Assessing the Relationship Between Patients' Ethnocentric Views and Patients' Perceptions of Physicians' Cultural Competence in Health Care Interactions

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Many studies have documented disparities in access to and satisfaction with medical care by race and ethnicity. Disparities are often attributed to providers' failure to accommodate differences. Studies have yet to document the association between patients' ethnocentric views and their perceptions of physicians' cultural competence in health care interactions as part of the explanation for these outcomes. In this paper we surveyed 306 participants in Appalachian Ohio using newly developed measures of patients' perceptions of physicians' cultural competence in health care interactions and an existing measure of ethnocentrism. Pearson's correlations revealed associations between higher levels of patients' ethnocentric views and greater perceptions that physicians do not accommodate macro-cultural and linguistic differences. Higher levels of ethnocentric views were also associated with greater perceptions that physicians provide patient-centered care. The findings indicate that practitioners should be cautious in assuming that culturally competent care is identical to patient-centered care. Implications for physician training and patient education are offered.

The U.S. health care system faces unique challenges as a result of an increasingly diverse population. As reported by the U.S. Census Bureau (2006), between 2000 and 2004, the White population increased by only 3.5%. In comparison, the African American population increased by 5.0%, the American Indian population and Alaska Native population increased by 6.0%, the Asian American population increased by 16.4%, the Native Hawaiian and other Pacific Islander populations increased by 9.3%, and the population of Hispanic or Latino origin increased by 17.0%. Likely continuation of this demographic trend will mean that, by the year 2050, the White population will no longer be the majority population (Smelser, Wilson, & Mitchell, 2001). Indeed, these trends indicate that no ethnic group will constitute a majority of the population (Smelser, Wilson, & Mitchell, 2001).

Because, as Betancourt (2004) correctly argued, "culture plays a large role is shaping health related values, beliefs, and behavior" (p. 953), the growing ethnic minority population groups will bring unique needs to health care interactions that may result from cultural differences between care providers and receivers (Berger, 1998; Betancourt, 2003, 2004). Since understanding cultural differences is important to accessing appropriate health care services, cultural competence in health care has emerged as a means to better serve the needs of this changing population (Ahmed, 2007; Ahmed & Bates, 2007; Betancourt, 2006; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Betancourt, Green, Carrillo, & Park, 2005; Wu & Martinez, 2006). Although health policy makers, administrators, and academicians alike recognize the significance of cultural competence to providing equitable

health care to diverse population groups (Betancourt et al., 2003), there is a lack of careful conceptualization of cultural competence (Betancourt, 2006; Betancourt et al., 2003; Perloff, Bonder, Ray, & Siminoff, 2006), systematic effort to conduct research to improve cultural competence in healthcare systems (Hayes-Bautista, 2003), and outcome/impact measures to assess cultural competence in health care (U.S. Health Resources and Services Administration [HRSA], 2001). Although some preliminary steps have been taken to understand how health care providers' ethnocentrism affects culturally competent care (Capell, Dean, & Veenstra, 2008), to our knowledge, the role of the patients' ethnocentric views has not been explored. Against such a backdrop, this study investigates the relationship between patients' ethnocentric views and their perceptions of physicians' cultural competence in health care interactions. To this end, we begin by defining a few essential terms.

Conceptualization of Key Terms

Concepts such as *culture*, *cultural competence*, *race*, *ethnicity*, *racism*, and *ethnocentrism* are often times used with little conceptual clarification in the literature, thus creating confusion regarding these already fuzzy, abstract, and fluid concepts. In view of that, we conceptualize the key terms (culture, cultural competence, race, ethnicity, and ethnocentric views) used in this study to provide the frames of references within which this study was carried out.

We take a comprehensive view of culture, defining it as the integrated patterns of beliefs, values, assumptions, attitudes, history, norms, traditions, customs, lifestyles, and institutions shared by a group of people within a community, organization, or nation, who have a common nationality, race, ethnicity, language, religion, or socio-economic status, or a combination thereof (Ahmed, 2007). We conceptualize cultural competence in health care as a process that acknowledges health care providers' and receivers' perspectives, and promotes knowledge and awareness of individual and cross-cultural differences in order to facilitate cultural adaptation (Ahmed, 2007).

