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ORIGINAL RESEARCH

Cultural Humility in Chronic Condition Management: Physician Perspectives from Houston's Culturally Diverse Communities

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Background

Chronic disease management for immigrant and refugee populations presents unique challenges influenced by cultural and socioeconomic factors. This study explored physician perceptions of chronic condition management for these populations, with a focus on cultural humility.

Methods

This qualitative study utilized purposive sampling and semi-structured interviews with physicians that serve culturally diverse communities. Qualitative semi-structured interviews were conducted remotely between January and April 2024. Cultural humility was defined during interviews. Thematic analysis was used to evaluate conversation transcripts. Data was coded collaboratively, and quality assurance was done through cross-validation by multiple team members.

Results

Participants included 16 physicians that worked with immigrant and refugee communities. These physicians practiced in the specialties of family medicine, internal medicine, psychiatry, and neurology. Participants had favorable views of cultural humility as integral to providing healthcare to immigrants and refugees, even if unfamiliar with the concept. Physicians thought that training on this was not adequate and required approaches with modeling, hands-on experience, and feedback. Clinical exposure to diverse populations and interdisciplinary teamwork assisted respondents to understand impacts of cultural and socioeconomic factors on health. Strategies to improve care included patient engagement, integrated care models, and continuing education focused on immigrant and refugee needs.

Conclusions

Many barriers exist to providing quality healthcare in the family care setting regarding immigrant and refugee communities. However, enhanced medical training, interdisciplinary support, and tailored strategies to empower clinicians are needed to effectively address their unique needs.

Background

Medical care can be impacted by individual or community-shared culture and beliefs.[1] Patients are more likely to adhere to treatment plans when clinicians understand how cultural backgrounds impact healthcare.[2] This type of awareness, known as cultural humility, is crucial to implementing sensitive patient care.[3] The practice of cultural humility consists of openness, self-awareness, humility, supportive interactions, constant self-reflection, and acceptance of constructive criticism.[4] Moreover, it has been described as "a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations."[5]

Key cultural factors that impact outcomes include socioeconomic status, language barriers, religion, family ties, interpersonal dynamics, gender norms, diet, lifestyle, lack of familiarity with the US medical system, and views on Western medicine.[1] Physicians serving diverse populations may experience resource limitations and conflicts between professional ethics and laws that restrict healthcare rights.[6] Cultural humility allows recognition of these critical barriers to optimize healthcare and facilitate deeper connections with patients.

This issue is particularly important to address in the Houston area, which is home to approximately 1.6 million immigrants, nearly a quarter of the region's population.[7] Despite major contributions to the local economy, immigrants utilize fewer health services and have lower annual expenditures than the US-born population.[8,9] Texas has the highest rate of uninsured in the US, with immigrants being disproportionately affected.[10]

Cultural humility is an increasingly important competency for clinicians. However, here is limited literature describing the application of cultural humility in medicine from the clinicians' perspective. Thus, the purpose of this study is to assess the attitudes and experiences of clinicians regarding cultural humility and better understand how to optimally address this concept in clinical care.

Methods

This qualitative study included purposive sampling of 16 physicians working in clinics and hospitals that serve populations with a high representation from immigrant and refugee communities in the Greater Houston area. Recruitment was done via email, flyers, and in-person inquiries. No previous relationships with participants existed with the interviewer prior to recruitment. This study was approved by the Baylor College of Medicine's Institutional Review Board.

Data Collection

Audio-recorded, semi-structured interviews were conducted between January and April 2024. Thirty minute interviews were conducted by video or phone call in a private setting. Physicians were asked a series of open-ended questions about their clinical experiences, with emphasis on topics relevant to culture and patient care. Cultural humility was defined before introducing related questions. Interviews were transcribed and cross-examined by a second person for accuracy (initials). Interviews were not repeated. Participants were not given transcripts or the option to modify their responses after the interviews. Participants did not receive compensation for participating.

