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Cultural Competence in U.S. Health Care: Voices of the Arab Community

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While there has been a rapid increase in the Arab population in the United States, health information specific to this ethnic group remains largely undocumented. This study seeks to understand the health-care experiences of Arabs in the United States, ehttps://ijoc.org/index.php/ijoc/editorxamining the extent to which their ethnic background and cultural competence within the health-care system impact their health outcomes. Semi-structured interviews were conducted with 20 Arabs aged 30 years and above. While the majority of participants did not perceive their ethnic background to significantly influence their health-care experiences, nearly all emphasized the need for increased and improved cultural competency training for health-care professionals. Negative experiences reported by participants included appearance-based assumptions, challenges in earning respect, language barriers, clinicians' lack of culturally specific knowledge, and cultural stigma. The study identified two factors that appeared to mitigate negative experiences: Living in a diverse community and having a background or connections in the health-care field. This research highlights the urgent need for health-care systems to prioritize culturally competent care.

Keywords: cultural competency, U.S. health care, Arab American, immigrant health, health disparities

There has been a rapid and continuous increase in the Arab population in the United States. The Arab American Institute estimates that there are currently nearly 3.7 million Arab Americans, though they note that this figure is probably significantly lower than the actual number due to limitations of the survey questions, outmarriage, and distrust or misunderstanding of government surveys (The Arab American Institute Foundation, 2021). It is generally difficult to find statistics encompassing Arabs and Arab Americans, in part because most censuses do not offer an "Arab" or "Middle Eastern" option, leaving Arabs to select "White," "Other," or some other variation (Alsharif & Tensley, 2022). Being invisible also means that health information specific to this ethnic population is widely undocumented and understudied, leaving them at a disadvantage without the culturally competent needs-based assistance that many other communities receive (Alsharif & Tensley, 2022). Consequently, this study seeks to understand the health-care experiences of Arabs living in the United States. More specifically, it questions the extent to which their health outcomes are shaped by their ethnic background and cultural competence in the system.

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Literature Review

Defining Cultural Competence

Cultural competence has come to supersede other terms—cultural sensitivity, humility, awareness, and suchlike terms—as the standard when working with diverse ethnic and racial populations, particularly in the fields of education and health care (Flaskerud, 2007). Cross, Bazron, Dennis, and Isaacs (1989) provide one of the more commonly used definitions: "A set of congruent behaviors, attitudes, and policies that . . . enables that system, agency, or those professionals to work effectively in cross-cultural situations" (p. iv). A culturally competent system of care incorporates five elements at every level:

1. Values diversity and recognizes the importance of culture
2. Has the capacity for cultural self-assessment
3. Is conscious of the dynamics caused by cultural differences
4. Has institutionalized cultural knowledge
5. Adapts services to meet culturally unique needs (Cross et al., 1989).

To understand how cultural competence manifests in health care, we can refer to Betancourt, Green, Carrillo, and Ananeh-Firempong's (2016) framework, which outlines cultural competence interventions at three levels. Organizational interventions aim to increase the numbers of underrepresented minorities in health professions and leadership. Structural interventions involve innovations in the system and structure's design, such as interpreter services or culturally appropriate materials. Finally, clinical interventions train health-care providers to deliver quality care to diverse populations (Betancourt et al., 2016).

It may seem that the final level, in which clinicians and patients directly interact, would be the most significant in shaping a patient's health-care experiences. Indeed, in a concept analysis, three defining attributes of cultural competence emerged: When a health-care professional (1) respects cultural differences and tailors care appropriately, (2) provides equitable and ethical care, and (3) demonstrates an understanding of the importance of other beliefs, values, and experiences (Henderson, Horne, Hills, & Kendall, 2018). However, minority health-care experiences are significantly affected by cultural competency at all levels, which is demonstrated in this study.

Arab Experiences With Western Health Care

A search of literature about Arab experiences with the U.S. health-care system reveals that the scholarship on this topic is limited and in many cases outdated. Kulwicki, Miller, and Schim (2000) examined health-care behavior among Arab Americans and the experiences of health-care providers related to culturally competent care. This study provides valuable insight into Arabs' health behaviors and perceptions. However, the health-care system and the Arab community in the United States have changed drastically in the last two decades. Moreover, the focus on cultural competency is from the perspective of health-care providers, not patients.

Several studies provide general insight into Arab experiences with Western health-care systems. Yosef (2008) described the health beliefs, practices, and priorities of the Arab Muslim population in the United States. More recently, a qualitative study found that cultural and linguistic barriers impact Arabic-speaking immigrants' understanding and satisfaction in Norwegian hospitals (Alkhaled, Rohde, Lie, & Johannessen, 2022). This may help understand Arabs' health attitudes and behaviors, but the context is largely different. Moreover, with the exception of Kulwicki and colleagues' (2000) work, these articles do not focus on cultural competency.

A 2018 comprehensive literature review on Arab American health concludes that most studies focus on health behaviors (vaccination, drug use), health outcomes (diabetes, mental health), and populations at increased risk of poor health outcomes. Abuelezam, El-Sayed, and Galea (2018) call for more research on Arab American health-care experiences and the cultural nuances that influence their health behaviors.

