

Lack of Client-Provider Consensus as a Barrier to Accessing Health Care

Bibliographic Essay & Fieldwork Analysis

ANTH688L Medical Anthropology

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BIBLIOGRAPHIC ESSAY AND FIELDWORK ANALYSIS

TABLE OF CONTENTS

I. Introduction.....	1
II. Barriers to Accessing Health Care	3
A. Financial Barriers	3
B. Structural Barriers.....	4
C. Sociocultural Barriers	4
III. Fieldwork Analysis.....	10
IV. Recommendations for Further Research	12
V. References Cited	13
V. Annotated Bibliography	19
VI. Appendix.....	31
A. Medical Anthropology Fieldwork: Client Interview.....	31
B. Medical Anthropology Fieldwork: Provider Interview.....	33
C. Medical Anthropology Fieldwork: Codes Elicited from Interviews.....	36

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BIBLIOGRAPHIC ESSAY AND FIELDWORK ANALYSIS

I. INTRODUCTION

Many studies focus on the explanatory models, or beliefs, that people have about illness from reproductive cancers (Balshem 1991; Chavez, et al. 1995; Chavez, et al. 2001; Hunt 1998; Markovic, et al. 2004; Mathews 2000; Modiano 1995) to diabetes (Arcury, et al. 2004; Ferzacca 2000; Garro 2000; Schoenberg, et al. 2005; Weller, et al. 1999) to AIDS (Baer, et al. 2004) to aging (Freidenberg 2000). And numerous studies have identified several barriers to accessing health care (Baer, et al. 2004; Brown, et al. 2002; Brown and Hanis 1999; Chavez 1984; Chavez, et al. 1995; Chavez, et al. 2001; Chinn, et al. 1999; Crum 2004; Elder, et al. 2000; Ferzacca 2000; Flores 2006; Gallant 2003; Janz, et al. 2002; Kagawa-Singer and Kassim-Lakha 2003; Lorig and González 2000; Moore 1986; Moreno, et al. 1997; Perez-Escamilla and Putnik 2007; Poss and Jezewski 2002; Reichenbach 2006; Rosal, et al. 2005; Shaw 2005; Stolley, et al. 2006; Two Feathers, et al. 2005; Valenzuela, et al. 2003; Weller, et al. 1999).

Compared to the copious amount of studies on barriers, only a few medical anthropological studies have focused on the significant lack of consensus between provider and client perceptions of these barriers (Baer, et al. 2004; Chavez, et al. 2001; Freidenberg 2000; Hunt 1998; Hunt and Arar 2001). Consensus between provider and client, or specifically, lack of consensus, is one of the most significant sociocultural barriers in accessing health care. In an effort to add to the anthropological

literature on provider-client consensus, this paper will provide a review of the literature and an analysis of fieldwork conducted on provider and client perceptions about barriers in accessing health care at a community health clinic in College Park, Maryland.

II. BARRIERS TO ACCESSING HEALTH CARE

Medical anthropologists have found three categories of barriers to health care, including: financial (e.g. income, prohibitive cost medical services, lack of health insurance); structural (e.g. transportation challenges, child care issues, social support, immigrant document status, acculturation, language); and sociocultural (e.g. lack of social support, lack of provider-client consensus of explanatory models).

Though these three categories are well defined, it does not necessarily mean they are distinct from one another. In fact, they usually complement each other. For instance, a person who lacks income (financial barrier) because she was laid off from her steady job may not be able to afford transportation (structural barrier) to her doctor for preventative medical service. Or she can't afford child care (structural) and does not a social support group such as family to care for her three young children (sociocultural barrier) while she accesses the health service. An multitude barriers can occur and prevent a person from accessing health care.

A. Financial Barriers

Financial barriers can be caused by many factors, including employment status or immigrant documentation status. Chavez has conducted a great deal of research on financial barriers among Latino immigrants in the U.S. (Chavez 1984; Chavez, et al. 1992; Chavez, et al. 1995; Chavez, et al. 2001). In one of his earlier studies, Chavez (1984) found that Mexican immigrants are less likely to seek medical care in the US due to the high cost of medical care and fear of exposing their undocumented

status. These informants explained that completing medical forms may lead to deportation, and they would rather avoid US medical services.

B. Structural Barriers

Since the 1960s, studies focus on “structural explanations for the use of medical services, such as the availability of services, poverty, medical insurance, work contingencies, lack of child care, and other factors associated with the political economy of health care. Language and other communication-related barriers were also engulfed in this structural framework” (Chavez, et al. 2001:1115). In her 2000 study, Freidenberg identifies several barriers to accessing health care. In addition to providers not prescribing a treatment regimen, including medications, that patients can follow and fit into their lifestyle, she finds that lack of communication between patient and provider is an important barrier. One of her informants states, “But doctors do not say anything to you, so I don’t tell them anything either!” (2000:130). Freidenberg also finds that language differences between patient and provider is a barrier, and Santiago-Irizarry (2001) argues that medical translation is perhaps the most common and readily accessible method to eliminate language as a barrier to health care.