Each co-investigator was trained by female Principal Investigator (JH). A female co-investigator (ZA) conducted interviews. After transcripts were generated, codes were applied and accuracy was checked by a second male co-investigator (MB). To develop preliminary codes, 3 team members (JH, ZA, MB) reviewed the first 5 transcripts and used emerging themes to develop a codebook. Each transcript was coded by ZA or MB and checked for accuracy by at least one other team member. Transcripts were discussed routinely by the team to identify any issues and maintain quality of data collection. Data saturation was reached after 12 transcripts, but interviews continued with all 16 participants to further explore key topics. The 32-item Consolidated Criteria for Reporting of Qualitative Research (COREQ) checklist was used to ensure comprehensive reporting of methods.[11]

Data Analysis

Evaluators started with a preliminary close reading of all transcripts and maintained written memos, enabling refinement of deductive codes related to interview guides and inductive codes from emerging themes. Interviews were analyzed using thematic analysis techniques to examine physician perceptions of cultural factors of chronic condition management. Coders held routine meetings to maintain accuracy and consistency, and to further refine the codebook. Conflicts in coding were resolved by JH. Coding summaries and written memos were used to conduct thematic analyses. Coding was conducted using the NVivo qualitative data analysis software (QSR International Pty Ltd. version 14, 2023).[12]

Results

70 physicians were contacted, of whom 17 responded (24%) and 16 (23%) ultimately participated in the study. Interviewees consisted of 7 males and 9 females between the ages of 34–59 years (average age, 47 years). Three interviews were conducted via phone and 13 via teleconferencing. Physicians were trained in diverse settings, with 56% reporting some training outside the US. The majority specialized in Family Medicine (69%), followed by Internal Medicine (19%), and psychiatry or neurology (12%). Mean time in practice

Table 1. Overview of main themes: reflections on cultural humility by physicians that serve diverse populations, qualitative (N = 16, January – April 2024)

1. Favorable views	"I think that [cultural humility] is exactly correct. It's a kind of a continuous learning and evaluation process that should be a part of medicine." (female, 43, 13 years in practice)
2. First time hearing about cultural humility	"I don't know that I've ever heard the term [cultural humility], but I think it makes a lot of sense." (male, 42, 11 years in practice)
3. Complexity standardizing cultural humility into clinical care	"It's [cultural humility] not something that you can teach in one class and clinicians will be able to implement it. It's something that you gain with experience. That might be challenging, and that might take time, but I think it's important to try to implement or introduce this concept within training so people start to have that early on." (male, 37, 11 years in practice)
4. Personal background reflection	
4a. Reflecting on culture and upbringing	"I'm African American. I have some Native American ancestry. I'm also a Muslim… I know the interactions that my family members have with the healthcare system... they are often more willing to share with me the experiences that they've had… I would say that that has made it potentially easier for me to take care of patients." (female, 43, 13 years in practice) "I think it's something I've had to work on. You know, because I come from a, at least in the U.S., privileged background." (female, 54, 24 years in practice)
4b. Gaps regarding previous reflection	"I don't really have ever thought about that question ["How does your cultural background influence your interactions as a provider?"]... So, my cultural background… is different from those of my patients... there's a lot to learn." (male, 42, 11 years in practice) "I don't particularly think if I was not from India or from any other country, if I would be a different doctor." (female, 46, 14 years in practice)
5. Patient-physician dynamics	"If you get to treat somebody with different cultural background, you are obligated to submit your ignorance to their wisdom." (male, 57, 34 years in practice)

was 18 years. Physicians served adult (100%), geriatric (88%), and pediatric (12%) patients. It was estimated that 65% of patients seen by these physicians were uninsured.

Reflections on Cultural Humility

Almost all physicians (15/16) expressed favorable views about cultural humility after a definition was provided [Appendix 1]. Incorporating components of cultural humility helped physicians resolve problems in clinical care (Table 1). Some described its implementation as "*an evaluation process that should be a part of medicine.*" However, a lack of training in concepts related to cultural humility exists and highlighted the need to address the topic early in medical curriculum through continuous training, experience-based learning, modeling, and feedback was faced by many.