Minority Experiences With Western Health Care

Due to the limited literature on Arabs and Arab Americans, it may be helpful to examine the literature on the experiences of other minority groups in the United States. A 2011 study examined the health beliefs, practices, and experiences of foreign-born Hispanic women with the U.S. health-care system. It found that lack of social support, cultural health beliefs, experiences with a new health culture, and perceived discrimination influenced if, how, and when they sought medical assistance (Sanchez-Birkhead, Kennedy, Callister, & Miyamoto, 2011). Similarly, Clough, Lee, and Chae (2013) reviewed the literature on barriers to health care for Asian immigrants in the United States. They highlighted cultural incompetency as a key barrier that can delay accurate diagnosis and treatment. Additionally, linguistic discordance, access barriers, and perceived discrimination pose significant challenges (Clough et al., 2013).

In a scoping review, Omenka, Watson, and Hendrie (2020) explained that the health needs of African immigrants in the United States are understudied because they are often categorized as Black alongside phenotypically similar groups. This lack of specificity impedes data-informed health-care decisions. Similarly, Arabs lack sufficient research on their health experiences due to inadequate categorization. The authors (Omenka et al., 2020) identified the absence of culturally competent health care as an access barrier that contributed to distrust and dissatisfaction with health outcomes. Perceived discrimination and stereotyping further exacerbated unfavorable provider attitudes (Omenka et al., 2020).

Immigrant Versus Domestic Experiences

The sample of this study is primarily immigrants. Accordingly, the literature referenced until this point features immigrant populations. It is important to distinguish between immigrants and domestic minorities and consider the role of migration in health experiences.

Luiking and colleagues (2019) conducted a meta-ethnography study on migrants' health-care experiences, examining factors such as enculturation and legal status. Their findings emphasized the need for person-centered care, in which the unique cultural background of each migrant is essential to effective care (Luiking et al., 2019). Likewise, Machado and colleagues (2022) interviewed im/migrant women in Canada and found that traumatic migration experiences increased their health-care needs but reduced their

desire to seek care. The erasure of their experiences as im/migrant women suggests that the health-care system is not designed to effectively serve their needs. Similarly, a needs assessment in the DC metropolitan area identified shortcomings in addressing the health needs of forced migrants, including insufficient cultural awareness and trauma-informed skills among providers (Sheth, Patel, O'Connor, & Dutton, 2021).

This brief examination of relevant literature serves three purposes. First, it highlights the need for increased research on the health-care experiences of Arabs in the United States. Second, it demonstrates that while culture plays an essential role in minority health experiences, health-care systems fail to effectively recognize and/or incorporate it into their approaches. Finally, it identifies various challenges faced by minority groups that may overlap with the experiences of Arabs in the United States.

Culture-Centered Approach

This study is grounded in the culture-centered approach (CCA) to health care developed by Mohan Dutta (2008). This approach acknowledges the erasure of the voices of communities at the global margins from dominant discursive spaces. The lack of a category that accurately encompasses Arabs means that their voices are absent from health research. The CCA (Dutta, 2008) offers a framework for addressing health inequalities by cocreating communicative infrastructures for amplifying knowledge claims rooted in the lived experiences of these communities. It presents participatory strategies for community engagement in developing health solutions (Dutta, 2008). Likewise, Vaughn, Jacquez, and Bakar (2009) emphasized collaboration *with* rather than *on* the target population as health-care interventions are more successful when the target population contributes to its development.

Dutta (2018) details the process of building communicative infrastructure for knowledge generation. The first step is ethnography. The researcher builds relationships with community members and participates in conversations about the key problems they face, research questions that should be asked, and potential solutions to be explored. This is what I sought to do through this research; speaking directly with community members about their health-care experiences was the first step in gaining insight into their perspectives on prevalent issues and discovering potential solutions.

Research Questions

Given the limited scholarship and the exigent need for health research on this ethnic population, this study investigates how Arabs in the United States perceive their health experiences. The following research questions were developed:

RQ1: *To what extent do Arabs in the United States perceive that their ethnic background affects their health experiences?*

RQ2: *In what ways do Arabs in the United States feel that their ethnic background affects their health experiences?*

RQ3: *What are the perspectives of Arabs in the United States on the importance of cultural competency in the health-care system?*

Study Design

The target audience is Arabs living in the United States aged 30 years and older. It is important to note that Arabs are not monolithic or homogeneous as an ethnic group. They are very diverse, originating from 22 different countries with different religions, beliefs, and experiences. However, Arabs are likely to have barriers specific to their culture and positionality in the United States that impact their health-care experiences in comparison with other ethnic groups (Alsharif & Tensley, 2022).

The focus on individuals aged 30 years and older is because young adults are statistically lower users of health care (Evans, 2014). A national poll found that 45% of those aged 18–29 years do not have a primary care provider, compared with significantly lower percentages for older age groups (Boodman, 2018). Additionally, according to a report by the Centers for Disease Control, 30% of those aged 18–29 years report that they do not see a doctor even once a year (Pratini, 2014). Thus, Arabs aged 30+ years will likely have more significant health-care experiences to speak of. The age requirement is not limited from the other end because the use of health services increases with age (Ortaliza, McGough, Wager, Claxton, & Amin, 2021).

