

Understanding Cultural and Linguistic Barriers to Health Literacy

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Abstract

Nurses today are providing care, education, and case management to an increasingly diverse patient population that is challenged with a triad of cultural, linguistic, and health literacy barriers. For these patients, culture and language set the context for the acquisition and application of health literacy skills. Yet the nursing literature offers minimal help in integrating cultural and linguistic considerations into nursing efforts to address patient health literacy. Nurses are in an ideal position to facilitate the interconnections between patient culture, language, and health literacy in order to improve health outcomes for culturally diverse patients. In this article the authors begin by describing key terms that serve as background for the ensuing discussion explaining how culture and language need to be considered in any interaction designed to address health literacy for culturally diverse patients. The authors then discuss the interrelationships between health literacy, culture, and language. Next relevant cultural constructs are introduced as additional background. This is followed by a description of how literacy skills are affected by culture and language, a note about culturally diverse, native-born patients, and a presentation of case examples illustrating how culture and language barriers are seen in patients' healthcare experiences. The authors conclude by offering recommendations for promoting health literacy in the presence of cultural and language barriers and noting the need for nursing interventions that fully integrate health literacy, culture, and language.

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Low health literacy, cultural barriers, and limited English proficiency have been coined the "triple threat" to effective health communication by The Joint Commission ([Schyve, 2007](#)). Nurses, who work with patients from increasingly diverse cultural groups, experience daily how these three threats offer a challenge to the effective provision of care at the system, provider, and patient levels. Over the past 15 years healthcare providers in the United States (US) have begun to address two of these threats to effective care, namely culture and language, and to demonstrate a growing awareness of the need for culturally and linguistically competent healthcare ([Campinha-Bacote, 2003](#); [Lester, 1998a, 1998b](#); [Lockhart & Resick, 1997](#); [Maier-Lorentz, 2008](#); [Racher & Annis, 2007](#); [Rees & Ruiz, 2003](#); [Silva, 1994](#); [Smith, 1998](#)).

However, health literacy, both conceptually and in practice, has often been siloed from interventions designed to overcome cultural and linguistic barriers. Because health literacy is an emerging field, examination of culture and language as determinants of patient health literacy has been limited ([Andrulis & Brach, 2007](#); [Chang & Kelly, 2007](#); [Nguyen & Bowman, 2007](#); [Zanchetta & Pourselami, 2006](#)). To-date, strategies to address health literacy have often been distinct from, and at times inconsistent with, strategies to increase culturally and linguistically competent care (Andrulis & Brach). Integrating cultural and linguistic consideration with health literacy necessitates an expanded paradigm.

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The purpose of this conceptual article is twofold. The first aim is to help nurses appreciate how culture and language can affect patient health literacy. The second aim is to demonstrate the need for nursing interventions that fully integrate health literacy, language, and culture. First we will describe key terms that

serve as background for the ensuing discussion explaining how culture and language need to be considered in any interaction designed to address health literacy for culturally diverse patients. Next we will discuss the interrelationships between health literacy, culture, and language. We will then introduce relevant cultural constructs as additional background. This will be followed by a description of how literacy skills are affected by culture and language, a note about culturally diverse, native-born patients, and a presentation of case examples illustrating how culture and language barriers are seen in patients' healthcare experiences. We will conclude by offering recommendations for promoting health literacy in the presence of cultural and language barriers and noting the need for nursing interventions that fully integrate health literacy, culture, and language.

Key Terms: Health Literacy, Culture, and Language

As authors we use the broadly accepted definition of *health literacy* developed by Ratzan and Parker (2000) and used in the 2004 Institute of Medicine (IOM) report, titled *Health Literacy: A Prescription to End Confusion*. In this report, health literacy was defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (IOM, 2004, p. 32). This definition expands upon earlier conceptual understandings of health literacy, which focused chiefly on the written word and native speakers of English. The IOM definition attributes importance to understanding health information for the purpose of decision making, which is integral to the multiple areas of health-related functioning.