C. Sociocultural Barriers

In the 1970s, Byron Good and Arthur Kleinman began to explore exploring a meaning-centered approach to medical anthropology (Good 1977; Kleinman, et al. 1978). “What was important to these researchers was the way in which groups and individuals constructed explanations of their own

suffering and the way in which those constructions encapsulated an expression of their social suffering" (Dressler 2001). The Cultural-Constructivist theoretical framework, derived from Good and Kleinman's work, "explores how sicknesses are culturally constructed" (Joralemon 2006:12). Cultural-constructivist research engages lay, folk, and professional health care sectors, including their illness experiences (Kleinman 1980).

Cultural-constructivists argue that members of a culture use an explanatory model to provide meaning and comprehension of an illness. Kleinman, Eisenberg, and Good's (1978) explanatory model framework does not insist on provider/non-provider differences. Rather, they offer a conceptual framework for thinking about the interface and communication between different points of view, experience, and involvement in curing and treatment. Health care providers share training focused on biomedical diseases; patients do not usually share the same experience and may have concepts or "explanatory models" about illness that differ from those of providers.

Chavez et al. ask, "To what degree do beliefs matter in using medical services?" (2001:1114). They argue, "Structural factors do not account for all the variation in behavior that humans exhibit" (2001:1115). Although they find that "structural factors such as medical insurance, age, marital status, education, and language acculturation explain Latinas' use of [cervical cancer screenings]" (2001:1114), sociocultural knowledge also plays an integral and combined role in accessing health care. For example, Chavez et al. write, "for Latina immigrants, arriving in the United States requires a negotiation of the cultural knowledge about disease and prevention they arrived with, the predominant popular cultural knowledge, and knowledge promoted by physicians. These competing

and overlapping models also promote specific behaviors, such as the need to access preventive medical services" (2001:1114).

In a study of cancer patients and oncologists in Mexico, Hunt argues "that causal reasoning strives to integrate abstract, biomedically-based explanations with everyday expectations and experiences, in order to give meaning to otherwise arbitrary events" (1998:299). Persons affected by cancer attribute their development of cancer for a reason. She writes, "In their causal explanations for cancer, people grapple with the problem of making sense of the illness within specific life circumstances, seeking to understand the abstract notion of 'risk' factors in concrete terms" (Hunt 1998:300).

Freidenberg (2000) argues that biomedical and layperson's explanatory models are similar in that they both emphasize finding a cause of illness (or disease). Like Freidenberg, Hunt (1998) finds that both providers and patients construct similar explanations, specifically in Hunt's study, relating cancer with behavior: a person who has cancer has it because she did not act properly. As Hunt explains, however, contextualization is key, as "physicians' causal stories tend to be based on generalized presumptions about how a category of person might act (i.e., members of a certain gender or class). Patients' causal explanations, in contrast, were based on specific experiences and events, seeking to connect the illness to the details of their personal histories" (1998:301).

Patients' and providers' explanatory models reflect their social position and their perspectives as subject and observer. Hunt reports:

"From the patients' point of view, the explanatory problem is to understand how cancer has come into their lives. Their explanations are thus framed from a subjective

perspective. Patient explanations thus seek a unifying interpretation capable of giving the disease coherent meaning by relating it to other problematic events within their biographies, such as spousal abuse or traumatic birthing experiences. In contrast, doctors, by virtue of their professional training and structural position as care givers, approach illness as a natural or technical object. They connect this impersonal biomedical entity to specific life circumstances in a very different way than do patients. Their perspective is necessarily distant from the subject, producing explanations that are not about a specific set of biographical antecedents, but about presumed sets of behaviors that they associate with a particular type of person (e.g., lower class, female, indigenous), locating the reason for illness in the supposed characteristics of the patient. Their causal explanations therefore reflect moral judgments about presumed lifestyles of categories of individuals” (Hunt 1998:310)

Baer et al. (2004) studied how much patient or lay models of illness are actually shared across communities and how patient models differ from physician models of a specific illness, AIDS. The researchers interviewed laypeople and physicians in Mexico and the US about AIDS in order to analyze explanatory models, “whether or not they may be biomedically correct” (Baer, et al. 2004:6). However, unlike the findings of Kleinman et al., in which they argue that the differences in patient and provider explanatory models of illness cause barriers to care and treatment, Baer et al. found that explanatory models of AIDS are largely shared. The researchers explain:

“One possibility is that it is not that explanatory models are so different, but that the class (education/power) differences between patient and provider may adversely affect communication and thus, outcomes. Physicians may recognize patients’/laypeople’s meaning, but patients/laypeople may not recognize a more detailed physicians’ model. Although in many cases problems in communication may be due to differences in explanatory models, much of the problem in physician-patient interaction may be due to the inability of physicians to really communicate with laypeople and explain themselves in plain English, or whatever the language of the patient is. Thus, while it is possible that physicians may have more themes than those captured in these interviews, it is clear that

they do understand and share the lay model of AIDS. This shared understanding is important to communication and is evident in that the physicians' responses were slightly more similar to lay members of their own community than they were to physicians in another setting. But perhaps the most important issue may be the small differences we did find between models. It may be that the real differences between cultures are not large-scale differences in models of any particular domain, but the aggregation of the many, but small differences over a large number of domains. Perhaps, as Barth (1969) has suggested, it is these small differences in many domains—boundary mechanisms—that are the real stuff of cultural differences. Perhaps, we are really all alike in many many ways, but different in only a few very important ones" (Baer, et al. 2004:18-19).