Methods

After Institutional Review Board (IRB) approval was obtained, a poster describing the study was distributed on social media. No incentive was offered. I shared the poster through my network of contacts and in various groups for Arabs in the United States on GroupMe, WhatsApp, and Facebook. My positionality as a researcher played a significant role in how I conducted this study. As I am Arab American, I was able to recruit using my network of contacts, and I experienced relative ease in building trust and rapport. I also speak Arabic fluently. Although the interviews were conducted in English, some participants used Arabic words or phrases to convey a specific meaning. My grasp of the language ensured important context was not lost. While completely objective and bias-free research is impossible, measures can be taken to account for biases and ensure systematic research processes. Obtaining IRB approval, including my research subjectivity in this article, and practicing self-reflexivity are some of the ways I worked to mitigate bias (Tracy, 2020).

Informed consent was obtained, and 20 semi-structured interviews were conducted from April to June 2023. The interviews lasted between 30 minutes and an hour and were conducted virtually via the video-conferencing application Zoom. To avoid potential discomfort, the questions were designed sensitively and it was emphasized that participation was voluntary and participants could stop at any time. The interviews were transcribed using Google's Pinpoint and coded inductively, following a bottom-up approach. Drawing on Braun and Clarke's (2006) six-phase framework for conducting a thematic analysis, I generated initial codes, identified key themes, and then revised and grouped them as I noted how they overlapped (Maguire & Delahunt, 2017).

Sample Description

The sample for this study consisted of 20 participants. Ages ranged from 35 to 72 years, with an average age of 50 years. Regarding gender distribution, 14 identified as female and six identified as male. Participants originated from seven different countries and were residing in 10 different states across the United States at the time of the study. Of the 20 participants, 15 were immigrants. The number of years participants had lived in the United States ranged from eight to 54 years, with an average duration of 32.8 years.

Table 1. Sample Description.

Name*	Age	Gender	Originally From	Currently Living in	Years in the United States**
Wadha	35	Female	Palestine	South Carolina	35
Aisha	35	Female	Palestine	North Carolina	12
Sarah	35	Female	Iraq	Texas	11
Lara	37	Female	Jordan	California	15
Alia	38	Female	Egypt	Texas	8
Jana	42	Female	Yemen	Texas	42
Adam	43	Male	Egypt	Kentucky	13
Noor	45	Female	Jordan	Michigan	23
Sahar	45	Female	Palestine	North Carolina	32
Yousef	47	Male	Egypt	Kentucky	21
Wisam	48	Female	Palestine	Kentucky	48
Shahad	53	Female	Palestine	Kentucky	53
Rana	54	Female	Egypt	New Jersey	54
Jassim	57	Male	Iraq	Kentucky	30
Mohammad	58	Male	Palestine and Lebanon	Kentucky	49
Lina	60	Female	Lebanon and the United States	Illinois	39
Ali	61	Male	Egypt	Kentucky	34
Maryam	67	Female	Palestine	Washington	44
Walid	68	Male	Lebanon	Florida	50
Samya	72	Female	Palestine	North Carolina	43

*Pseudonyms were assigned to protect participants' identities.
**Some participants described periods of moving back and forth between the United States and other countries. This column describes the years since they officially settled in the United States.

Results

Does Ethnic Background Affect Health?

RQ1 asked about the extent to which Arabs in the United States perceive that their ethnic background affects their health experiences. Of 20 participants, only eight explicitly stated that their ethnic background makes a significant difference in their personal health experiences or outcomes. The remaining 12 responded that their background has minimal or no impact. However, some of these participants later

shared stories in which loved ones faced different treatment because of their backgrounds. Moreover, it became evident that two factors appeared to mitigate the impact of their backgrounds, resulting in more positive health-care experiences.

How Ethnicity Creates Negative Health Experiences

RQ2 asked about the ways in which Arabs in the United States feel that their ethnic background affects their health experiences. As participants articulated the influence of their backgrounds on their health experiences, four overarching themes arose: Having to fight for respect due to assumptions made about them, language barriers, clinicians' lack of culturally specific knowledge, and cultural stigma.

Assumptions and Fighting For Respect

Participants with both positive and negative experiences noticed that assumptions are made about them as soon as they step into health spaces. Noor explained that when health-care professionals see her and hear her accent, they tend to ask where she is from. However, they are usually accepting and professional. Likewise, Sarah stated that when clinicians recognize that she is not from the United States, they are very accommodating and explain themselves more thoroughly.

This experience was not shared by Maryam; while she did not encounter any negative responses, her husband has been questioned aggressively after clinicians hear his accent, including "Where the hell are you from?" and "Why are you here?" Similarly, despite her background as a clinical pharmacist, Lara realized that when a clinician first hears her accent, they often speak slower and louder. "But then as soon as I start speaking and asking questions, they directly ask me: 'Do you have a medical background?' And then the whole interaction changes." Wisam shared Lara's experience of being spoken to slowly and loudly despite having been born and raised in the United States.