We rely primarily on Leininger's definition of culture, a definition grounded in the transcultural nursing field upon which others concerned with the importance of culture in nursing practice continue to build (Maier-Lorentz, 2008; Racher & Annis, 2007; Smith, 1998). According to Leininger (2002):

Culture refers to the learned, shared and transmitted knowledge of values, beliefs, and lifeways of a particular group that are generally transmitted intergenerationally and influence thinking, decisions, and actions in patterned or in certain ways (p.47).

Purnell and Paulanka (2008) have added to Leininger's basic definition that culture is largely unconscious; both implicit and explicit; and dynamic, changing with global phenomena.

At a practical level, nurses must be cognizant that culture affects individual and collective experiences that are directly and indirectly related to health. Examples of cultural influences on patient health beliefs and behaviors can be found in patients' perceptions of locus of control, preferences, communication norms, and prioritization of needs, as well as in their understanding of physical and mental illness and of the roles of the individual, family, and community. We would add the acquisition and application of health literacy skills to this list.

Language, according to Random House's [dictionary.com](#) (n.d.) is "a body of words and the systems for their use common to a people who are of the same community or nation, the same geographical area, or the same cultural tradition". Language in its many forms is a primary purveyor of culture, yet it does so in ways that are not always easily translated. Limited English proficiency (LEP) is the restricted ability to read, speak, write, or understand English by patients for whom English is not the primary language.

Interrelationships between Health Literacy, Culture, and Language

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The concepts of culture and language formally entered discussion of health literacy with the IOM's acknowledgement that culture affects health literacy skills (2004). More recently, Andrulis and Brach (2007) have noted that language and culture provide the experiential context for comprehension of health information. The culturally bound beliefs, values, and preferences a person holds influence how a person interprets healthcare messages. Knowing about a patient's language and culture is key for knowing how health literate the person is in a given situation.

The seminal 2003 National Assessment of Adult Literacy (NAAL) (Kutner, Greenberg, Jin, & Paulsen, 2006) measured health literacy disparities in several culturally diverse populations of American adults. Notably, the average health literacy scores for Black, Hispanic, American Indian/Alaska Native, and multicultural adults were lower than those of White and Asian/Pacific Islander adults. Especially striking was the finding that 58% of Black and 66% of Hispanic adults exhibited "basic" or "below basic" health literacy compared to only 28% of white adults. Moreover, bilingual adults, i.e. adults who spoke a language other than English before starting school, had lower average health literacy scores than adults who spoke only English before starting school. It has been recognized that health literacy disparities contribute to racial and ethnic health disparities (Institute of Medicine, 2009), which are widely measured (Agency for Health Care Research and Quality, 2008; U.S. Department of Health and Human Services, 2002).

Researchers are working to clarify how health literacy, culture, and language affect health outcomes ([Berkman et al., 2004](#); [Salant & Lauderdale, 2003](#); [Timmins, 2002](#)). We suggest that nurses think about these factors not as neatly co-occurring, but rather as messily interacting in different ways, to different degrees, for different patients. Patients from cultural minority groups may be more subjected to the effects of low health literacy than patients from the dominant culture because of interactions between literacy, cross-cultural communication barriers including language, and the experience of bias ([Berkman et al.](#)). For example, a U.S. born patient with low health literacy and hypertension might be able to communicate with nurses, navigate the healthcare system, and self-manage the disease more effectively than a recent refugee who also exhibits low health literacy and hypertension. The native-born patient would be able to rely on English proficiency and some familiarity with the U.S. healthcare system whereas the refugee would lack experiences in these areas. The ability of nurses to recognize likely interactions between language, cultural, and health literacy barriers; solicit additional information; and adapt communication approaches and care plans accordingly is important for effectively meeting the individual needs of patients.

Cultural Constructs: Background for Health Literacy Discussion

The following section presents relevant cultural constructs/concepts. These constructs, which will be referred to in the ensuing discussion of health literacy and culture, include health belief models, priority identifications, time orientations, and cultural contexts.