Although race and ethnicity are part of culture, they are not synonymous with culture. We believe that "race" is not a biological construct based on simple observable physical characteristics, such as skin color, but is "widely used as a social category" that does not reliably or accurately differentiate people into groups (U. S. Department of Health and Human services [DHHS], 2003, p. 9). The contents of the category race are unclear, and there is little in the way of a shared or cohesive definition (Dubriwny, Bates, & Bevan, 2004). Because of its inaccuracy and lack of referential power, race should not be a preferred term, particularly in health studies. Recognizing the social construction of the term *race* and the discrimination accompanying its abuse by powerful groups, Stringer (2006) argued, "because race is neither scientifically accurate nor socially positive, it is tempting to replace the term *race* with the term *ethnic* as a more accurate word, indicating shared systems of cultural beliefs, behaviors, and history" (p. 171, emphasis in original). Accordingly, in this study, we privilege the term ethnicity and use the term race only in reference to other people's work. Ethnicity refers to a particular group who shares common heritage including "history,

language, rituals, and preference for music and foods" (U. S. Department of Health and Human services [DHHS], 2003, p. 9).

Finally, McDaniel, Samovar, and Porter (2006) characterized culture as ethnocentric. They recognized "a strong sense of group identity" as giving rise to ethnocentrism or "the tendency to value or place one's own culture in a superior position relative to other cultures" (p. 11). Hence, ethnocentric views in this study will refer to the assumption and feeling that one's group is superior to other groups.

Culture, Health, and Cultural Competence in the Patient-Provider Encounter

Scholars have documented how physicians and patients use different explanatory models of health and illness that shape their health perspectives (Du Pre´, 2000; Helman, 2000). Street (2003) argued that communication in a medical encounter is influenced by each interlocutor's worldview and explanatory model, "including beliefs about the cause of an illness, degree of personal control over health, and best ways to manage health problems" (p. 78).

Socio-economic factors such as poverty, educational background, employment status, transportation, housing, childcare, awareness of community resources, and existing support within communities add more levels of complexity to cultural differences in health care encounters (Haas, Lee, Kaplan, Sonnebron, Phillips, & Liang, 2003; Saldana, 2001; Yu, Huang, & Singh, 2004). Socio-cultural and economic diversities between and among health care providers and receivers have important implications for health outcomes (van Ryn & Burke, 2000). A considerable body of research has documented disparities in health status and levels of care and in satisfaction with medical care by race and ethnicity at a group level (Cooper-Patrick, Gallo, Gonzales, Vu, Powe, Nelson, & Ford, 1999; Doescher, Saver, Franks, & Fiscella, 2000; Elster, Jarosik, VanGeest, & Fleming, 2003; Jacobs, Karavolos, Rathouz, Ferris, & Powell, 2005; Mayberry, Mili, & Ofili, 2000; Murray-Garcia, Selby, Schmittdiel, Grumbach, & Quesenberry, 2000; Ngui & Flores, 2006; Park, Kogan, Overpeck, & Casselbrant, 2002; Probst, Moore, Glover, & Samuels, 2004).

As significant as group level comparisons are, interpersonal aspects of health care, such as healthcare provider-receiver relationships, also have important implications for health outcomes. In its 2002 (Smedley, Stith, & Nelson) report, the Institute of Medicine indicated that differences between physicians' and patients' race and ethnicity can lead to health disparities. Highlighting the importance of provider-patient communication in relation to ethnicity, Street (2003) argued that "another way the cultural context may have an impact on communication in a consultation is with respect to ethnicity-related attitudes and stereotypes possessed by clinicians and patients" (p. 79). Many studies have documented racial/ethnic differences in doctor-patient relationships (Doescher et al., 2000; Murray-Garcia et al., 2000; Whittle, Conigliaro, Good, & Joswiak, 1997). Most studies have focused on one side of the patient-provider relationship, emphasizing the physician's role in determining the health care interaction (Feldman, Novack, & Gracely, 1998; van Ryn & Burke, 2000). Several scholars (Betancourt et al., 2003; Betancourt et al., 2005; Culhane-Pera, Reif, Egil, Baker, & Kassekert, 1997; U.S. Department of Health and Human services [DHHS], 2001; Like,

Steiner, & Rubel, 1996) have urged health care providers to learn to manage complex differences in communication styles, attitudes, behaviors, and worldviews in their everyday encounters with culturally different patients. These scholars, among others, assign individual practitioners primary responsibility for being culturally competent during health care interactions. Both development and delivery of culturally competent services are thought to hinge on the "sensitivity" of the providers to offer culturally sensitive and culturally appropriate care, and several studies have underscored the importance of provider training for promoting intercultural communication competence (Morales, Cunningham, Brown, Liu, & Hays, 1999; Skelton, Kai, & Loudon, 2001).