Reflections on Personal Background

Upon reflection on their cultural backgrounds, physicians noted the importance of self-awareness, self-reflection, and critique, all considered pillars of cultural humility (Table 1). Physicians that identified themselves as part of minority racial/ethnic groups expressed how their personal experiences helped them empathize with patients of diverse upbringings. Exposure to diverse communities helped them provide sensitive care, with one noting, "if you get to treat somebody with different cultural background,

Table 2. Overview of main themes: medical training and clinical experiences of physicians about serving diverse populations, qualitative (N = 16, January – April 2024)

1. *Exposure*	
1a. Cultural experience	"I think what really helped the most was actually practicing in settings where you are surrounded by diverse group of patients... so really just clinical exposure." (female, 38, 5 years in practice)
1b. Lack of cultural exposure	"Whenever I trained at [state university], we did not have much immigrant population as compared to Houston... so I believe I wasn't very prepared to take care of the immigrants and refugees whenever I got out of my residency." (female, 50, 25 years in practice)
1c. Lack of training	"I feel like residency programs should be teaching us more… it taught me like maybe 20%..." (female, 48, 14 years in practice)
2. *Clinical care approaches*	
2a. Immigrant/ refugee involvement	"I think one of the big things there's room for improvement on the academic side is just involving different communities, and particularly immigrant and refugee communities in the decision making about what's happening with the clinic…" (female, 54, 24 years in practice)
2b. Continuing education	"I think starting on education and early on in medical career… everybody in our healthcare gets some kind of training or education on refugee, immigrant medicine, cultural humility." (female, 50, 25 years in practice)
2c. Integrated healthcare facilities	"Most of them [patients] are working class… most of them work day by day, so it's hard to get them appointments… they'll try to work with them, so everything gets done the same day because it's hard for them to get days off." (female, 48, 14 years in practice) "…there's challenges like food insecurity, difficulties paying for medications, and a lot of financial barriers… I work with, you know, very qualified nursing staff, case management, nutrition, diabetic educator, and many other staff, social workers, to help kind of fill in those gaps." (female, 37, 10 years in practice)
2d. Checking for common experiences	"The system has to change... from a clinician standpoint, you know, we try to be engaged in research that highlights disparities and outcomes..." (female, 38, 5 years in practice)
2e. Appointment scheduling development	"...an easier channel to get them [refugees] appointments and get them established primary care physicians... that would be good because I know it's hard to get them appointments… I had this patient and he had waited a month to establish care with me and I felt so bad." (female, 48, 14 years in practice)
3. *Public healthcare safety-net provider*	
3a. Public healthcare safety-net provider system	"Our patient population tends to skew more towards the disenfranchised or disadvantaged. They're not that well off financially… most of our patients are either recent immigrants or people that, you know, some of them are undocumented or they're refugees." (male, 34, 2 years in practice)
3b. Financial Assistance Program	"If the patient qualifies, we can either talk to a social worker who can help them fill out the paperwork or tell them where to send it… the [Financial Assistance Program] can pretty much cover everything for free, including medications, so if the patient qualifies that's usually your first go-to." (male, 34, 2 years in practice) " Some of them are from other counties where they don't even have means to get [Financial Assistance Program] eligibilities so those patients are very, very difficult because it's hard to set up any kind of follow up... " (female, 38, 5 years in practice)

you are obligated to submit your ignorance to their wisdom." Motivational interviewing techniques and meeting the patients where they are regarding their health beliefs helped physicians develop effective treatment plans consistent with cultural humility approaches. Some physicians (2/16) had not previously considered how their background impacted their clinical practices, with one indicating it did not make a difference in clinical outcomes.

Experience with Diverse Populations

Physicians who trained in settings with diverse populations or outside the US thought they were more prepared to address medical needs of immigrants and refugees in comparison to those without similar training experience (Table 2). Conversely, one noted, "Whenever I trained at [state university], we did not have much immigrant population as compared to Houston... so I believe I wasn't very prepared to take care of the immigrants and refugees whenever I got out of my residency."