Andrews and Boyle ([2008](#)) present health belief models/systems that different cultural groups use to explain health and illness. Beliefs relevant to the health literacy discussion include, but are not limited to, *magico-religious*, *biomedical*, and *deterministic* beliefs. *Magico-religious* refers to belief in supernatural forces which inflict illness on humans, sometimes as punishment for sins, in the form of evil spirits or disease-bearing foreign objects. This view may be found among Latin American, African American, and Middle Eastern cultures. *Biomedical* refers to the belief system generally held in the US in which life "is controlled by a series of physical and biochemical processes that can be studied and manipulated by humans" ([Andrews & Boyle, 2008, p.68](#)). Disease is seen as the result of the breakdown of physical parts from stress, trauma, pathogens, or structural changes. *Determinism* is the belief that outcomes are externally preordained and cannot be changed. Those holding to this belief system ask questions, such as "If illness is bestowed by God, why try to prevent it or seek treatment?"

Familism and *individualism* determine whose needs are held as priority needs. In *familistic cultures*, the family is given priority over the individual. Health-related decision making and problem solving are typically done as a family unit. In contrast, *individualism*, favored by those living in the US, values independent problem solving and achievement.

Time orientation determines whether a person's worldview will focus on the past, present, or future, with the latter two most applicable to health. *Present orientation* may preclude preventive health practices as it prioritizes survival and managing crises over warding off future problems. In contrast, much of the U.S. mainstream healthcare has a *future orientation*, emphasizing preventive care, new technology, progress, and change. In this orientation time is very specific and promptness is important to people. Time orientation influences situations that can be misinterpreted as numeracy deficiencies; time orientation can impact how strictly a patient adheres to an appointment time or medication instruction. People from predominantly agricultural cultures tend to be less clock-oriented than those living in industrialized cultures ([Galanti, 2008; Purnell & Paulanka, 2008](#)).

In *high context* cultures, members have a group orientation, i.e., closer connections with each other over longer periods of time. There is less need for formal, direct, and written communication, as communication is more about process and relationship than problem solving. In high context cultures the group has a strong external boundary, so outsiders must work harder to earn trust. Alternately, in *low context* cultures, such as that of the mainstream U.S., members have many superficial connections in which the goal of communication is specific and task oriented so as to clarify rules and procedures and solve problems ([Giger & Davidhizar, 2008; Hall, 1981](#)).

How Patient Health Literacy Skills are Affected by Culture and Language

Basic skills applied in health contexts form the basis of health literacy. To be health literate in the US, one needs to be able to effectively apply a variety of skills to accomplish health-related tasks that are often very demanding. Skills include reading and writing in English; speaking and listening in English; numerical computing; critical thinking; and decision making. Culture and language affect how patients acquire and apply these skills in health situations. While applying these skills, one must be able to move with some comfort between one's own cultural values and beliefs and those of the dominant healthcare system, which in this article is the U.S. healthcare system. One also needs familiarity with the technical, jargon-rich, biomedical vocabulary used in the English-speaking U.S. healthcare system. The following sections explore some of the necessary health literacy skills and their interconnection with cultural and linguistic skills needed by culturally diverse patients.

Reading and Writing Skills

Reading and writing are the skills people often first consider when thinking about patient health literacy.

Patients need to be able to read various items, such as discharge instructions, health education materials, insurance statements, medical bills, nutritional information, and consent forms. Writing skills are needed to complete enrollment and intake forms, insurance claims, living wills, and appeal letters. Reading and writing skills vary for the many foreign-born users of the U.S. healthcare system because language structures and educational opportunities vary from country-to-country. Those who speak English as a second language may be non-literate or semiliterate in their primary language. They may also be accustomed to a different alphabet than the one commonly used in the US. These descriptors represent various skill levels, such as no familiarity with written expression or high literacy in a non-Roman-alphabet system. Each category is predictive both of the level of English proficiency that may be achieved if one is afforded the opportunity to study English and of how well one is likely to comprehend written and/or pictorial health information ([Burt, Kreeft-Peyton, & Adams, 2003](#)). There is also a subcategory of LEP patients who, while possessing some skills in reading and writing, may have a cultural tradition of folk medicine, for which information is typically conveyed orally. This can create a disadvantage when patients must transition to the reading and writing demands found in the U.S. healthcare system.