The health communication dyad, however, consists of both providers and patients communicating. A limited number of researchers have investigated patient's beliefs about racism and preference for physician race in relation to satisfaction with care and health outcomes (Chen, Fryer, Phillips, Wilson, & Pathman, 2005; Gray & Stoddard, 1997; Howard, Konrad, Stevens, & Porter, 2001; Saha, Taggart, Komaromy, & Bindman, 2000). Although racism has been explored, at least preliminarily, Street (2003) noted that "very little research has examined how the *patient's* perceptions of the provider's ethnicity affect communication in consultation" (p. 79, emphasis in original).

Because people's communicative practices are governed by their group identity alongside their personal identity (Hecht & Krieger, 2006), patients' communicative practices are likely influenced by ethnocentricity. Moreover, because of "the nature of the physician-patient relationship as a meeting of people of difference" (Cline & McKenzie, 1998, p. 61), the intercultural interaction of the encounter is likely complicated by the context as well. Yet, studies have not looked into assessing possible cultural differences in physician-patient interactions resulting from a patient's "strong sense of group attachment," "enculturation," and/or "underexposure to other cultures" (McDaniel, Samovar, & Potter, 2006, pp. 11-12). We thought it would be worthwhile, therefore, to assess the relationship between patients' ethnocentric views and their perceptions of physicians' cultural competence in health care interactions. To this end, we focus on rural Appalachian Ohio, a Medically Underserved Area (MUA) (Finerman, Blanchard-Horan, Jowers, & Brittman, 2003; Pope, Hancock, & Sills, 2006), with diminishing access to health, education, employment, and other socio-economic opportunities (Simpson, Isaac, Burger, Gerson, Gemmel, & Pheley, 2000).

Differences in social, cultural, behavioral, genetic, and environmental factors contribute to inequalities in health care services among subgroups of the population and among geographic locations. Studies have documented disparities in health resulting from significant disparities between people of different genders, races, ethnicities, socioeconomic statuses, and geographic locations (Eberhardt, Elsie, & Pamuk, 2004; Hartley, 2004). Studies have identified Appalachia as having a unique cultural identity (Jones, 1998; MacAvoy & Lippman, 2001). Along with the people came their distinct beliefs and values, which include a high worth given to freedom, independence, and solitude (MacAvoy & Lippman, 2001). While Jones (1998) argued that the early mountaineers neglected formal education, Weller (1965) indicated that they were isolated from the mainstream of American life, thus allowing them to defend their cultural heritage. Weller further advanced the argument that folk culture is a strong marker of Appalachian people, especially those in rural areas who still retain many

of the values that are characteristic of their rich heritage. Studies have also identified the rural Appalachian identity as being further complicated by issues of race, sexuality, and gender roles (Dees, 2006); yet to our knowledge, this study has made the first attempt to examine the relationship between patients' ethnocentric views and their perceptions of physicians' cultural competence in health care interactions in an Appalachian Ohio context.

Studies have documented the role of ethnicity in physician-patient communication from the providers' perspective (Perloff et al., 2006; Street, 2003). Street (2003) considered ethnic differences between physician and patient to be a serious obstacle to physician-patient interactions, "especially if one holds negative attitudes toward the other's ethnicity" (p. 79). In view of that, we expect that patients' ethnocentric views will be negatively associated with their perceptions of physicians' culturally competent behaviors. Therefore, the following hypothesis is posed:

> H1: Patients' ethnocentric views will be negatively associated with perceived physicians' cultural competence, both global and patient-centered.

Method

Participants

A sample of 306 participants was recruited from the patient base at Holzer Clinics in Athens (N = 100), Jackson (N = 103), and Gallipolis (N = 103). Employing a purposive sampling method, "which may be used to select sampling units at one stage of a multistage sample that uses a probability-based method for selecting elements" (Schutt, 2001, p. 134), we relied on referrals from personal networks to contact physicians and business administrators at the clinic to allow us to conduct surveys with patients in their clinics. After securing permission from the clinic, we used a representative sampling method (Schutt, 2001) to select participants, who represent a larger population, to fill out the surveys.