Rana described how she and her husband have to "perform" every time they enter a health-care space. Assumptions are made about them because she wears the *hijab* (headscarf), and he has a beard and speaks with a heavy Egyptian accent. Health-care personnel speak rapidly with the assumption that neither of them will understand. However, she has a background in microbiology and her husband is a medical technologist, which they leverage to alter the course of the interaction. With the combination of her fluent, unaccented English and her husband's credentials—which he makes known by identifying the medical center he works at—they can ensure that they receive the information they need. "The look on their face just changes . . . these people are floored. Because now they're not talking to the couple they thought they were."

Despite mastering this "performance," Rana feels that it is awful that this behavior is necessary. In addition to dealing with the emotional weight of the situation, they must be on high alert to ensure their children receive complete care. She narrated a story in which a waitress accidentally dropped a tray of tea in her son's lap, resulting in third-degree burns and an airlift to the hospital. "The entire time we're in the burn unit we're being tested: what did you do?" Rather than being able to focus solely on their son's well-being, they were questioned about whether they did something wrong. Rana wondered, "Are the police going to be walking in any minute?" She ruefully noted that she was grateful that the accident happened at a restaurant with more

than 300 witnesses and not at home, where their story could not be corroborated. This performance was repeated endlessly as they faced skepticism at every turn about their intentions and behavior, with the exception of a nurse who advocated for them and whom she spoke of fondly.

I noted similarities between the experiences of Rana and Wisam. Wisam also shared that she had to fight an uphill battle and bear the emotional weight of being dismissed in her attempts to secure diagnoses for her Hashimoto's thyroiditis and her husband's Mediterranean fever. She had to go to four different doctors—and was even referred to a psychiatrist because it was "all in her head"—before receiving the correct diagnosis. "It's a fight and it puts tension on the family too. Somebody ends up looking like they're crazy and that's usually me." She mentioned that she feels worse for many of her Black friends hearing the stories they have shared with her. This emphasizes how intersectional these experiences can be, as highlighted in the literature review.

Jana also experienced health-care professionals making assumptions about her because she is visibly Arab and wears the *hijab*. She reflected on the most difficult time in which her culture was "an issue"—during the delivery of her first child.

> I was actively in labor and the nurse was telling me to open my legs, like: "What's wrong with you people? Do you guys not open your legs from where you're from? Like, how do you even conceive?" Oh my goodness, that was such a dehumanizing situation.

Even in retelling the story, shock, and frustration were evident in her tone as she questioned how a woman who took a pledge to ensure her comfort and care could speak to her that way. She was only 20 years old, 10 centimeters dilated, uncomfortable, and afraid. She felt humiliated and began to wonder if she was doing something wrong. She had the nurse removed but questions until today: "How many times has she told that to women that look like me?"

Among the 12 participants who did not feel that their backgrounds impacted their health-care experiences, some mentioned that it may be because they are not easily identified as Arab. Mohammad said, "My accent is not as bad as most, and maybe for that reason I don't see it as much as someone else." Similarly, Noor spoke about how her appearance may have played a role because she is not easily identified as Arab or Muslim. However, just because one is not easily identified as Arab does not mean that they pass as White. When Sahar was in labor with her first child, it was assumed that she was Hispanic and did not speak English. A nurse began speaking to her very loudly and slowly, exaggerating each word, which baffled and frustrated her.

Alia recalled listening in on a conversation among her pregnant friends. They thought it was strange that when they went in for regular checkups, nurses would pull them away from their husbands to privately ask if they were victims of domestic violence. They wondered if this happened with everyone, or if they received this treatment "because of the stereotype associated with our ethnicity, that we don't have a voice, we don't speak up, our husbands beat us and have control of us." This experience was shared across states (California, Texas, and Arizona) and the women concluded that it was implicit bias.

These are just a few of the many stories that were shared with me, demonstrating how judgments made about participants reflected directly in their treatment. Rana described other situations in which she was constantly working to gain the attention and respect of health-care professionals. "I feel like I was never heard . . . never listened to." She spoke about negative experiences throughout all five of her pregnancies, her pain being dismissed for a year before discovering she had a parasite, and her gynecologist laughing at her and later discovering she had undiagnosed polycystic ovary syndrome (PCOS). She feels that many of these experiences stemmed from bias against Arabs as she lives in a predominantly White area and would witness similar cases being handled differently when it was a White family. "I'm wearing *hijab*, I'm a woman . . . I'm not the White man."

Language

Many participants identified language as an issue for older family members. For most, this affected them more severely in the past than now. They spoke of a lack of translation services or the inadequacy of such services when available. As a result, they had to function as mediators between family members and health-care professionals.

Jana spoke about the privilege of speaking English and being college-educated, which many of her relatives did not share. Without her, she felt certain they would be unable to articulate their feelings to doctors. She reflected on instances in which her family's language barrier was met with scorn and judgment. "This one doctor asked me to ask my grandmother, "Why in the world has she not learned English yet, and she's been in America for so long?" Explaining that she was only a teenager at the time and familiar with anti-Arab sentiment, Jana said,

> I didn't have the social capital to be able to defend myself or my family. These are older people, they're White people, they're esteemed, they're in places of authority . . . it's kind of uncomfortable and awkward to say: "Well actually don't talk to my grandmother like that."