Listening and Speaking Skills

Speaking and listening are also health literacy skills that are influenced by culture and language. Lack of English proficiency is itself a clear barrier to a patient's ability to effectively listen and speak. Even when an interpreter is used to facilitate understanding, or when a patient for whom English is a second language appears to have competent speaking and listening skills in English, cultural issues may still interfere with the effectiveness of communication between the patient and a healthcare provider. For example, many cultures emphasize showing politeness and deference toward healthcare providers who are perceived as authority figures. High context cultures have a preference for indirect, non-confrontational styles of communication; a cultural preference for conflict avoidance can lead patients to say what they believe the healthcare provider wants them to say, or voice agreement or understanding whether or not they actually agree or understand. Asking questions and self-advocating in high context cultures might not be acceptable. Sometimes culture even influences which healthcare provider(s) a patient or family member will listen to and/or speak with. For example, there may be a preference for listening to a doctor over a nurse, or a male over a female. These cultural preferences can influence a patient's listening and speaking practices in clinical encounters.

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Numeracy Skills

Numeracy, or skill with numbers and calculations, is also important in managing one's health.

Numeracy, or skill with numbers and calculations, is also important in managing one's health. It is required for understanding measurement and/or frequency directions, which are important for understanding medication dosing, health insurance and payment information, and test results, as well as managing one's weight and interpreting blood levels of chemicals and hormones in the body. Although a person's numeracy skill is most often related to available educational opportunities, some aspects of numeracy can be culturally or linguistically driven. Differences in vocabulary and measuring systems between cultures can result in serious medication errors. As Andrulis and Brach ([2007](#)) pointed out, if someone from a culture that does not use spoons is reading a medication label calling for a teaspoon of medication, the person, not realizing spoons come in different sizes, may take too much or too little of the prescribed medication. Additionally,

hearing numerical information presented in English, when English is a second language, can be challenging because many numbers sound similar when spoken. For example, in English, the numbers 14 and 40 can sound very similar.

Understanding the concept of risk and/or the degree of risk of developing a disease or experiencing an adverse event involves complex, numeracy-based, health literacy skills. Determining risk is often dependent on a complicated equation including family history, personal medical history, exposures, and health behaviors. Risk is also socially, culturally, and politically constructed, and dependent on perceptions of danger, hazard, choices, and power ([Harthorn & Oaks, 2003](#)). These perspectives and perceptions vary across groups. Magico-religious or deterministic health beliefs may keep some patients from comprehending and acting on risk information.

Critical Thinking and Decision Making

Critical-thinking and decision-making health literacy skills are required for patients to make crucial health decisions, such as selecting between treatment options, insurance plans, and care providers; deciding when to seek care and what level of care; weighing risks and benefits of health decisions, and deciding on end-of-life preferences. These skills draw upon culturally driven value and ethical systems, preferences, norms, and

perceptions. A limitation of the IOM definition of health literacy is the use of the word *appropriate* in the definition. The IOM uses the term *appropriate* in regard to health decisions, but *appropriateness* involves culturally bound values. What the U.S. healthcare system considers appropriate health decisions can be at odds with what culturally diverse patients consider appropriate decisions. In the US it is assumed that individuals are responsible for their own health and health-related decisions. In familistic cultures, individuals may look to the nuclear family, extended family, or family head, be that male or female, to make their decisions. In some patriarchal cultures, males may make decisions for females. In addition, patients make decisions that are congruent with the health belief system(s) to which their culture subscribes. If the provider does not subscribe to the same health-belief system regarding disease etiology as does the patient, health directions may not be followed and conflict may arise between the patient and the provider. Hence, it is important that the provider consider the patient's beliefs when providing health education and interventions ([Chang & Kelly, 2007](#)).