Suggested Clinical Care Approaches

The importance of integrating immigrant and refugee feedback into the implementation of healthcare was noted (Table 2). Incorporating education on culture and socioeconomic status throughout medical training and practice was discussed as a path to improve patient engagement. Integrated healthcare was recognized as valuable and convenient, providing accessible interdisciplinary collaboration to address the needs of patients. Physicians also noted unique barriers to healthcare access for immigrants and refugees. For example, one participant noted "...an easier channel to get them [refugees] appointments and get them established primary care physicians... that would be good because I know it's hard to get them appointments..."

Public Healthcare Safety-Net Provider

Many patients served by the physicians were from disadvantaged and low-income backgrounds (Table 2). The county-administered financial assistance program improved healthcare access and coordinated care for immigrant and refugee recipients who would otherwise be relegated to a fragmented system of clinics and clinicians that are dependent on inconsistent funding from other foundations or organizations. One participant mentioned "The [Financial Assistance Program] can pretty much cover everything for free, including medications, so if the patient qualifies that's usually your first go-to." The community safety-net clinics that many of these physicians worked in were geographically bound to serve only those who live within Harris County. This constituted a barrier that excluded inhabitants of surrounding communities with similarly diverse populations from accessing healthcare.

Psychological Trauma Among Patients

Participants noted the high prevalence of psychological trauma among immigrant and refugee patients (Table 3). One physician mentioned, "Trauma is pretty prevalent, but even more so in our immigrant population... issues with either trauma within their home country before they relocated to the U.S. or on their journey... sometimes here within the US from profiling and targeting and also from isolation and communities that they can afford or have access to live in when they move in may have higher rates of street-level crime and things like that and then in their work-life." Poor mental health

Table 3. Overview of main themes: psychosocial dynamics that affected patient-physician communications and clinical care, qualitative (N = 16, January – April 2024)

1. *Psychological trauma*	
1a. Prevalence of psychological trauma in patients	"It [psychological trauma] does affect [patients] tremendously, you know, a lot of people who have had psychosocial trauma… they have a lot of depression, anxiety, PTSD and that does affect quite a bit in medical management, in aspect of trust to the health system, trust towards the provider." (female, 50, 25 years in practice)
1b. Relevance to chronic condition management	"I did a study about diabetes and distress that a lot of patients with diabetes also go through a lot of depression, and they won't just say it. So, a lot of people with chronic disease do have side by side mental issues going on too… and with every chronic condition, I always ask them about mental health." (female, 48, 14 years in practice)
1c. Psychological trauma not prioritized in some clinical contexts	"It's very infrequent that from a clinical perspective we [neurologists] ask about past psychological trauma." (female, 43, 13 years in practice) "Sometimes we [internists] are privy to what that trauma might have been. Sometimes we may not know about it… I don't think it really changes my practice..." (female, 38, 5 years in practice)
1d. Delayed disclosure of psychological trauma to physicians	"I think it takes couple of sessions before we understand that this is a combination of medical as well as the psychological… I feel like it takes a little bit more time and more frequent visits to know about them." (female, 48, 18 years in practice)
1e. Mental healthcare stigma	"...it seems to be for some immigrant cultures... they carry more [mental healthcare] stigma with them, so a lot of internalized stigma. And so I think it takes a lot for some of our patients to make that first appointment. So we try to really work hard to help our patients feel like this is another chronic medical illness that we're treating. Just like diabetes or hypertension and try to at least model non-stigmatizing attitudes and embrace acceptance in our work." (female, 54, 24 years in practice)
2. *Family Dynamics*	
2a. Social support	"[There are] challenges in the form of language, education, cultural barriers, as well as transportation. So all these challenges can be minimized with the help of their family members." (male, 53, 28 years in practice) "I can have two patients that might look similar, but then one has support, one doesn't, and it has a huge impact..." (male, 42, 11 years in training)
2b. Patient dependence on family members for care management	"He [patient] started coming to the visits independently and we thought everything was under pretty good control... the spouse came with him and she's like he wasn't doing anything that he told you he was doing and… she was really kind of supporting like, making sure everything was taken care of, all of his appointments were being made... And that's not infrequent that I will see that happening. Less frequent that I will see that happening with the husband and wife." (female, 43, 13 years in practice)
3. *Gender*	
3a. Closer follow-ups represented by females	"Female patients, you know are more likely to follow-up and also come for routine screenings and physicals versus male patients, they typically come when there's a problem." (male, 34, 2 years in practice)
3b. Female agency	"...it can conversely be really hard to reach those women [with substance use disorders] and feel like they have agency at times... we find it harder to... if I'm working with the female partner to feel like they can advocate for themselves and maybe setting some boundaries around use in the home for example... versus for men, it seems to be easier for them to set those boundaries with their partner." (female, 54, 24 years in practice)
4. ***Religion and spirituality***	
4a. Holistic view	"We know that religion, especially particularly mental health, it's a strong protective factor for a lot of mental health conditions… religion can be a really important way to engage the patient in treatment too." (male, 37, 11 years in practice)
4b. Value-based restrictions	"If someone has a fixed either religious diet or religious belief about certain medications, I don't view that as my role to change that.." (male, 47, 14 years in practice)