In a study of breast cancer support groups, Mathews (2000) found that in sharing their personal stories, the support group members "worked to negotiate points of agreement among the varying sources of knowledge and oftentimes conflicting belief systems they held about breast cancer. The synthetic model they created rejected many of the assumptions underlying the dominant biomedical view of cancer 'survivorship,' particularly its emphasis on the autonomous individual as decision maker and its attendant male-gendered sports and military imagery—assumptions that often implicitly structured the agendas and topics discussed in the formal, medically sanctioned support groups these women found unappealing" (2000:394).

Regardless of demographics, the support group members created a meaningful and consensual explanatory model, i.e. staying in harmony with God will prevent cancer from recurring. However, Mathews reports that that support group members who do not share the same explanatory model will not feel a part of the group. If one support group member does not use or agree with the same explanatory model, then they may feel outcast or seek support elsewhere.

One of Mathews's informants articulated that as a nurse and breast cancer patient, she felt more comfortable with the biomedical model, not the spiritual explanatory model that the support group members had created. Mathew states, "[This] hints at the way she has compartmentalized her religious views to contexts other than her illness experience. She does not completely accept, therefore, the way in which the [support group] members have attempted to integrate the religious and biomedical viewpoints, finding the religious emphasis and imagery overwhelming. For Alice, the mediation of conflicting beliefs was not an issue. She accepted the biomedical model, and what she wanted from a support group was a chance to obtain the latest information on treatment alternatives. Thus, she eventually joined a group at the local hospital and continued to attend until she completed therapy. She did not rely on that group for social support, turning instead to her friends and family" (2000:410).

III. FIELDWORK ANALYSIS

For this paper, I conducted fieldwork at a community health clinic in College Park, Maryland. In an effort to assess how clients and providers negotiate barriers to health care, and how clients interpret providers' views and vice versa, I interviewed a teenaged pre-natal patient and the nurse practitioner who treated her.

I found that the provider and client clinic clearly have different viewpoints of what they consider to be important features of health care, including how to access health care knowledge and services. The client emphasized that quality health care meant empathy and gentle treatment on the part of the provider, while the provider felt that quality health care means educating the client about barriers to being a sound mother, specifically lack of education. The provider was especially concerned that her patients get their education about the birthing process from TV programs, while on the other hand, the client felt more knowledgeable about birthing process because she watched birthing shows on the TLC and the like.

The provider perceived that a gap existed between herself and the client due to age. Although there was only 15 years difference between the two, the provider felt that the client thought she was an old lady lecturing her on the responsibilities of motherhood and the importance of a high school education. However, the client perceived the provider to be caring and empathetic and did not perceive any communication challenges between the two, and moreover, the client felt that if the provider had any issues with the client, she would have spoken up. In fact, the provider did have concerns that she felt she perhaps did not address strongly enough because of the client's lack of

response. Yet, in my interview with the client after the consultation, the client did express that she had understood.

Clearly communication between client and provider is an integral part of health care. Just because the client leaves the exam room feeling satisfied with her treatment does not necessarily mean that the provider feels satisfied about her level of treatment. These issues go beyond structural and financial barriers; they delve deep into sociocultural issues of lack of communication.

IV. RECOMMENDATIONS FOR FURTHER RESEARCH

The literature review and evaluation findings have identified several barriers to accessing health care. Yet, as Chavez et al. (2001) find, structural, financial, and sociocultural barriers are not mutually exclusive. In the case of Latinas, they write, "Structural factors such as medical insurance, education, and acculturation (increasing familiarity with English) are significant influences [on patients access to health care]. Clearly, the disadvantaged position of Latinas, especially immigrants, in US society defines, to a large degree, their access to medical services, a finding consistent with the political economy of health care and critical medical anthropology perspectives. The finding that individual Latinas' consonance with ideal Latina beliefs did not lead to less use of Pap exams undermines the argument that Latina cultural beliefs in themselves are an obstacle to the use of medical services. In this sense, the cultural explanation for why Latinas may not use preventive medical services is not supported" (2001:1125).

Freidenberg writes, "In theory, there are at least five perspectives in assessing a person's health status: the clinician's, the person's, the clinician's view of the patient's view, the patient's view of the clinician's view, and—finally—the agreement or disagreement between these views" (2000:124). More anthropological research is needed on these viewpoints in order to eliminate, or at least decrease, barriers to accessing health care. Understanding provider-client consensus would help educate providers and help improve quality of health care for patients.

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This article emphasizes Cultural Consensus Theory and its impact on anthropological and public health data analysis. Its reflection of response patterns and variations around a cultural norm is highly effective in understanding cultural similarities and difference, in this case, between a community's explanatory model and a physician's biomedical model.

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1991 Cancer, Control, and Causality: Talking about Cancer in a Working-Class Community. *American Ethnologist* 18(1):152-172.

In a nutrition education seminar held for working class participants in Philadelphia, some participants felt social pressure not to participate in group discussion. However, during the dessert break after the workshop, several participants began to share their perceptions of health and nutrition with the educator. However, the ethnographer-educator found that focus group participants were more relaxed and willing to share their perception.

Chavez, Leo R.

1984 Doctors, Curanderos, and Brujas: Health Care Delivery and Mexican Immigrants in San Diego. *Medical Anthropology Newsletter* 15(2):31-37.