A Note about Culturally Diverse Native-Born Patients

This article encourages nurses also to consider health literacy, culture, and language when caring for culturally diverse, native-born patients. Much of the discussion in this article is most applicable to foreign-born patients whose language, culture, and health literacy barriers are easier to identify because of more obvious cultural and linguistic differences. The NAAL findings are a reminder that diverse, native-born patients can also struggle with health literacy. This is particularly true for the African American population. Nurses must tune into the socially transmitted, culturally based health values, beliefs, and preferences of native-born patients that may be missed in the absence of language barriers. Additionally, culture can influence the spoken and written vernacular language for native-born, English-speaking patients, including vocabulary, grammar, pronunciation, and accents.

There are many reasons why culturally diverse, native-born populations exhibit lower health literacy. One reason is because basic literacy and educational opportunities, which are lower in most native-born minority populations than in the majority population, are highly correlated with health literacy ([Kutner et al., 2006](#)). Additionally, Speros ([2005](#)), in her concept analysis of health literacy, emphasized that health-related experience is an antecedent to health literacy by noting that "individuals with adequate health literacy skills must have had a health-related experience where they were exposed to the language of health care (p. 637)." Native-born minority patients may have less experience with healthcare because historically healthcare opportunities have been unavailable to them ([Eiser & Glenn, 2007](#)). Current healthcare opportunities may be limited by access barriers, such as insurance status. Furthermore, experiences of discrimination and stigma in the healthcare system can feed mistrust of healthcare institutions and clinicians ([Smedley, Stith, & Nelson, 2003](#)) and keep these patients from even seeking healthcare. Racher and Annis ([2007](#)) have encouraged nurses to identify and redress their own cultural biases, which become barriers to seeking healthcare for culturally diverse patients.

Rural-dwelling Americans are another native-born population for whom culture and health literacy interact. Rural populations experience negative health outcomes in a number of different areas, including unintentional injuries, oral health, addiction, mental health, and access to care ([Gamm, Hutchison, Dabney, and Dorsey, 2003](#)). While most rural-dwelling populations are White, non-Hispanic, and English-speaking, as with native-born minority groups, the acquisition and application of health literacy skills are hampered by lower than average educational attainment and basic literacy, as well as limited prior health-related experiences due to access barriers. Culturally, both Coyne, Demian-Popescu, and Friend ([2006](#)) and Giger and Davidhizar ([2008](#)) found familism, high context communication, a connection between health and religious beliefs, use of folk remedies, and distrust of outsiders, including healthcare providers, to impact health and health-related communication in rural Appalachian communities.

Case Examples

The following case examples connect the dots of the preceding discussion by illustrating how culture and language can influence patient experiences within three functional domains relevant to health literacy, namely, the health system navigational domain, the clinical domain, and the public health domain ([Kutner et al., 2006](#); [Pleasant & Kuruvilla, 2008](#)). Patient experiences illustrating health literacy challenges in each of these domains are presented below. (NOTE: These case examples are not real patients).

Case 1: Navigational Health Literacy Domain

Adriana was a 25 year old high school graduate who recently moved to Connecticut from Puerto Rico with her husband and two young children to be closer to family. She was bilingual, but more comfortable speaking Spanish. Her cousin initially helped her fill out the forms to enroll the children in the state's Medicaid plan. When Adriana called the pediatrician's office closest to her job to establish care, she felt she was treated with disrespect as she was told that the practice was not accepting new patients on Medicaid. Feeling deterred from seeking healthcare for her children she did not continue her search to find a pediatrician. When her daughter came down with an ear infection several months later, Adriana

Adriana did not understand the time-sensitive responsibility placed on parents to re-enroll children yearly.

took her to the emergency department. Adriana and her children spent the summer in Puerto Rico. Upon returning to Connecticut, a friend put her in touch with a pediatrician who was accepting new patients with Medicaid. In attempting to make an appointment, however, Adriana was surprised to find out her children were no longer covered by Medicaid. She had not complied with annual renewal procedures while she was gone.