could affect decision-making related to screening and follow-up for chronic conditions. However, psychological trauma had not always been prioritized, as one physician disclosed that knowing about trauma would not change how they delivered care.

Physicians noted that it was difficult for patients with psychological trauma to disclose their traumatic experiences early on. Disclosure was more likely to happen over time, and one appointment was usually not enough to gain patients' trust. Furthermore, seeking mental healthcare is often stigmatized, making it difficult to screen and treat mental health conditions. One physician described "...there's a huge stigma with mental health and seeing the psychiatrist and I always kind of preface it like 'hey, it doesn't mean you're crazy. You just need a little extra help'... it's really tough because I think a lot of underserved population, they don't believe in mental health or they don't understand it..."

Family Dynamics in Clinical Care

Family members played key roles in communication, including supporting loved ones in adherence to their care plans (Table 3). One physician shared about a patient "...we thought everything was under pretty good control....the spouse came with him and she's like he wasn't doing anything that he told you he was doing and... she was... making sure everything was taken care of, all of his appointments were being made..." Conversely, family members sometimes played a negative role. For example, family members who spoke on behalf of patients during appointments could make it difficult to establish a good rapport with patients. In addition, some believed that their roles as parents would be compromised if they sought medical treatment, contributing to delays in receiving timely care.

Observations of Gender in Clinical Care

Gender also played a role in chronic condition management as wives more often supported and facilitated the healthcare of their husbands than vice versa (Table 3). In addition, women engaged with their healthcare and follow-up more frequently compared to males. Conversely, a lack of agency among women was sometimes observed, with women reported as more likely to rely on their spouses or someone else for medical decision-making. Female immigrants were also more likely to be victims of abuse, complicating their care.

Role of Religion and Spirituality in Medical-Decision Making

Religion and spirituality were important in discussions surrounding end-of-life care, traditional medicine, and protective factors for mental health (Table 3). Value-based restrictions among patients could affect their preferences regarding clinician gender, restrictions on medication ingredients, and

Table 4. Overview of main themes: barriers to providing quality care to culturally diverse patient populations, qualitative (N = 16, January – April 2024)

