Beyond Translation and Tolerance

Cultural Competence in Health Care Organizations

Healthcare Georgia Foundation
grantmaking for health

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Introduction

In spite of a need for immediate medical care, a young woman refuses to sign a consent form until her husband is summoned. An otherwise stoic Irish woman begins complaining of pain, but the nurse who regards women as soft on pain, dismisses her cries as overreacting: the woman dies. A young administrator/ trainer hides out in her office, instead of visiting a group home for African American and Hispanic juveniles, where health education is taking place: she is uncomfortable around Black and Hispanic youth. A gynecologist asks a woman how many pregnancies she has had. She replies, "Two," but actually she has had three. One child was stillborn, a source of shame, so it's not mentioned. A young family interpreter "misinterprets" a medical condition as explained by the attending physician, because the illness could cause shame for the parent. What's a common thread among these seemingly different incidents?

The answer: The degree to which there is shared cultural understanding.

Prejudgments or missed cues can be the difference between prevention and disaster, between life and death. Cultural competence is not just a nice-to-have consideration; it is essential to competent delivery and utilization of health care.

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The Goals for This Manual:

- To define the concept and practice of cultural competency
- To raise awareness of the need for cultural competency in health care organizations
- To provide practical examples and approaches to building competence for individual providers, staff members, boards of trustees and other organizational stakeholders
- To provide useful information about consumers for greater comfort in interactions
- To identify resources that can assist health care providers to develop or improve their cultural competence

Note: Throughout this manual, the term "consumer" is used to denote patient, client or customer. The term "health care professionals" refers to physicians, nurses, health educators and other health care service providers. Stakeholders include everyone who has a stake in the efficient and effective delivery of health care programs and services.

Business Case for Cultural Competence in Health Care Organizations

Cultural competence encourages an inclusive approach to health care, but there are glaring health disparities to resolve. The Department of Health and Human Services (DHHS) has established the Office of Minority Health (OMH) to improve the health of minority populations through health policies and programs aimed at the elimination of disparities.

In spite of the government's initiative, there needs to be a sustained and coordinated engagement of health care providers in order to effect real change in the practice of culturally competent health care. Identified stakeholders in this effort are ethnic and racial minority communities and providers of care, as well as government agencies, academic and research institutions, state and tribal governments, faith and community-based organizations, private industry, philanthropies and individuals.

Class issues can interfere dramatically in the delivery of care.

A key to sustaining the effort to become culturally competent is a *commitment* to observation and educational awareness, leading to changes in levels of cultural expertise, skills in interacting effectively with different consumers and improvements in the overall attitudes toward cultural differences.

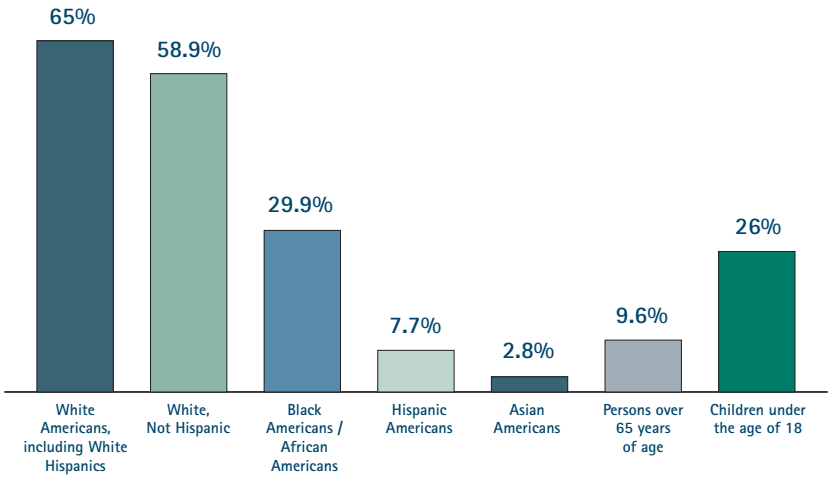
Health disparities and delivery of service stood out boldly during the Hurricane Katrina catastrophe. Preparedness and response to natural disasters is routine for relief organizations, yet the resources and coordination for Hurricane Katrina failed miserably. Health disparities interfere with the capacity of responders to intervene, but more importantly, the lack of cultural competence can be deadly.

Class issues can interfere dramatically in the delivery of care. According to a Kaiser Family Foundation report, there was and continues to be a two-tiered health care system in New Orleans, with 25 percent of the population in poverty and 20 percent lacking health care.