Navigating procedures for enrolling in and utilizing public healthcare programs can feel convoluted, paperwork intensive, and bureaucratic to patients. In a study of the barriers to insuring children under Medicaid and the State Children's Health Insurance Program, Latino parents indicated a lack of knowledge about the application process and eligibility, language barriers, difficulty with paperwork, and systems problems (Flores, Brown, & Tomany-Korman, 2005). Culturally, in familial, high context fashion, Adriana relied on family and friends to connect her with health information, even though Spanish language materials and outreach had been part of the public program. After an initial unsuccessful attempt to navigate into primary care, including perceived discrimination based on her accent and type of insurance, she decided to seek treatment for a common childhood ear infection in the emergency department, often the default source of care when challenges deter vulnerable patients from more appropriate sources of care. Adriana also did not understand the time-sensitive responsibility placed on parents to re-enroll children yearly.

Case 2: Clinical Health Literacy Domain

Sola, a 20 year old Cambodian woman who had just come to the US, and her husband Deng, a 40 year old Cambodian refugee who had been living in the US for 15 years and was semi-fluent in English, were expecting their first child. Doctors told the couple that the baby's heart rate was dangerously irregular. The couple went to several specialists who ultimately told them that the baby had an abnormally large valve in his heart. A cardiology nurse drew a picture of the heart with its chambers and valves to show the couple. Deng was astonished, stating that he couldn't believe the heart had different parts inside of it. The doctors proposed giving Sola a beta-blocker to slow the baby's heart rate. Sola, new to western medicine, didn't know what to think about the treatment being proposed. Fortunately the problem corrected itself later in the pregnancy, so she did not need to make a decision while concerned about what a beta-blocker might do to her and her baby.

[Sola and Deng] did not know that Sola had a right to an interpreter and the responsibility to ask questions of her care providers.

Sola and Deng, who were semiliterate in their primary language and who had been raised in a familistic, high context, deterministic culture, had not learned about human anatomy in Cambodia. They struggled to understand the potentially serious heart problem that their unborn child faced. Their exposure to doctors in their native country had been limited. They did not know that Sola had a right to an interpreter and the responsibility to ask questions of her care providers. They felt lost without extended family around to help with making these important decisions.

Sola and Deng's issues are common for people with LEP who lack awareness of the culture of the U.S. healthcare system. While they may know how to seek and participate in healthcare in their native culture, many of these people do not have an understanding of what *the U.S.* system expects of them as patients in terms of practicing preventive behaviors, compiling and providing one's personal medical history, adhering to treatment, being proactive in one's care, and finding ways to pay for care. Nor are these patients necessarily aware of what they can expect from care providers, such as the right to an interpreter or the right to a second opinion.

Depending on their culture of origin, LEP patients with low health literacy may avoid printed health materials, not only because they are printed in English, but also because they are presented in a printed rather than an oral manner. They may also avoid printed materials because of the illustrations showing people who do not resemble them and/or because of the pictures of body parts presented in isolation, which they may never have seen before. In one study, Hunter (2005), a nurse health educator, found cervical cancer education pamphlets were not relevant to her target audience of Mexican immigrant women's learning needs because of the reading level and because of culturally linked issues of language, content, structure, and visual images.

Case 3: Public Health Literacy Domain

Debra was a 38 year old African American woman with a tenth grade education living in Houston. She was one of thousands of people living with HIV to be displaced by Hurricane Katrina. Despite a mandatory evacuation decree from Louisiana's governor and New Orleans' mayor, Debra had decided to stay in her home. Later, in a temporary shelter, a nurse who was part of the medical response team partnered with Debra to ensure her medication needs were met and to transition her into primary and specialty care. This proved challenging due to the unavailability of Debra's medical records and the complex medical history that she struggled to recount.

Debra's story is an example of how culture and health literacy interact for native-born minority patients. Preparedness for a public health emergency, especially for patients like Debra with existing medical

conditions, calls for the implementation of future-oriented health literacy tasks. Preparedness tasks include generating plans, procuring medical supplies and extra medications, and constructing personal health records. In the face of an impending public health threat, people must think critically and make decisions as they work to decode low-context information and weigh the risks and benefits of acting on health directives. Communicating risk is challenging for health professionals and accurately interpreting risk is challenging for these patients. Elder et al (2007), in a qualitative study of African Americans' decisions not to evacuate New Orleans before Katrina, found that many did not accurately perceive the risk of staying and were confused by inconsistent evacuation recommendations. From a cultural standpoint, the investigators found that African Americans who did not evacuate tended to be optimistic that they would be okay because of religious faith, did not trust law enforcement to protect their property, and often decided to remain with extended family members who were unable to leave.