In San Diego County, over 75 percent of Mexican immigrants surveyed sought care from medical providers located in San Diego County. Yet, 10 percent of those surveyed did not seek any

medical care, citing barriers such as the high cost of medical care, fear of exposing their undocumented status, (e.g. completing medical forms would lead to deportation), inability to speak English, lack of trust in US medical system, lack of knowledge in where to seek care, and belief that US medical doctors lack understanding of their health problems, particularly folk illnesses. However, belief in folk illnesses including *mollera caida* (fallen fontanelle), *empacho*, *susto*, and *mal de ojo*, does not correlate with not accessing U.S. health care services. People who sought care in Mexico did so because they felt it was more convenient and knew their doctors, Mexican health care is less expensive, they had had bad experience in the U.S., and they spoke the same language as their Mexican health care provider. Seventy percent of those interviewed had used complementary medicine, specifically herbal remedies, for gastrointestinal conditions in addition to accessing biomedical care. U.S. health care providers need to have a better understanding of folk illnesses in order to treat patients effectively; if they do not, patients will feel frustrated and misunderstood, which will prevent them from accessing U.S. health care services.

Mexican immigrants who are less likely to seek medical care cite barriers including fear of exposing their undocumented status, e.g. completing medical forms would lead to deportation, and the high cost of medical care. [This article is a good example of how to combine quantitative analysis with ethnographic findings.]

Chavez, Leo R., et al.

2001 Beliefs Matter: Cultural Beliefs and the Use of Cervical Cancer-Screening Tests. *American Anthropologist* 103(4):1114-1129.

Latinas (i.e. Chicanas and Mexican and Salvadoran immigrants) who have explanatory models about cancer that are similar to Anglo women are more likely to have accessed cervical cancer screening more recently than Latinas whose explanatory models were similar to physicians. However, Latinas are more likely to perceive normative and non-normative behavior, e.g. vaginal infections correlating to multiple sex partners, as barriers to accessing the screenings, while physicians take an

epidemiological viewpoint, e.g. sexual activity correlating to increased risk of HPV transmission. The health sector needs ethnographic methods to understand these explanatory models and develop health education programs addressing them. [Chavez again effectively combines quantitative analysis with ethnographic findings in a succinct way.]

Chinn, D. J., et al.

1999 Barriers to Physical Activity and Socioeconomic Position: Implications for Health Promotion. *Journal of Epidemiology and Community Health* 53(3):191-192.

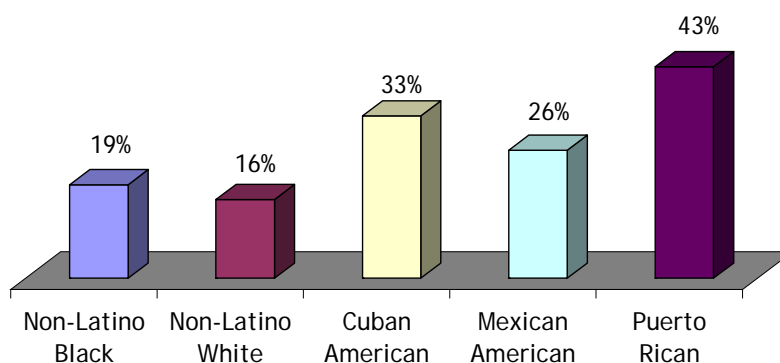
Health promotion programs should consider external and internal factors as barriers to exercise. External factors include not having enough leisure time to exercise, lack of money, illness or disability, and lack of transport. Internal factors include lack of motivation and belief that clients already get enough exercise.

Commonwealth Fund

2002 The Commonwealth Fund 2001 Health Care Quality Survey.

A 2001 Commonwealth Fund study found that Latino patients from different nationalities had different perceptions of their quality of health care.

Figure 1. Percentage of adult patients who had at least one problem communicating with their doctor by ethnicity and nationality



Davidson, Mayer B.

2005 Counterpoint: Self-Monitoring of Blood Glucose in Type 2 Diabetic Patients Not Receiving Insulin - A waste of money. *Diabetes Care* 28(6):1531-1533.

For diabetics, self monitoring of blood glucose with glucometers can be an expensive endeavor for those with and without insurance. Purchasing accessories, including reagent strips, lancets, lancing devices, meters, batteries, and calibration solutions or chips, on a regular basis is cost prohibitive for most people, especially those without insurance. The author argues that money spent on glucometers and accessories could be better spent on other aspects of diabetes care.

de Alba Garcia, Javier Garcia, et al.

2007 "Diabetes is my companion": Lifestyle and self-management among good and poor control Mexican diabetic patients. *Social Science & Medicine* In Press, Corrected Proof.

In a study conducted in Guadalajara, Mexico, the researchers found that diabetics with an Hemoglobin A1c level between four and seven percent continue to eat traditional food, such as corn tortillas, but have modified their behavior to eat these traditional foods in lesser quantities. Instead of eating three meals daily, they eat two meals a day and snack on fruits, they drink low-calorie beverages like unsweetened tea and coffee, and they do not consume food prepared with a high degree of saturated fats. In addition, they have integrated exercise into their lives.

The Mexican study participants with good glycemic control were more likely to have family support than the participants with bad glycemic control, or an HbA1c level above seven percent.