Three hundred and ten survey respondents yielded a response rate of 100%. However, after screening for completeness and missing values, 306 cases were used for the final analyses; four surveys were incomplete. Among the participants, 64.4% of them described themselves as being from Appalachia and 29.4% described themselves as not being from Appalachia, while 3.9% described themselves as being from "outside the U.S." About one-fourth (26.5%) of the participants were male (M = 44.1, SD = 16.8) and the remainder (73.5%) were female who were primarily between the ages of 18-92 (M = 44.1, SD = 16.8). The majority of the participants described themselves as European American/White (83.0%), while 2.3% described themselves as African American/Black, 11.8% as Native American, 1.0% as Hispanic, 0.3% as Asian American, and 2.6% as Other. Participants who described themselves as "Other" may include people who are non-Americans, people of two or more racial backgrounds, and people who do not identify with any of the given substantive response choices. Full background characteristics of the participants are presented in Table 1.

Table 1
Demographic Characteristics of Participants (N = 306)

	Demographic Characteristics	N	%
Sex	Male	81	26.5
	Female	225	73.5
Age	Range: 18-92	*M*: 44.1	*SD*: 16.8
Race	European American/White	254	83.0
	African American/Black	7	2.3
	Native American	36	11.8
	Asian American	1	0.3
	Other	8	2.6
Ethnicity	Of Hispanic descent	3	1.0
	Not of Hispanic descent	297	97
	Refused	6	2.0
Birthplace	Appalachian	197	64.4
	Not Appalachian	90	29.4
	Outside the U.S.	12	3.9
	Refused	7	2.3
Education	Less than 8th grade	8	2.6
	Some high school	36	11.8
	High school graduate	109	35.6
	Some college	73	23.9
	College degree	53	17.3
	Some graduate school	5	1.6
	Graduate or terminal degree	21	6.9
	Refused	1	0.3
Income	Less than $10,000	63	20.6
	$10,000-$19,999	52	17.0
	$20,000-$29,999	44	14.4
	$30,000-$39,999	34	11.1
	$40,000-$49,999	25	8.2
	$50,000-$59,999	23	7.5
	$60,000-$69,999	16	5.2
	$70,000-$79,999	15	4.9

	$80,000 or more	25	8.2
	Refused	9	2.9
Health Insurance	Yes	272	88.9
	No	30	9.8
	Refused	4	1.3

A University Institutional Review Board approved the study. Participants older than 18 years of age were recruited; no other inclusion or exclusion criteria were used. Although there was no direct benefit for participation, individuals who participated in the survey received a $5 gift card for their participation. Each participant provided informed consent before participating in the study.

Instruments

We used a 39-item (including nine demographic questions) paper-and-pencil survey to assess the relationship between patients' ethnocentric views and patients' perceptions of physicians' cultural competence in health care interactions. The survey consisted of structured, closed-ended questions and employed 5-point Likert-type scales ranging from 1 ("strongly agree") to 5 ("strongly disagree"). Thus, for these measures of cultural competence, a lower score indicates a greater perception of the physician's cultural competence. Survey items were drawn from Ahmed's (2007) measures of physicians' cultural competence to create four subscales (see Appendix A):

Physician's global cultural competence related to macro-cultural issues. This scale includes five items inquiring into perceptions of the doctor's development of cultural knowledge; for example, "My doctor wants to know about my religious practices related to health issues" (α =0.90).

Physician's global cultural competence related to proxemics/chronemics. This scale includes three items inquiring into perceptions of the doctor's understanding of the space and time dynamics of cross-cultural differences; for example, "My doctor wants to know if time is a concern for me with regard to medical treatment" (α =0.73).

Physician's global cultural competence related to language issues. This scale includes three items inquiring into perceptions of the doctor's awareness and recognition of patient's cultural and linguistic difference; for example, "My doctor considers using the help of an available translator" (α =0.79).

Physician's patient-centered cultural competence. This scale includes four items inquiring into perceptions of the doctor's adaptation to patient's cultural plurality; for example, "My doctor wants to know my viewpoint on illness" (α =0.90).

We also drew 15 items from the Generalized Ethnocentrism Scale (α = .82-.92) (Neuliep, 2002; Neuliep & McCroskey, 1997) which inquire into perceptions of other cultures in relation to one's own (for example, "Other cultures should try to be more like my culture."). A 5-point Likert-type scale, with higher scores indicating higher levels of ethnocentrism (1 = "Strongly agree" and 5 = Strongly disagree") was used and the scores were summed for a total score of ethnocentrism. The scale was reliable (α = 0.82).

Data Analysis

We ran Pearson's correlation analysis to assess the relationship between patients' ethnocentric views and their perceptions of physicians' cultural competence in health care interactions.