Recommendations for Nursing

The realities of today's healthcare environment require solutions that are practical and effective. We offer the following recommendations to help nurses and all healthcare providers enhance the health literacy of our patients whose backgrounds reflect diverse cultures and languages. The following paragraphs include suggestions related to self assessment, patient assessment, professional education, interdisciplinary collaboration, patient advocacy, educational settings, and interpreters/cultural brokers.

Far too often providers rely on uninformed approaches to assess the health literacy of their patients.

First and foremost nurses should continually develop their ability to practice cultural self-awareness so as to better recognize their own cultural and linguistic assumptions and biases (Purnell & Paulanka, 2008; Racher & Annis, 2007). We would add the ability to recognize health literacy assumptions and biases as part of cultural awareness. To-date, provider self-assessment in the area of health literacy has not been a routine part of nursing practice; there is a need for cultural competence self-assessment tools that incorporate health literacy.

Far too often providers rely on uninformed approaches to assess the health literacy of their patients. Schlichting et al. (2007) found that 63% of providers in community health center settings reported using "gut feelings as a clinician" to estimate patient health literacy. Gut feelings can be imprecise and influenced by unconscious biases. Because health literacy depends on cultural and linguistic factors, there is a need for patient assessment tools that can efficiently collect information on patient health literacy, linguistic ability, and cultural beliefs (Andrulis & Brach, 2007) so that providers do not rely on gut feelings, but rather on assessed data. Nurses can work with other healthcare providers to develop patient assessment tools, as well as strategies that use these tools, to strengthen the healthcare provided. Broad-based patient assessments will enable nurses to explicitly incorporate health literacy into transcultural nursing practice.

New educational settings for patients, nursing students, and practicing nurses that address the interconnections between language, culture, and literacy are needed. This training could involve partnering with a local, adult education center. Adult learners in these centers are eager to practice health literacy skills, such as preparing and asking health-related questions and receiving appropriate health guidance, with nurses in a supported setting. The learners, in turn, can share their cultures and their experiences of accessing health care with nurses.

Nurses can also facilitate partnerships with colleagues in medicine, social work, and public health. All health-related disciplines are struggling to communicate health messages to client populations for whom language, culture, and literacy can be barriers. One approach could involve forming an interdisciplinary learning collaborative on health literacy, culture, and language, in which to share approaches to improving patient care.

Health literacy advocates are needed to motivate healthcare organizations to address patient- communication barriers. Nurses are in an excellent position to serve as such advocates by describing how impaired communication negatively affects patient safety and outcomes, noting how the Joint Commission and federal standards support improvements, and illustrating how decreasing health literacy barriers can bring down legal costs related to communication breakdowns and medical errors (Joint Commission, 2007, 2009; Office of Minority Health, 2001; Minnesota Health Literacy Partnership, 2007). Nurses are encouraged to pursue self-directed learning using the free, web-based resources presented in the [Table](#) to develop knowledge and advocacy skills.

Nurses are also well qualified to develop patient forms and educational materials that are appropriate from cultural, linguistic, and literacy standpoints. They are encouraged to develop these materials for the most common patient populations they encounter.

Nurses should make appropriate use of trained medical interpreters and cultural brokers. Andrulis and Brach (2007), and Jackson-Carroll, Graham, and Jackson, (1998) have stressed that interpreters should be cross-trained in cultural competence and health literacy in addition to medical interpretation training. A skilled interpreter will be able to help nurses understand the patient's cultural perspectives. Chang and Kelly (2007) have reminded us that patients' cultural beliefs about interpreter use should be considered so as to avoid potential communication barriers. Purnell and Paulanka (2008) have offered additional tips for effective use of interpreters.