Elder, John P., et al.

2000 Results of Language for Health: Cardiovascular Disease Nutrition Education for Latino English-as-a-Second-Language Students. *Health Education and Behavior* 27(1):50-63.

A successful cardiovascular health education program was designed based on an ESL Institute curriculum. Students in the ESL Institute comprised the participants. In the three-hour classes, the educators provided an overview of previous sessions, followed by a brief introduction of the new lesson, and then presentation of the new material. The program incorporated such topics as understanding dietary fat and cholesterol, classification of foods, modifying eating habits, reading food labels, understanding blood pressure and its relationship to salt intake, shopping for low-fat and low-cholesterol foods, and modifying recipes. The sessions also discussed stress management topics included defining and identifying stressors, stress reduction techniques, and how to apply these techniques in real life. [Excellent article for best practices in health education, although this article had no qualitative data from participants to support the statistical findings of lower cholesterol levels, lower blood pressure levels, and decreased fat avoidance.]

Flores, Glenn

2006 Language Barriers to Health Care in the United States. *New England Journal of Medicine* 355(3):229-231.

Misinterpretation is a major obstacle to receiving appropriate healthcare. Patients who explain their symptoms to their provider via an interpreter and vice versa are at risk of being misdiagnosed and are less likely to adhere to prescribed medication. Although most commonly used, "ad hoc" interpreters, including family, friends, and untrained medical personnel, are more likely to misinterpret, leading to more adverse clinical consequences, than professionally trained interpreters.

Gallant, Mary P.

2003 The Influence of Social Support on Chronic Illness Self-Management: A Review and Directions for Research. *Health Education and Behavior* 30(2):170-195.

Reviewing several quantitative and qualitative studies, the author found that most research has been conducted on the correlation between social support and self-management of diabetes. Despite

this disparity, a cross-comparison look at the research shows that the more social support a diabetic has, the more likely the person is to successfully self-manage her health. Gender plays an integral role in the correlation between social support and self-management. Men are more likely to report that they receive stronger spousal support than women, because husbands state that their wives prepare their meals according to dietary restrictions, but wives are more likely to cook two meals, one modified for dietary reasons and one for their husband's preferences. The author recommends that future research focus on how to maximize the significant role that family and friends play in a person's self management of chronic disease.

Janz, Nancy K., Victoria L. Champion, and Victor J. Strecher

2002 The Health Belief Model. *In* Health Behavior and Health Education: Theory, research, and practice. K. Glanz, B.K. Rimer, and F.M. Lewis, eds. San Francisco: Jossey-Bass.

Attitudes about physical activity and its relationship to health and disease may influence Latinas' participation in physical activity.

Kieffer, Edith C., et al.

2002 Perspectives of Pregnant and Postpartum Latino Women on Diabetes, Physical Activity, and Health. *Health Education and Behavior* 29(5).

Latinas' beliefs about physical activity and diabetes risk factors are an aspect of health belief and behavior that needs addressing in order to develop and implement a successful diabetes education intervention. Engaging Latinas who are at risk of developing or have GDM in a discussion of their diabetes-related health beliefs and behaviors can help in developing realistic and appropriate strategies for improving pregnant and postpartum Latinas' health. Discussions may include their perceptions of diabetes risk and impact; their nutrition and physical activity-related beliefs, attitudes, and practices; and factors influencing their nutritional meal intake and participation in physical activity during and after pregnancy. Mexican American women mentioned specific dietary practices, such as

frequently eating sweet foods and fats and drinking sweet beverages as an integral part of their culture. Some Mexican American women do not believe a relationship exists between physical activity and the risk of diabetes; instead they believe dietary factors to be the primary cause.

A focus group of Latinas recommended that an intervention addressing barriers such as communication (increasing English literacy), transportation (learning how to drive), nutrition (learning how to select and prepare healthy meals), and exercising safely (dance lessons for pre-natal women) would provide opportunities for women to expand their social networks.

In addition to community members collaborating together, the physical locale of the community is integral to a successful intervention. Community safety helps make regular physical activity possible. Latinas, in discussing with aspects of the community that would help motivate them to increase their physical activity levels, described neighborhoods where women felt free to walk, even at night, and where there were places for children to play. Community center-based group activities also help motivate intervention participants and provide social support for physical activity while addressing safety and other environmental concerns.

Kleinman, Arthur, Leon Eisenberg, and Byron Good

1978 Culture, Illness, and Care: Clinical Lessons From Anthropologic and Cross-Cultural Research. *Annals of Internal Medicine* 88(2):251–258.

Kleinman's framework recommends eliciting the patient's views, or explanatory model, about her illness, cause, and treatment so that a health care provider can treat the patient effectively within the patient's own cultural sphere. Kleinman developed eight questions to help elicit the patient's explanatory model.

Mauldon, Maria, Gail D'Eramo Melkus, and Mayra Cagganello

2006 Tomando Control: A Culturally Appropriate Diabetes Education Program for Spanish-Speaking Individuals With Type 2 Diabetes Mellitus--Evaluation of a Pilot Project. *The Diabetes Educator* 32(5):751-760.

This study focuses on Puerto Rican and Mexican immigrants in the U.S. and Mexicans and Guatemalans in their native countries describe family support as a key variable in ensuring compliance with dietary and other aspects of diabetes management.

