purposefully bringing to the forefront the understanding that Communication is not just about verbal responses going back and forth. Much of the *behavior* is nonverbal accounting for as much as 93% (55% visual, 38% vocal) of how the patient perceives the staff's sincerity and believability.
(3) All behavior is assigned based on prior enculturation/socialization processes and thus is always filtered through an individual's values, attitudes and beliefs, for both physician and patient.
(4) Residue (memories) creates the lens through which most people respond and interact with others.
(5) Residue is the chief instigator of progress or resistance to healthy lifestyle challenges and changes.

The concepts of **behavior and residue** aptly describe the patient/physician relationship. Health Care Providers make a diagnosis of a patient's **behavior** such as overeating or poor eating habits; the patient responds from their residue – habits, relationship to food, previous association to physical activity. Behavior and residue are the primary considerations of physician/patient communication.
There are no fewer than seven (7) Communication Arenas working in tandem to create the *communication climate* of the organization. These communication arenas bring forth the communication experiences of the environment. These experiences happen on an individual

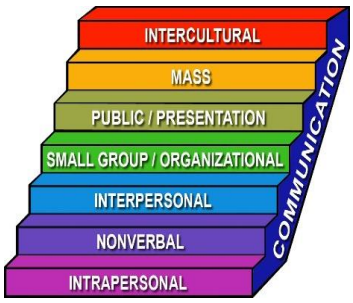
and collective behavior. They happen for both the provider and the patient. Consider this communication scenarios:

1. **Intrapersonal Communication**: Patient and Provider arrive to the provider environment with *residue* determining their experience with each communication experience
2. **Nonverbal Communication**: Patient misreads Doctor's lack of eye contact as a serious health problem.
3. **Interpersonal Communication**: Staff receiving and prepping patients for Physician's input
4. **Small Group Communication**: Staff consultations about patient treatment
5. **Public Speaking**: Orientations, meetings, provider-family discussions
6. **Mass/Persuasive Communication:** All communications created to influence – waiting room announcements, provider health pamphlets, provide-patient written communications
7. **Intercultural Communication**: Provider-Patient Cross-Cultural communication experiences that alter one or both perception of the situation

The above communication scenarios are common and multiple in occurrence during the institutional workday. They are fluid and can be experienced alone or more likely as a communication experience that includes multiple steps (arenas). Understand the frequency with which these communication arenas interact with one another:

A physician meets with a new patient, a young Mexican child (accompanied by his mother, grandmother, aunt and uncle) that is struggling with being overweight to the point of health emergency. There is the Intrapersonal Communication from the residue from the physician's perspective (daily load, prior experiences with the culture, etc.) as well as residue of each family member that has become the positive or negative residue of the child. Nonverbal Communication signals being interpreted correctly or incorrectly by the physician and patient/family. There is Interpersonal Communication as the physician addresses the patient. There is Small Group Communication as the physician and staff interacts with the family. There is even a case where Public Speaking is present as the attending physician communicates with the entire family (though more aptly described as Small Group. There is the "reading" of the physician/staff gives family recommendations through pamphlets and other Mass Communication that helps instruct the family on adopting proper eating and physical activity habits. There is Intercultural Communication between the differing cultures of the physician and family. ALL these Communication experiences build a staircase we climb up and down all day

depending on our communication environments – some arenas more, some less. interconnected as the Communication Staircase Model diagram below suggests:



HCI, Communication Staircase Model™

PROVIDER TOOLKIT HANDOUT #2

COMMUNICATION HEALTH INTAKE FORM*

Communication Intake Form to be completed by each health-client to support their level of communication comfort and clarity during the care process.

NAME _____ **ID# _____**

DATE _____

Language: English Y N Preferred Language _____

Do you need an interpreter? Y N

Cross-Cultural Communication Influences: (Optional but beneficial to health care assessment)

Age_____

Ethnicity/Nationality_____

Practicing Religion/Philosophy_____

Sex/Gender_____

Rate the following communication experiences on a scale of 1(Strongly Agree) – 5 (Strongly Disagree), to help us better serve you during the healthcare examination. Please circle the appropriate number.

1. I can confidently express the words I want to use to explain my health situation in the health care providers language. 1 2 3 4 5
2. When sharing my physical concerns with others I feel comfortable. 1 2 3 4 5
3. When sharing health concerns with others outside of my close family circle I feel comfortable. 1 2 3 4 5
4. When sharing my mental and emotional concerns with others I feel comfortable. 1 2 3 4 5
5. When a practitioner/doctor is discussing my examination results, I am are capable of clearly restating/rephrasing the diagnosis.

1 2 3 4 5

6. I am comfortable consulting with a provider of any sex or culture.

   1 2 3 4 5

7. I require a family member in the room during consultation or physical examination.

   1 2 3 4 5

8. My current communication environment within the community where I live is healthy and comfortable. 1 2 3 4 5

9. My health concern/problem is rooted in family history.

   1 2 3 4 5

10. My health problem is based on environmental factors – my past or immediate surroundings. 1 2 3 4 5

11. My current communication environment at home is one where I feel comfortable.

    1 2 3 4 5

12. My health condition is based completely on biomedical science beliefs.

    1 2 3 4 5

13. I take prescribed medicines from a health care facility.

    1 2 3 4 5

14. I do not consult with cultural/spiritual healers when experiencing health problems.

    1 2 3 4 5

15. Physical/mental health is a matter of harmony and balance with natural laws.

    1 2 3 4 5

16. My current communication environment at work is one where I feel comfortable.

    1 2 3 4 5

17. According to my cultural understanding, health care visits should take as long as needed to diagnose and advise health problems.

    1 2 3 4 5

PLEASE NOTE: Adding the scores above may give insight into the cognitive state of the patient in the effort to be more aware of and understand the course of action when consulting, diagnosing

and advising patients of varying cultural backgrounds. THIS IS NOT a diagnostic instrument but one designed to provide insight to the increasing cultural complexities of diverse systems. There are many cultural factors that play a role in determining the best approach to healthcare. This questionnaire attempts to address just a few. Use it as a guideline or base line to create your institutions personalized **Communication Healthcare Intake Form.**

SCORING	**POSSIBLE PATIENT HEALTHCARE WORLDVIEW**
0 -20	Patient may view healthcare through the **Scientific/Biomedical Approach**
21 – 56	Patient may view healthcare through the **Holistic/Naturalistic Traditions Approach**
57 – 85	Patient may view healthcare through the **Supernatural/Religious/Personalistic Traditions Approach**

NOTE TO USERS:** ***Language Shaping is the mechanism used to create ***Behavioral Communication*** patterns that determine output and outcomes. Human thoughts, words, and emotions produce actions/behavior. The language context within which we develop our perception, perspective, personality, is the language environment we create and live in. Communication is not stagnant nor stable. As communication contexts expand or diminish, so does language and the resultant behavior.

All context is communication and communication is context. The Public Health System is a specific, unique context that brings together a multiplicity of people's worldviews concerning health and health care. The recent COVID pandemic of 2020 till the present, is a clear example of the varying attitudes cultures have towards health, heath care and compliance with health care guidelines. No matter the worldview, effective communication is the foundation of understanding, compliance, efficiency and recovery within the individual and within the institutions that support health services.

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