Conclusion

Understanding a patient's level of health literacy requires an assessment of the patient's linguistic skills and cultural norms and the integration of these skills and norms into health literacy strategies for the patient's plan of care. The challenges related to this integrative process are daunting considering all the other challenges nurses face in providing daily care to their patients. Likewise, the menu of opportunities for improvement can seem long and under resourced. However, nurses can begin to make a difference by working to integrate cultural, linguistic, and health literacy considerations into daily efforts to effectively communicate with culturally diverse patients. It is important to recognize, though, that over the coming years, quality care will not be the mere inclusion of health literacy alongside cultural and linguistic competence. Rather it will be an expanded paradigm that involves the substantive integration of all three in ways that are practical for nurses to implement and that make a difference in the patient experience.

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Table. Web Resources on Culturally and Linguistically Competent Care and Health Literacy (compiled by authors).

Note: The availability of web resources that take an integrated view of literacy, culture, and language in healthcare is limited. These suggested resources underscore the authors' call for the development of more integrated models and materials.

- Bridging the Cultural Divide in Healthcare Settings
www11.georgetown.edu/Cultural_Broker_Guide_English.pdf
- Cultural Competence Practice and Training
www.diversityrx.org/HTML/MOCPT1.htm
- Cultural Diversity in Healthcare
www.ggalanti.com
- Cultural Orientation Resource Center
www.cal.org/co/publications/profiles.html
- Cultural Profiles Project
www.cp-pc.ca
- CulturedMed
<https://culturedmed.sunyit.edu>
- Ethnomed
<http://ethnomed.org>
- Harvard School of Public Health: Health Literacy Studies
www.hsph.harvard.edu/healthliteracy
- Health and Literacy Special Collection
<http://healthliteracy.worlded.org/>
- Joint Commission Report: What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety
www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/O/improving_health_literacy.pdf
- National Institute for Literacy Health Literacy Discussion List
www.nifl.gov/mailman/listinfo/Healthliteracy
- Providers' Guide to Quality and Culture.
<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>
- Transcultural Nursing Society
www.tcns.org/
- Virginia Adult Education Health Literacy Toolkit
www.aelweb.vcu.edu/publications/healthlit/

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- **Promoting Health Literacy Through Storytelling**
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This article argues that the extensive science communications literature needs to be joined by the health literacy literature and anthropological work on cultural variations in hearing and understanding messages. Fischhoff discusses in detail how the complexity of our terminology is a barrier, the confusion when evidence leads to changes in findings and recommendations, and the difficulty of communicating uncertainty (8). Braschers maintains that we are too hesitant to communicate uncertainty for fear of creating anxiety, and suggests that health communication practice include carefully developed discussions of uncertainty (9). Han et al. In sum, it is essential to understand cultural and linguistic parameters for the group you are trying to reach and that one message does not fit all. Effective communication is understood by both persons. These barriers to communication include differences in language, cultural differences and low health literacy. By recognising and using preventive measures for these barriers, health care staff can communicate effectively. Language Barriers. The growing diversity of our nation brings more health care providers and corporations into contact with patients with different languages. Effective communication is at risk in such cases. Language and cultural barriers are linked with low health literacy. Low health literacy is also observed in patients who are adept in English and who are a part of the collective American culture. There is a high risk this group's low health literacy may go unnoticed. Health literacy is the ability to obtain, read, understand, and use healthcare information in order to make appropriate health decisions and follow instructions for treatment. There are multiple definitions of health literacy, in part, because health literacy involves both the context (or setting) in which health literacy demands are made (e.g., health care, media, internet or fitness facility) and the skills that people bring to that situation. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. (Healthy People). "The term 'health literacy' means the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services in order to make appropriate health decisions." (Patient and Affordable Care Act of 2010, Title V). For people from different cultural backgrounds, health literacy is affected by belief systems, communication styles, and understanding and response to health information. Even though culture is only one part of health literacy, it is a very important piece of the complicated topic of health literacy.