Moreno, Carmen, et al.

1997 Heart Disease Education and Prevention Program Targeting Immigrant Latinos: Using Focus Group Responses to Develop Effective Interventions. *Journal of Community Health* 22(6):435-450.

In a focus group of Latinos in the Washington, DC area, participants mentioned *phonovelas* as an effective tool for educating Latinos, especially those with low literacy, about their health because they present information briefly and concisely. They also prefer bilingual education materials with the Spanish and English texts side-by-side in order to easily find the corresponding English word.

The participants see worries and stress caused by job insecurities, family problems, financial concerns, and adjusting to life in the US as major factors in the development of heart disease and perceive heart disease to be caused by a poor diet: eating too much fat, not eating a balanced diet, or eating too much food. They also describe how eggs and high-fat foods contain too much cholesterol, which is "a type of fat that blocks the veins and prevents blood from flowing to the heart." And the participants describe how their eating habits have significantly changed since immigrating to the U.S. In their native country, they were more likely to eat three meals per day, but once in the U.S., they only eat one to two meals daily. They explained this was due to having two or more jobs, so they are not able to eat at regular times, and they buy more fast food meals than they did in their home country. They also report that they have gained weight since moving to the U.S.

The focus group participants listed behaviors a person “should not” do but could not list behaviors a person “should” do to be healthier. The participants perceived that exercise and accessing a health care provider before heart disease develops as the most effective steps toward the cardiovascular disease prevention.

Nakamura, Raymond N.

1998 *Health in America: A Multicultural Perspective*. New York: Benjamin-Cummings Publishing Company.

Cultural differences between Latino patient and non-Latino provider is the common denominator in a patient’s barrier to accessing healthcare.

Otero-Sabogal, Regina, et al.

2003 *Access and Attitudinal Factors Related to Breast and Cervical Cancer Rescreening: Why are Latinas Still Underscreened?* *Health Education and Behavior* 30(3):337-359.

The authors advise that health care providers advise patients that they are at risk for disease, e.g. cervical or breast cancer. Their Latina patients may have misconceptions about risk factors, and “because of their low literacy skills, some women may not understand what the word *risk* means.” Also, because some Latinas feel healthy and asymptomatic, they may perceive that they do not need health care or that getting a medical exam when they feel healthy will cause the illness.

The authors recommend that health care providers can help motivate Latina patients to be screened (for cancer) by advising patients that the screening will benefit their family using the value of *familismo*. Providers should also allow family members to participate in discussions about (cancer) treatment.

Park, Elyse R., et al.

2005 Mixed Messages: Residents' Experiences Learning Cross-cultural Care. *Academic Medicine* 80(9): 874-880.

The Commonwealth Fund supported a study involving interviews and focus groups of 68 residents to explore preparedness to deliver cross-cultural care and to assess the educational climate and training experiences. These residents felt that cultural competency training was a low priority due to lack of time and resources. The residents "developed ad-hoc methods to treat culturally diverse patients, more like 'coping skills' (using visual cues to overcome language barriers, eye contact and other signs of empathy to build patients' trust) rather than 'skills based on best practices.'" But the residents supported evidence-based learning and experiences working with patients from a variety of cultures.

Pendry, De Ann

2003 Control, Compliance, and Common Sense Power Relations in Diabetes Care for Mexican Americans. Ph.D. dissertation, University of Texas at Austin.

In order to elicit the diabetic patient's explanatory model and understand why s/he decides to access and follow a specific treatment, the author shifted the interview question from "What causes diabetes?" to "Have you thought about what caused *your* diabetes?".

Rosal, Milagros C., et al.

2005 Diabetes Self-Management Among Low-Income Spanish-Speaking Patients: A Pilot Study. *Annals of Behavioral Medicine* 29(3):225-235.

In an intervention targeted at low literacy level Latino immigrants, researchers and participants developed soap operas, or *telenovelas*, to convey key diabetes-related messages. In addition, the participants helped create posters depicting food color-coded by category using graphic symbols based on traffic lights. Foods shown in the red category were high calorie, laden with carbohydrates and saturated fats.

Schoenberg, Nancy E., et al.

2005 Situating Stress: Lessons from Lay Discourses on Diabetes. *Medical Anthropology Quarterly* 19(2):171-193.

The author used Kleinman's framework, an approach that has proved successful in her research on the correlation between stress and diabetes.

Teufel-Shone, Nicolette I., Rebecca Drummond, and Ulrike Rawiel

2005 Developing and Adapting a Family-based Diabetes Program at the U.S.-Mexico Border. *Preventing Chronic Disease* 2(1):A20.

Successful interventions for Latina/os provide diabetes education to the entire family and address prevention and treatment. By targeting the family social behaviors to change health behaviors, a successful intervention's objectives should include teaching family members how to improve nutrient intake, activity levels, and diabetes management/prevention for all family members. Implemented along the U.S.-Mexican border in southern Arizona, the intervention *La Diabetes y La Unión Familiar* focused on enhancing family members' social support of diabetic patients and increasing these family members' range of primary prevention behaviors. Using local lay health outreach workers, or *promotoras*, the program reached 72 patients and 177 family members, including children and grandchildren. The intervention included teaching team building and communication skills to build and reinforce family communication and collective esteem and efficacy.