Lina shared the same experience of mediating for her parents because of a language barrier, acting as a "negotiator, navigator, translator." Ali, who is heavily involved with his local Muslim community, would often help new immigrants or refugees communicate with doctors before interpretive technologies were widespread in health-care settings.

Although Walid stated that his background does not affect his health experiences, he spoke about how this does not apply to his wife. She strongly dislikes visiting doctors because she feels as if they will not understand her. She speaks English so it is not a matter of linguistic ability but more so about comfort. Walid feels more comfortable speaking up because he has been in the United States since he was 18 years old, so he frequently mediates for his wife. Walid's daughter was listening in on his interview and chimed in to point out that her mom wears the *hijab*, which makes a difference. "[My dad] doesn't look Arab . . . they'll see him as foreign, but Arab isn't written on his forehead. My mom when she goes to the doctor, Arab Muslim is written all over."

Most participants felt that language barriers are more easily overcome now. While Adam described minor struggles adapting to the accents, slang, and terminology on moving to the United States, he felt that this was normal and adjusted after a while. (Note that he has spoken English since he was a child, which likely helped him adapt more quickly.) Lara, Ali, and Jana pointed out that now translation services are offered in pharmacies, clinics, and hospitals. However, they believe that there is still work to be done. Providing an example of how language is still an issue, Jassim explained that his mother does not speak English well. While she is readily provided with a translator at the hospital, the Arabic language has a lot of dialects and accents, which many people do not recognize.

> My mom is an old lady in her 90s and she speaks Iraqi Arabic with a Moslawi accent, which is a certain city in Iraq. Then they put you for example [with] somebody from Libya—forget about it! . . . Yes they speak Arabic but you cannot understand them.

He highlighted the importance of accurate translation and suggested that telecommunication through technology that recognizes different accents and dialects is preferable to a human translator proficient only in a specific dialect.

Lack of Culturally Specific Knowledge

Genetics. Many participants highlighted situations in which their clinicians having a better grasp of culturally specific knowledge would have improved their health-care experiences. Samya commented that there are diseases specific to certain countries and cultures, and clinicians should have a foundational awareness of this. Referring to the lack of a category for Arabs on censuses and surveys, Sarah noted that if there was more awareness of these differences before appointments, it would be possible for clinics to assign a clinician with the knowledge necessary for diagnosis and treatment.

Alia recounted the experience of her sister-in-law, who struggled to conceive and suffered both a stillbirth and a miscarriage. Unable to identify the issue, doctors told her that she was young and healthy, so "just keep trying." Eventually fed up, she traveled to Egypt for testing and was told: "Your issue is so simple, I don't understand why no one told you that all you had to do was take an aspirin." It was explained that women from the Mediterranean and Middle East and North Africa (MENA) regions clot easily when pregnant and are promptly prescribed aspirin to prevent this. Alia stated that her sister-in-law could have avoided four years of trauma had she known this. She concluded that the lack of health-care research on people from the MENA and the Mediterranean regions is because "we're just White to them." This story inspired Alia's ongoing research into Arab Americans.

Wisam had a lot to say about the importance of culturally specific knowledge. She explained that people from the Middle East metabolize anesthesia slower, which she learned the hard way during her husband's surgery when doctors could not wake him up and he almost died. Unfortunately, she had many other stories to share along these lines. It took her husband 12 years to be diagnosed with Mediterranean fever, a genetic autoinflammatory disorder that mainly affects people of the Mediterranean origin. She believes it should have been a default diagnosis due to his background, but it took over a decade for the thought to occur to his doctors. Similarly, for three years, her daughter experienced extreme weight loss and missed her periods. She was

dismissed by multiple pediatric specialists until a holistic doctor conducted a DNA test and confirmed that the medication she was on would not help due to differences in the MTHFR gene specific to people from the Middle East. Within four months of the new treatment, her daughter had recovered.

Wisam is firm in her belief that these experiences are a result of bias because of her ethnicity. Despite her top-of-the-line insurance, she still feels she is being undercut in her treatment and laments the number of doctors she has to go through to find one familiar with her biology. Each time she asks them, "Do you know what people from my ethnic background deal with?" Many doctors fall back on the excuse that they do not have a lot of clientele from that ethnic group, but she refutes this, arguing that they simply do not recognize many patients as Arab because they pass as White.

Cultural and Religious Beliefs

In addition to genetics, participants spoke about the importance of cultural competency when it comes to treatments that may not align with cultural or religious beliefs. Lina and Jana commented on how modesty is also frequently misunderstood, particularly with regard to more conservative Muslims. Jana reflected on being asked to take her *hijab* off when seeing a male physician even though the checkup did not involve her head or neck area. This also happened repeatedly with her grandmother, who is very conservative and wears both the *hijab* and *abaya* (full-length robe/dress). "There were a couple of times where doctors were yanking it off of her. She was ready to take it off because she was covered underneath but she felt really violated." She made it clear that these instances mostly happened in the past, around 10 years ago, and extended beyond modesty to include cultural incompetency regarding dietary restrictions and fasting during the holy month of Ramadan, among other things.