1. *Language*	"Some [interpreters] are pretty good… some are not as good and a lot of the things I'm trying to convey get mistranslated or sometimes a chunk of really important information are kind of missing altogether." (female, 38, 5 years in practice)
1. *Financial*	"Most of it [problems encountered when caring for a patient who wasn't born in the U.S.] is lack of insurance and lack of affordability of the medical care." (female, 50, 25 years in practice)
1. *Cultural*	"That's part of the the culture that I mean, a lot of times within the Latino population, that they usually don't see care unless they have physical symptom that affects their daily function." (male, 37, 11 years in practice)
1. *Educational*	"Because they [patients that are immigrants or refugees] have a very, very poor health literacy, I do spend significant time explaining about the medication, lifestyle changes… they don't understand where to get the medicine, how to get them, how to schedule a specialty appointment." (female, 50, 25 years in practice)
1. *Policy*	
5a. Fear	"Patients might be afraid to come be seen because they're afraid that we're going to report them... so they're afraid to come in until like they're really, really sick..." (male, 34, 2 years in practice)
5b. Border politics/ undocumented	"Policy is big. I've had a liver patient admitted under me. Basically, he was medically sick enough to really qualify for liver transplant evaluation. But because he was undocumented, there was no path to get him Medicaid or any insurance in the US that would qualify him for transplant evaluation. Before he came to Texas, he had lived in New York, where even without being documented, there was a pathway for him to get Medicaid." (female, 38, 5 years in practice)
5c. Insurance	(Response to 'In what ways does health policy impact your professional care of migrant and refugee patients with chronic conditions?') "I think mostly in insurance coverage. You know, just the clinic I work at, is largely insurance driven." (male, 47, 14 years in practice)
1. *Adjustment to U.S. healthcare system*	
6a. Fragmented care	"So I think sometimes it's very hard for like patients that are like coming from a different cultural background to understand kind of that idea that different clinics do different things." (male, 34, 2 years in practice)
6b. Appointment length	"There's too much to do and too little time… even if I try to address 10 things, I don't feel like I address them well enough because I'm always having problems with time." (male, 42, 11 years in practice)
6c. Missing medical records	"If the chronicity of these problems predates [when] they're coming to the U.S., getting records to understand their condition prior to our first encounter is one of the problems I face." (male, 57, 34 years in practice)
1. Treating patients without regard to diverse values or backgrounds	"I did not see different trends based on gender or sex... the way we treat the immigrants that come to our clinic doesn't differ from the care that patients born in the United States are cared for." (male, 57, 34 years in practice)

treatment adjustments during fasting for religious purposes. One physician mentioned "if someone has a fixed either religious diet or religious belief about certain medications, I don't view that as my role to change that."

Language Barriers in Clinical Care

Language was emphasized as a primary barrier to chronic condition management among immigrants and refugees (Table 4). Clinic interpreters sometimes mistranslated physicians' words or skipped over relevant context. The tone of the encounter that physicians were trying to convey was not always captured, making it difficult to build rapport, especially when sensitive information needed to be shared. Language barriers also made it difficult

for patients to follow treatment plans and obtain health resources in the patients' primary languages. Furthermore, required forms contained language or concepts beyond the patients' understanding.

Financial Barriers in Clinical Care

Lack of insurance, unaffordability of medical care, and appointment schedules were all discussed as financial barriers among diverse communities (Table 4). Other barriers involved transportation, increased cost of healthy food items, difficulty obtaining employment, low access to phone and internet, and lack of housing.

Cultural and Educational Barriers in Clinical Care

Barriers to chronic condition management attributed to cultural differences included a lack of self-advocacy and the need for additional time to build rapport, disclose problems, and obtain treatment (Table 4). Educational barriers among immigrant and refugee patient populations were also highlighted, "Because they immigrants or refugee patients] have a very poor health literacy, I do spend significant time explaining about the medication, lifestyle changes... they don't understand where to get the medicine, how to get them, how to schedule a specialty appointment."

Policy-related Barriers in Clinical Care

Some apprehension about receiving medical care among immigrants and refugees was due to fear of deportation, causing patients to delay obtaining care until more severe symptoms presented (Table 4). Undocumented immigrants had significant barriers due to local insurance and financial assistance policies, with one participant mentioning "I try... to come up with a plan together. Sometimes that's kind of sending them back to a country or sometimes moving out of state where they might have better [family] support and more lenient Medicare coverage standards."

Adjustment to the U.S. Healthcare System

Adapting to a new healthcare system was identified as a barrier to care for chronic health conditions among immigrants and refugees (Table 4). The American healthcare system is fragmented in comparison to other countries, requiring a combined approach from primary care clinicians and specialists who are often not located in the same facility and who may have limited availability for new patients in their schedules. One physician noted "I think sometimes it's very hard for patients that are coming from a different cultural background to understand that different clinics do different things."