Valenzuela, Glenn A., et al.

2003 Knowledge and Beliefs Regarding Type 2 Diabetes Mellitus in Rural Mexico. *Ethnicity & Health* 8(4):353-360.

To provide a successful outreach program, community health clinic staff, including medical directors, physicians and mid-level providers, need to work with community leaders and members, including patients, to recommend culturally-based diet and lifestyle changes.

Weller, Susan C., et al.

1999 Latino Beliefs about Diabetes. *Diabetes Care* 22(5):722-728.

This study focuses on Puerto Rican and Mexican immigrants in the U.S. and Mexicans and Guatemalans in their native countries describe family support as a key variable in ensuring compliance with dietary and other aspects of diabetes management.

VI. APPENDIX

A.. Medical Anthropology Fieldwork: Client Interview

PREGNANCY AID CENTER, GREENBELT, MD

CLIENT – *Before* the Consultation

Section 1: Client Demographics

Sex:	Female	Marital status:	Single
Age:	16	Country of Origin:	US
Ethnicity:	Anglo	Number of Years Living in US:	16
Occupation:	Former high school student (completed 10th grade), now stays at home	Language Spoken:	English

Section 2: Interview Questions

1. What is the reason(s) you have come to PAC today?
Always thought it was a good place. My doctor was too rough, too aggressive. He was aggressive during the exam and when he was taking my blood pressure. Trying to go too fast. My friends and family told me this was a good place.
2. Is this your first visit to PAC, or have you been here in the past?
I was here to open up my chart so I could make an appointment and start coming here.
3. Why do you want to come to PAC for health care?
I am 9 months pregnant, but I lost Medicare. So I could go to my old doctor, who was in PG Plaza. I didn't like him anyway. I heard good things about PAC.
4. What other options did you consider before deciding to make an appointment here? (Prompt: another provider, community health clinic, hospital)
Once my cousin's wife told me about it, I took a chance and came here.
5. Who did you discuss your health issues with before coming here? (Prompt: social support network, media)
Talk to my mom. She agreed this was a good place. She's helpful when I need something. She makes me feels okay about this. I watch TV programs, like on TLC there's a show called Birth Day and another show, I don't remember the name. It's helpful watching the birth.

6. What kind of treatment do you think you should receive?
I expected good doctors. I want to feel comfortable, not have something rough.
7. What results do you hope to receive from this treatment?
Make sure my baby is healthy.
8. What are your concerns about your visit here today? (Prompt: health, communication with provider, payment)
I'm concerned about the baby's health since it's been 3 months since I saw a doctor. I'm not concerned about payment, because when I came to open a chart, they explained that I need to reapply for Medicare and what type of insurance to get and what they will and won't accept. So that's okay.

CLIENT – *After* the Consultation

1. How do you feel this visit with your provider went today?
Feel good because got what I expected. I got the help I expected. Good treatment. The exam was normal, not rough. [Her sister who accompanied her then stated that the provider told them a lot of information they didn't know.] She talked about clothes. And about the car seat. I didn't know it was the law that a baby had to be in one. How the social worker can help with school.
2. What impression did you get of how the provider felt the visit went today?
Not sure.
3. Was your provider as helpful as you were hoping she would be during this visit? Why?
Yes, she offered more suggestions.
4. What are the issues you did not get to address with your provider that you wanted to talk about?
Nothing. Talked about everything I wanted to talk about. It lasted about 20 or 30 minutes, which is good.
5. What prevented you from discussing these issues?
[Not applicable.]
6. What concerns do you have about the treatment or advice that your provider gave you?
Nothing.
7. What concerns do you think your provider has about your health?
Guess nothing because she would've said.
8. Would you prefer an in-person follow up visit or a phone call from your provider?
In person. It's better to talk in person, doesn't feel the same over the phone.
9. Who else on staff at PAC could help you? In your family? Community?

The social worker. I can talk with my mom. And if my friends were pregnant, I would recommend here.

B. Medical Anthropology Fieldwork: Provider Interview

PROVIDER – *Before* the Consultation

Section 1: Provider Demographics

Sex:	Female	Marital status:	Married
Age:	32	Country of Origin:	US
Ethnicity:	Anglo	Language Spoken:	English
Occupation:	Nurse Practitioner	Number of Years Worked as NP (and at PAC):	1.5 (1)

Section 2: Interview Questions

1. Have you treated this client before?
No
2. Why has this client visited with you for in the past?
[Not applicable.]
3. What are common medical issues your clients have? (Prompt: top 5)
Pregnancy, types of vaginitis, birth control, abnormal pap, irregular bleeding
4. How did your nurse practitioner school program train you for these issues?
We had to do clinicals at different clinics. So I got a good sense of the women's health issues. But I wasn't prepared for working with the Hispanic population. They have more myths. They're mom or friend tells them things. They don't want to take a pill for birth control because their friend said they would get breast cancer. I try to educate them. I do say they are at increased risk for breast cancer, but having more children would be worse. I say to outweigh the benefits with the risks. Sometimes they get a clue, but sometimes they don't. It's about their education level. They can't think beyond the concrete. Like hello! Mary [PAC founder and executive director] says they don't have education then they tend not to grow in their thought process. Especially teens. Teen mothers. They stopped growing when they had the baby. But I don't know if this is a cultural thing. A lot of the clients get information from others without a medical background or TV. They don't all watch Discovery Channel, and even though I don't watch TV, I just watch the news, I know they aren't getting education from the TV shows. Some think their cycle is irregular if it's not on the same day. Oh okay. That's one of my questions I ask them, are their periods regular. And they seem like they don't know because their period didn't start on the same day as last month. So I have to tell them, "Yeah, it is regular."