Some of the participants who had positive experiences indicated that cultural sensitivity played a role, which further highlights the importance of clinicians having culturally specific knowledge. In discussing her mother's health-care experiences, Sahar said it was helpful for her to have somebody sensitive to her religious and cultural beliefs. Similarly, Lara felt that having a clinician with an awareness of her background was very helpful as cultural awareness is critical when it comes to giving thoughtful advice to patients. She provided an example of when she was pregnant during Ramadan. Although not Muslim, her clinician was familiar with how fasting affects pregnant women, had read the relevant clinical studies, and was able to provide informed care. Likewise, all of Noor's attempts to communicate preferences specific to her culture and religion were successful, such as when she requested a female doctor when giving birth. She concluded, "I think the system here respects cultures, respects your privacy, respects your space."

Cultural Stigma

Finally, in exploring health-care challenges faced by Arabs in the United States, it became apparent that cultural norms play a role. Rana detailed her diagnosis of PCOS and her slow realization that PCOS is hereditary in her family, but the women had been suffering in silence. "I believe it's immigrant culture. I believe it's also Arab culture, that women have to be stronger. They have to be silent." She is attempting to break this cycle with her children.

Alia expressed similar frustration at booking her first cervix exam at the age of 31, shortly after moving to the United States, despite wanting to do so much earlier. When she lived in Kuwait, it was not expected or even socially acceptable to seek those types of checkups before marriage. "Why do I have to wait until a problem happens for me to go and check on myself?"

Jana echoed this sentiment, noting that often Arabs and Arab women specifically are taught not to speak up. Particularly when dealing with elders or authority figures, silence and deference are signs of respect. Consequently, questioning a doctor's words can be viewed as disrespectful. "You grow up with all those things and then you go into these spaces where there are these really educated people . . . they tell you something and you're supposed to say no?" She recalls attempts to advocate for her grandmother when she was younger. Her grandmother would *shush* her and say: "That's inappropriate, don't argue with him."

Lara, Lina, and Wisam are very familiar with these cultural expectations. Lara explained that before she came to the United States from Jordan, it was as if getting a second opinion was not an option. Whatever the doctor said should be followed. According to Lina, "In the Arab world, doctors are second to God. You don't question the doctor." She recalled questioning the doctor extensively during her mother's cancer treatment and both her parents angrily telling her to stay quiet because "he knows his business. I'm like, I don't care if he knows his business, I want to know his business." Wisam repeated this nearly word for word, stating that her culture elevates doctors to right below God. She is strongly against this mentality because of how often she has been dismissed, which has taught her not to blindly trust doctors.

Mediating Factors: Positive Health Experiences

As noted earlier, 12 of 20 participants stated that their ethnic background does not significantly impact their health outcomes. However, it became evident that this can be attributed to one or both of the following factors: Diversity among clinicians and the general population, and the ability to draw on health-care connections. Most of these participants acknowledged that these factors resulted in more positive health-care experiences, which would likely not be the case with many other Arabs in the United States.

Diversity and Increased Exposure

Diversity Among the Population. I noted a direct connection between positive health experiences and clinicians' increased exposure to people of different backgrounds. Maryam explained that she lives in an area with people from all around the world and spoke about how she has a good relationship with her clinicians. She made a direct connection to diversity: "Overall it's much better because here they're exposed to different cultures." Her clinicians have been very respectful toward her culture. When she first moved to the United States and struggled with English, she was often asked if she needed a translator or wanted to bring someone with her to interpret. Her doctor asked if she was comfortable with a male student being present, and her male gynecologist asked if she wanted a female nurse to be present, demonstrating sensitivity toward her desire for modesty. Today, she believes there has been further improvement: It is easy to request a translator ahead of time and pamphlets are available in different languages. "They write: we speak your language."

Aisha, Shahad, and Lina expressed similar feelings. Aisha explained that she lives in a diverse area, and despite her occasional struggles with English when she feels nervous or uncomfortable, the clinicians tend to be very friendly. They ensure she has all the information she needs, respect her need for modesty, and provide her with a female doctor when she requests it. Along the same lines, Shahad said she that the clinicians in her area have been culturally sensitive. She noted that a large public university is based in her city, which attracts visitors from different areas and results in a diverse population. Lina lives in an urban center and also explicitly highlighted this connection, explaining that doctors serving a diverse community would be familiar with those sociocultural and religious groups.

Diversity Among Clinicians. Rather than diversity within the population, Mohammad and Ali spoke about diversity among clinicians. Mohammad explained that many of the hospitals in his area are staffed with Arab and Muslim doctors. As a result, doctors are "more comfortable" with Arab patients, expressing familiarity with food restrictions and other cultural norms. "So I don't think we have the gap where we're completely strangers." He also noted improvements in cultural awareness over the years because the Muslim community in the city has grown and many work on interfaith councils and other initiatives. "The non-Muslim community has gotten used to us." Ali similarly pointed out that there are many Arabs and Muslims in the medical field where he lives, "so they are aware of Muslims." He spoke about instances in which larger clinics have reached out to the local Muslim community and requested to speak with representatives about how to best support their Muslim patients.