Treating Patients Without Regard to Diverse Values or Backgrounds

Further, the time allocated to patients with complex social situations was not enough to comprehensively address all their medical needs (Table 4). Immigrants and refugees often had missing medical records, complicating clinical care. One participant did not tailor clinical care practices to patients' unique backgrounds, stating "the way we treat the immigrants that come to our clinic doesn't differ from the care that patients born in the United States are cared for."

Discussion

Physicians who serve diverse patients recognized the value of education and training in cultural humility, despite the lack of standardization of this concept in medical and residency curricula. Almost all physicians had favorable views on cultural humility and practiced some elements regardless of preexisting knowledge of the concept. These elements were often acquired through experience serving diverse communities and not formal training. There is an incongruence among physicians regarding preparedness to address culture and social determinants of health as a part of clinical care due to the lack of incorporating cultural humility into standardized training.

In this study, physicians identified health factors impacted by cultural contexts, including psychological trauma, family dynamics, gender dynamics, religion, and spirituality. Observations regarding psychological trauma for those who have experienced migration is well documented in the literature. For example, premigration trauma exposure predicted more initial post-traumatic stress disorder symptoms and both pre- and post-migration trauma and stressors increased recovery time from mental health issues.[13] Integrating the practice of cultural humility in clinical care can help navigate the complexities of patient health factors influenced by cultural context and thereby increase treatment adherence.

Barriers identified in this study are similar to previous findings including language, financial, cultural, educational, policy, and adjustment to the US healthcare system.[14-16] Similar barriers have been identified internationally, including in Canada and included lack of awareness of the healthcare system, stigma, competing priorities, and direct costs. These results highlight similarities in barriers to healthcare worldwide. Thus, it should be noted that mitigating these barriers may need more than structural change. Simply providing translation resources, for example, does not always eliminate barriers to developing understanding between patient and clinician. Bringing the practice of cultural humility to the forefront in clinical care can help bridge misunderstanding that can lead to poorer health outcomes among culturally diverse populations.

Cultural humility could be incorporated into medical training through continuous experience-based learning, modeling in clinical practice, and feedback on clinical approaches from clinicians and communities. Medical programs that implemented cultural humility curricula have successfully increased patient engagement. For instance, one residency program in Colorado resulted in increased efforts of clinicians to engage in collaborative care with their patients.[17] Another program demonstrated that a diversity curriculum resulted in increased attentiveness to differing perspectives and social context.[18] An interactive workshop that incorporated medical students and practicing physicians, demonstrated an increase in knowledge and perceptions about cultural humility practices.[19] Effectively implementing cultural humility in training and clinical care settings can help reduce health disparities, increase adherence to treatment plans, and foster positive communication between patients and clinicians.

Study strengths include participation by clinicians who serve communities with a large proportion of immigrant and refugee patients. While previous cultural humility studies have been theoretical in nature, this study assessed viewpoints and experiences of practicing physicians.[20-22] Study limitations include potential introduction of social desirability response bias in response to discussing sensitive clinical care topics. Results may not be generalizable to all populations or all medical training experiences due to focused recruitment in a singular geographic region. However, because the study was conducted in the most ethnically diverse metropolitan area in the US,[23] this can provide key insights into cultural factors in healthcare and provide insight into provision of training to clinicians.

In conclusion, this study underscores the importance of integrating cultural humility into medical education and clinical practice to enhance patient care. The lack of standardization in family medicine training leaves gaps in preparedness to address cultural factors influencing health. Formalizing cultural humility within medical curricula can improve patient engagement, treatment adherence, and communication, particularly for culturally diverse populations. As the field of medicine prioritizes comprehensive and patient-centered care, implementing structured cultural humility programs can advance health equity and serve as a model for other medical disciplines.

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SUPPLEMENTARY MATERIALS

Semi-structured interview guide

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