Results

The hypothesis predicted that patients' ethnocentric views would have negative association with their perceptions of physicians' cultural competence. We examined this hypothesis by computing Pearson's correlations (see Table B2). Pearson's correlations indicated negative associations between patients' ethnocentric views and physicians' global cultural competence related to macro-cultural issues and physicians' global cultural competence related to language issues. The negative correlation of patients' ethnocentric views (M = 54.17, SD = 8.37) and perceptions of physicians' global cultural competence related to macro-cultural issues (M = 3.54, SD = 0.90) was statistically significant, r (302) = .209, p = 0.01. The negative correlation of patients' ethnocentric views (M = 54.17, SD = 8.37) and perceptions of physicians' global cultural competence related to language issues (M = 3.57, SD = 0.90) was statistically significant, r (302) = .117, p = 0.05. The correlation of patients' ethnocentric views (M = 54.17, SD = 8.37) and perceptions of physicians' global cultural competence related to proxemics/chronemics (M = 3.20, SD = 1.03) was not statistically significant, r (305) = -.023, p = .698. There was, however, a positive association between patients' ethnocentric views and perceptions of physicians' patient-centered cultural competence. The positive correlation of patients' ethnocentric views (M = 54.17, SD = 8.37) and perceptions of physicians' patient-centered cultural competence (M = 2.13, SD = 0.87) was statistically significant, r (304) = -.233, p = 0.01. Thus, the hypothesis was not fully supported; rather, mixed associations were found.

Table 2
Intercorrelations Between Measures of Cultural Competence and Patient Satisfaction

Measure	1	2	3	4	5
1. Ethno	---	.209**	-.023	.117*	-.233**
2. PGCC-Macro		---	.442**	.626**	.144*
3. PGCC- Proxemics/ Chronemics			---	.500**	.274* *
4. PGCCM-Language				---	.181**
5. PCCCM					---

Note. Lower scores for measures of cultural competence indicate greater perceptions of the physician's cultural competence. Higher scores for the items on the Generalized Ethnocentrism Scale indicate higher levels of ethnocentrism.
*p < .05 level
**p < .01 level
Ethno: Ethnocentric Views
PGCC-Macro: Physician's Global Cultural Competence related to Macro-cultural issues
PGCC- Proxemics/Chronemics: Physician's Global Cultural Competence related to Proxemics/Chronemics
PGCC-Language: Physician's Global Cultural Competence related to Language issues.
PPCCC: Physician's Patient-Centered Cultural Competence

Discussion

This study was designed to assess the relationship, if any, between patients' ethnocentric views and their perceptions of physicians' cultural competence in health care interactions. Results of the Pearson's correlation analysis indicated that patients with ethnocentric views may judge physicians in relation to their own particular ethnic group or culture, especially with concern to customs, religion, and language. Specifically, the more ethnocentric a patient is, the less he or she recognizes the physician as adapting to macro-cultural and linguistic dimensions of cultural competence. Conversely, the less ethnocentric a patient is, the more he

or she perceives the physician as accommodating macro-cultural and linguistic differences in care. The findings also suggest that patients with higher levels of ethnocentrism may judge physicians to be less patient-centered.

Altogether, the findings of this study challenge the often simplistic notions of patient-centered care to resolve health disparities. Broad claims such as "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" (Beach, Saha, & Cooper, 2006, p. 11) may overstate the case. We agree with Betancourt (2006) that patient involvement is not synonymous with patient-centered care that highlights "compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient" (p. 9). We therefore disagree with Beach, Saha, and Cooper's (2006) contention that, although patient-centeredness ("broadly focused on the specific needs of people") and cultural competence ("historically focused on the specific needs of people and communities of color") are distinct approaches to improving the quality of health care, they "may look fairly similar in practice" (p. 13). Given that both movements share some common principles (i.e., benefiting patients and promoting high quality care), Beach, Saha, and Cooper (2006) recommended that "patient-centeredness and cultural competence remain distinct but aligned efforts to both elevate and balance the quality of health care for all patients" (p. 14). Rather than concentrating on areas of limited overlap, we believe that the positive associations between patients' ethnocentric views and perceptions of physicians' patient-centered cultural competence, whilst being negatively associated with macro-cultural and linguistic competence, highlight the variable effect that the feeling of one's group being superior to other groups has on patients' perceptions of physicians' cultural competence in health care interactions. As perceived by patients, our data suggest that these care tactics are not received similarly in practice; recommendations that accommodations of group differences can be overlaid on accommodations of individual differences are likely too simplistic. Simply put, patients appear to see a competition between patient-centeredness and cultural competence. And, depending on their level of ethnocentrism, patients see these modes of care as more or less preferable.