5. What are your challenges to working with and treating your clients?
Language barrier! I don't speak Spanish and even though we have translators, I don't know if everything I saw is getting translated exactly. And cultural barriers. Like hygiene. They wash their vulva with soap and water. Then they get infections. Soap changes the pH in the vagina and is an irritant. Especially the women who tend to get a lot of infections. I tell them to use warm water. But I don't know if that's cultural. Other people have the same problems. But Wendy and Karen tell me that in their culture [they are medical assistants from El Salvador who serve as interpreters] that's what women do. And they don't know why, but they wash 3 to 4 times a day like this. But I don't know if this is cultural. Hispanics, and African Americans, too Hispanics have children at earlier ages. Not really people in our culture [Anglo] and Asians, I don't know why, we have them later. But the literature says this a lot, especially Hispanics. And they have them out of wedlock. It's not a problem. And they feel the need to have children all the time. They live in perpetual poverty. No support. The child grows up in a neglected place, because the mom works. Not a stable environment. And the literature shows this. Hispanics and African Americans, but especially Hispanics, are more likely to have sex and do drugs. But this is a risk factor for all the groups.
6. What do you think are the challenges your clients face in accessing health care?
Language! Transportation. Money. Lack of knowledge.
7. What do you think providers like you can do to enhance your clients' access to health care?
Hook up with the social worker. Provide translators. Do the best in resources, educate the clients about what resources are available, like food, clothing.
8. What do you think healthcare organizations can do to enhance clients' access to health care?
Insurance. It's a big mess. That's a whole dissertation. Insurance companies don't reimburse, so clinics can't provide health care. We have to pay for malpractice insurance. Not enough salary. And continuing education classes. So can't afford to see clients.

PROVIDER – *After* the Consultation

1. How do you feel this visit with the client went today?
Went okay with the part about the signs of labor, the pregnancy process, what to expect. I tried to stress about continued education, want to scare the client enough about poverty, she can do for herself and her baby. I told her she should value herself and her child. Not sure if this got through. She seems reluctant to go back. She said she wants her GED. I told her a GED is good, but a high school diploma is better.
2. What impression did you get of how the client felt the visit went today?
Guess she's okay about what to expect. She seemed a little more comfortable. But beyond that, not sure. At 16, it's different. Maybe she thinks I'm an old lady. She thinks like a teenager. She needs more than this, I can sit down and tell her, but when she has a baby her life would be different, but she can do it.

3. Was there anything that you did not get to address with the client that you wanted to address during this visit?
Concerned about how to raise a baby. Parents there, but boyfriend isn't really supportive. Hook up with the social worker. Really bothers me for the baby's aspect. He can follow same cycle as the mom. It breaks my heart.
4. Do you feel you were able to be as helpful as you hoped to be during this visit? Why?
Probably not. She's like, "Yeah, whatever lady." Her priorities aren't my priorities for her. 16 is different than 32. It's hard for me with a husband and child, and that's us. This child is a human being, not a doll. I talk with my husband a lot about this. This child needs to have the same opportunities, and maybe he won't. I used to be pro life before I worked here. Now I see a lot of clients and think maybe it's better they didn't have the baby. Maybe a child born to a mother on crack is not the best. Maybe it's good she decided not to have the baby, to have an abortion. Or maybe adoption or giving the baby to another family member is better. I come from a religious background. And I talk with my husband, and he says, maybe they had a 2% chance at surviving and now they have no chance, zero. And I'm like, that's true. I don't know what the right answer is.
5. Do you think the client feels this visit was as helpful as they wanted it to be today?
Don't know. Helped with physical care, but didn't say a lot.
6. What confusion or concerns does the client seem to have about the treatment or advice you gave her?
If she did, she didn't say. She has a lot in front of her [having a baby at 16], maybe she'll talk more next week.
7. Based on how your visit with this client went today, do you think they would return for a follow-up if you or she felt it were necessary?
Even if she didn't want to see me, she would come here for a follow up.

Since the provider seemed worried that the client did not find her helpful, I paraphrased what the client's responses were about the consultation. Here are a couple of the responses:

Provider's response to the client's relief that she was given more information than she expected:
I'm glad. I really had no idea what she was thinking.

Provider's response to the client's lack of understanding about the car seat:
Like what? How? [shakes head] How could she not know?

C. Medical Anthropology Fieldwork: Codes Elicited from Interviews

Codes	Number of times used		
	Client	Provider	Total
Education	1	9	10
Client	1	8	9
Provider	0	1	1
Social support	4	3	7
Ethnicity	0	5	5
Quality of care	5	0	5
Treatment	4	0	4
Length of consultation	1	0	1
Insurance	2	1	3
Morals/Religion	0	3	3
Language: interpreters	0	2	2
Age	0	2	2
Communication	1	1	2
Media	1	1	2
Client's explanatory model	0	1	1