Somewhat in line with the idea that exposure to people from different backgrounds increases clinicians' cultural competency, four of the eight participants who claimed that their culture impacts their health-care experiences live in less diverse communities. Nearly all of Lara's clinicians, as well as all of Wisam's and her husband's, have been White. Rana lived in a predominantly White area during the majority of her negative health experiences. Sahar lives in a very small city lacking diversity and claimed that "diversity among care providers is a challenge." However, the remaining four participants do not fit this pattern: Jana, Lina, Alia, and Sarah live in cities with large Arab American communities. Although, Sarah did state that almost all of her doctors have been American.

Health-Care Connections

A second pattern became evident as I spoke to the participants with positive health-care experiences. Most of them either had a background in health care or were closely connected to someone in the medical field.

Background in Health Care. As a clinical pharmacist, Lara explicitly stated that her medical background enabled her to ensure she was satisfied with her health experiences. She described having pelvic floor issues after giving birth and suffering from symptoms often dismissed as typical post-birth symptoms. However, she insisted that something was wrong and was able to address it through pelvic floor physical therapy. While speaking with friends who had struggled with similar issues for years, she found out that they were unaware that physical therapy was even an option. Due to her medical background, she had persisted in this matter.

Samya has a degree in health promotion and has worked in different health settings. She stated that her background allows her to make informed decisions when it comes to her family. At one point, her granddaughter had a severe immune reaction and the doctor dismissed the symptoms. Along with her daughter who also has a health background, she insisted that something was wrong, and her granddaughter had to be finally admitted to the intensive care unit. She acknowledged that dismissing the child's symptoms was not intentional on the doctor's behalf but could have had deadly consequences.

Similarly, Sahar feels she is "blessed" due to her experiences working in health care for 25 years. As a result, she can navigate a very complex system on behalf of her family. "I'm well aware because of the work I do that not everybody has that privilege . . . my experience has been easier than most and I recognize that."

One final example is Wadha, who expressed generally positive experiences with U.S. health care. "I feel like I'm listened to and taken seriously for the most part . . . I don't feel like I'm being brushed off because of my religion or my background or the way I look." Wadha did not directly point to her health background, but she explained separately that she worked in urgent care for eight years and has been a registered nurse for seven years. In addition to living in a diverse community, this may in part explain her positive experiences. Her experiences provide a stark contrast to those of Rana, who never felt that she was heard. Rana has a background in microbiology and her husband is a medical technologist. Despite this, their health-care experiences were overwhelmingly negative. However, Rana feels that their experiences would have been worse if not for their health backgrounds.

Connections in Health Care. Other participants referred to the advantages of having connections in health care. Maryam explained how if she did not understand something, she would ask for it in written form so that she could later confer with her close friend in the medical field. Similarly, Jassim felt that he had been "amazingly lucky" with his health-care experiences thus far. He elaborated, "I have about 20 doctor friends on my phone that I can access at any time . . . I can always find somebody who can help me get through the system in one way or another." Adam also referred to his many doctor friends who have answered questions and helped refer him to other doctors for specific situations. Yousef shared that his family members are physicians of all different kinds, which has contributed to his overall positive experience with health care. Reflecting on the value of these connections, Sahar stated that almost everyone she knows has not had great experiences with the U.S. health-care system, but "if you know somebody who knows somebody who knows somebody who can figure it out for you, yes, your experience will be better. And it shouldn't be that way."

Walid described a situation in which his health-care connections protected him from severe consequences. After visiting an ophthalmologist to receive a shot in his eye, he found himself completely unable to see out of that eye. He called an Arab doctor in his social circle to receive a second opinion and was instructed on how to proceed. If he had waited an hour longer to seek help, he would have lost his vision in that eye. His ability to immediately receive expert medical advice, rather than attempt to schedule another appointment or wait for hours in the emergency room (which he described doing in other instances) helped him avoid a disastrous outcome.

Is Increased Cultural Competency Needed?

RQ3 asked about the perspectives of Arabs in the United States on the importance of cultural competency in the health-care system. All but three participants—Shahad, Aisha, and Adam—firmly believed that increased cultural competency is needed.

Shahad felt that there are many other aspects in which there is a need for more cultural awareness, but from her positive experiences with the medical system in Kentucky, there is no urgent need. She felt that there are many resources in place to help immigrants navigate the U.S. health care. Aisha expressed that her experiences had led her to believe that health-care professionals will not treat you differently because of your culture. Adam said that when it comes to psychiatrists or therapists, cultural awareness is very important. However, for doctors dealing solely with the physical—a nephrologist or a cardiologist, for example—culture does not make a difference. "I don't think that there is a difference between the kidney of someone from China and the kidney of someone from Norway. They are all kidneys," he reasoned.

The remaining participants spoke at length about the importance of cultural competency training, lamenting either its absence or inadequacy. Sahar emphasized that cultural awareness and relatability are crucial when it comes to building relationships and trust between patients and clinicians. Wadha reflected on what she was taught in nursing school about different cultures, which she states was not sufficient. Moreover, the hospital she currently works in does not provide any training. "I feel like that's something that just comes with experience and the more you're exposed to different cultures." This supports the pattern highlighted in this article in which increased exposure to people from different backgrounds results in increased cultural sensitivity toward them as patients.