This study has validated an abridged version of the Generalized Ethnocentrism Scale to measure association between patients' ethnocentric views and physicians' cultural competence in health care interactions. Results indicated that patients' ethnocentric views were negatively associated with their perceptions of physicians' global cultural competence related to macro-cultural issues and perceptions of physicians' global cultural competence related to language issues and positively associated with perceptions of physicians' patient-centered cultural competence. These associations imply that, while patients with ethnocentric views may perceive physicians' global cultural competence related to macro-cultural issues and language issues to be less present, patients with ethnocentric views may be more inclined to recognize physicians' patient-centered care. Hence, the ethnocentrism scale validated in this study can be used to systematically study connections between culturally competent care and physician-patient interactions.

Limitations

Certain limitations need to be taken into account when considering the findings of this study. The first limitation concerns the sample of the study. Associations between patients' ethnocentric views and their perceptions of physicians' cultural competence were studied within an Appalachian Ohio context. Although Appalachian Ohio does have a unique culture, other populations may have different patterns in accepting different kinds of culturally competent health care. Therefore, future investigation should also consider other ethnically diverse samples. The second limitation is that this research, like most research in the area of cultural competence, relied on quantitative data. Although this approach allows for direct comparisons of the findings in different contexts and surroundings, it may ignore other, less quantifiable, details. Therefore, the findings of this study only offer support for the association found among physicians' global cultural competence, physicians' patient-centered cultural competence, patients' ethnocentric views, and greater variance in patients' perceptions of these associations. Future research may examine the nature of these associations using qualitative measures to determine more deeply the causality of these relationships. The final limitation of the study lies in its perception-based approach. We did not observe individual behavior, but rather provided the conceptual and operational tools for investigating a person's views in the context of recalled interactions. Future research may want to directly observe interactions to determine whether perceptions of culturally competent behaviors are associated with the manifestation in the clinic.

Conclusions

Although this study has limitations, the findings suggest two directions for better design of cultural competence interventions for quality health care delivery and outcomes. First, the findings suggest that, in order to provide culturally competent care, physicians need to make efforts to balance their treatment of patients as individuals and as members of a group. Because there appears, on average, to be an implicit trade-off between an ethnocentric patient's perception of the physician's accommodation of group levels of cultural difference and accommodation of that patient's individual differences, current suggestions that conflate patient-centered care and culturally competent care are unlikely to be received equally well and may diminish overall patient satisfaction and associated health outcomes. Second, although previous studies have associated high levels of patients' racism with lower levels of patient satisfaction (Chen et al., 2005), ethnocentric views may serve as an additional variable to consider in patient education measures. To our knowledge, this study has been the first to include ethnocentric views in the study of patient perceptions of physicians' cultural competence in health care interactions. The results indicate that patients with higher levels of ethnocentric views will likely prefer individual-level patient education and view it as more competent, but those patients with lower levels of ethnocentric views will likely prefer patient education that emphasizes group differences. Although curricula and training programs for cultural competence are in use for health professionals to improve their knowledge, skills, and attitudes, an important challenge remains in providing patients education to improve patient

satisfaction with care. Against such a backdrop, the findings of this study underscores the significance of patients' perceptions of physicians' cultural competence in creating a persuasive case for realizing the different ways patients may act and may want to be treated in health care settings to ensure the best possible health care outcome.

Author's Note

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Appendix A: List of Subscales

Physician's global cultural competence related to macro-cultural issues

- My doctor wants to know about my nationality
- My doctor wants to know about my racial background
- My doctor wants to know about my religious practices related to health issues
- My doctor wants to know about my cultural background
- My doctor asks me who makes important decisions in my family

Physician's global cultural competence related to proxemics/chronemics

- My doctor asks me if I would feel discomfort if the doctor touches me during the physical exam
- My doctor wants to know if time is a concern for me with regard to the health exam
- My doctor wants to know if time is a concern for me with regard to medical treatment

Physician's global cultural competence related to language issues
• My doctor wants to know about my language skills
• My doctor wants to know about my language preference
• My doctor considers using the help of an available translator

Physician's patient-centered cultural competence
• My doctor tries to understand my feelings
• My doctor tries to understand my emotions
• My doctor wants to know my viewpoint on illness
• My doctor wants to know my viewpoint on treatment goals