However, Jana does not think that it is enough to rely on exposure when a lack of cultural competency can have serious consequences. "I know for sure if I was not there for those times that I helped translate for my relatives that they would have been misdiagnosed." She spoke of knowing many Arab Americans who engage in this labor to protect their families. Jana believes cultural competency training should be mandated and led by community leaders and local people of color. Committees should be created to ensure accountability and consistency. She emphasized that systemic change is needed because the existing one-off training sessions are largely ineffective. "You can't have one training that covers all cultures—that's ridiculous. We're all so different and diverse, even amongst Arabs."

As many participants recognized, there has been significant improvement. However, the negative experiences described throughout this article are not a thing of the past, which Jana highlighted: "I continue to hear from community members and family members about health-care professionals saying certain things that are racist, Islamophobic . . . I think they just don't have the proper training to understand what Arab culture looks like."

Discussion

This study examined the health-care experiences of Arabs in the United States, a rapidly growing population that is understudied and overlooked. The framework introduced in the literature review by Betancourt and colleagues (2016) details cultural competence interventions at three levels: Organizational,

structural, and clinical. Participant responses highlighted pivotal experiences at each of these levels, underscoring the need for an intentional shift toward culturally competent care to better serve Arabs and other minorities in the United States.

RQ1 sought to understand whether participants perceived that their ethnic backgrounds affect their health experiences, and if so, how substantial the impact is. While the majority (12/20) did not feel that their backgrounds significantly affected their experiences, it soon became evident that mediating factors played an essential role.

RQ2 asked participants to articulate the influence of their ethnic backgrounds on their health experiences. Their responses were overwhelmingly negative. Participants spoke about assumptions made based on their appearances, constantly having to fight for respect in health-care spaces, language barriers, clinicians' lack of culturally specific knowledge, and cultural stigma. While some participants shared positive health experiences, these appeared to be despite their backgrounds rather than because of them. Positive experiences were largely attributed to living in a diverse community, clinicians' exposure to people from different backgrounds, and participants having a background or connections in health care. These factors seemed to mitigate the negative impact of their backgrounds. Many participants provided the disclaimer that they felt their positive experiences were not the norm in their community.

RQ3 asked about the importance of cultural competency in the health-care system. Almost all participants (17/20) believed there is a need for increased and improved cultural competency training. They highlighted instances where training was either nonexistent or too brief and generalized to be effective. Consequently, training programs need to be developed and refined to better equip health-care providers to treat Arab patients.

The stories shared reveal that for Arabs, health-care spaces can be sites for hostility and stereotyping. Often, patients are dismissed or treated with suspicion and have to work hard to make their voices heard. These narratives cannot be removed from the sociopolitical context. In addition to their paradoxical position within the U.S. racial/ethnic classification system, a history of Western prejudice and imperialism in the Middle East contributes to the unique positioning of Arabs in the United States. For decades, U.S. media and politicians have reinforced the idea of an inferior Other and conflated the categories of Arab, Middle Eastern, and Muslim, fueling anti-Arab racism and Islamophobia (Naber, 2000). However, the September 11 attacks drastically increased discrimination, racial profiling, and hate crimes (Jamal & Naber, 2008). "Arab and Middle Eastern Americans have been racialized not only as brown and foreign but more specifically as anti-American Muslim terrorists" (Zopf, 2018, p. 189). Given that they continue to face negative prejudice in their day-to-day lives, it is not surprising that their health-care experiences also differ from those of other ethnic groups. These interviews shed light on how the persisting image of Arabs as Other dramatically shapes their experiences with the U.S. health-care system.

Future Research

This research is grounded in Dutta's (2008) CCA. To work toward building communicative infrastructure in which the community is the primary resource for knowledge generation, Dutta (2018) asserts that a researcher should learn from community members the key problems they face and what

research questions should be asked. In line with this approach, defining pathways for future research is essential. First, future research should compare the experiences of immigrants and domestic Arabs. This sample included both but did not look at the differences between their experiences. Additionally, all of the male participants stated that their background did not impact their health experiences. It may be worth exploring how the experiences of Arab communities in the United States differ by gender. Other recurring themes that can be further investigated include (1) the privilege provided by passing as White, (2) how social and cultural capital can mediate negative experiences, and (3) patient preferences for Arab clinicians, intersecting with literature on physician-patient racial concordance. Finally, because the theme of patient advocacy and empowerment arose frequently, this theme should be explored in a separate study.

Conclusion

This study underscores the importance of understanding the health-care experiences of the Arab population in the United States. Participants repeatedly emphasized the importance of this research, both personally and within their larger community. As Alia explained, visibility is crucial for identifying discrepancies in health-care services and catering to the needs of the underprivileged. Without this kind of health data, "you become invisible and therefore not acknowledged."

These findings also echo broader concerns about the failure of the U.S. health-care system to incorporate culture effectively, as highlighted in the literature and supported by this study. There is a pressing need for purposeful and strategic efforts to adopt culturally competent care. This includes the development and implementation of comprehensive training programs that better equip health-care professionals to deliver care to patients from diverse cultural backgrounds. This is one step toward fostering a health-care environment that is safe, inclusive, and equitable.

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