Without health care, many poor residents of New Orleans tended to be sicker with chronic illnesses and diminished mobility. Because there were limited health care facilities for the poor in New Orleans, health care workers had to devote a good deal of time and resources to help those weakened by an interruption in services normally provided by the destroyed Charity Hospital. Poor people face challenges that require cultural sensitivity and understanding from health care providers.

Georgia Census Data: Embracing Racial and Ethnic Diversity

Figure 1: The population of Georgia according to 2006 U.S Census data indicated that 9,363,941 people live in the state.



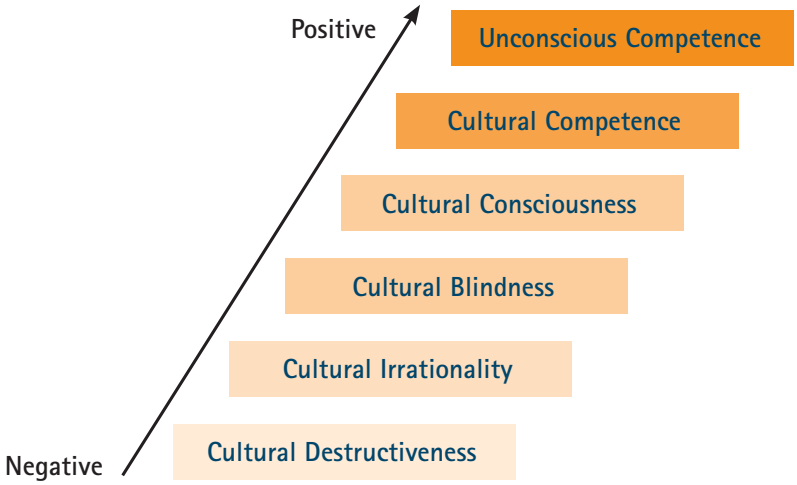
What is Cultural Competence?

Cultural competence is a set of integrated behaviors, attitudes and standards among professionals that enable effective work and excellent results in intercultural situations. Fourteen (14) national standards exist for "Culturally and Linguistically Appropriate Services (CLAS)," but achieving cultural competence requires more than adherence to standards in the treatment of individuals. Real cultural competence (CC) is systematically institutionalized throughout an organization, so that the organization itself is a model of community understanding, continual learning and expansion and respect for different perspectives and personal desires.

Cultural competence is a set of integrated behaviors, attitudes and standards among professionals that enable effective work and excellent results in intercultural situations.

The Continuum of Cultural Competence

Figure 2: Where Am I Now? Where Could I Be?



Cultural Competence Definitions

- **Cultural Destructiveness** is forced assimilation, subjugation of personal needs and establishment of the rights and privileges of dominant groups only. Behaviors are driven by arrogance and the desire to be powerful and significant.
- **Cultural Irrationality** is characterized by racist and other discriminatory behaviors that maintain and reinforce stereotypes, support unfair hiring practices and deny the rights of others to have different perspectives and worldviews. Behaviors are driven by fears and prejudices.
- **Cultural Blindness** is ignoring differences, believing that "treating everyone the same" is the best approach, and that the needs of the majority/dominant group are the best and only needs that should be met. Behaviors are driven by discomfort with conflicting views and practices, and a longing for the comfort of acceptance.
- **Cultural Consciousness** is exploring cultural issues and seeking answers to questions about differences in expectations and practices among people who are culturally different. Needs of the organization and the individual are considered in determining the best approach for quality care.
- **Cultural Competence** is recognizing individual and cultural differences, seeking counsel from diverse groups including diverse boards and hiring or developing culturally unbiased staff.
- **Unconscious Competence** is naturally engaging competently with others who are different because of recognition of one's own biases, continual intellectual curiosity and humility, and a strong desire to provide quality programs and services to everyone. Culturally competent behaviors are institutionalized within the health care organization as policies, practices and measures of progress. Unconsciously competent health care professionals implement changes to improve services, conduct appropriate research and teach others.

The problem to be faced is: how to combine loyalty to one's own tradition with reverence for different traditions.

The Truth about Tolerance

The problem to be faced is: how to combine loyalty to one's own tradition with reverence for different traditions. – Abraham Joshua Heschel

Since the 1980s the Southern Poverty Law Center has sponsored a program entitled "Teaching Tolerance." The program has provided successful ideas through a creative magazine and resource guide to encourage students in the nation's schools to develop tolerance. The work in schools has led to more inclusiveness and understanding among youth across the country, and has been responsible in part for raising the cultural awareness of teachers and other educators.

While on the surface the idea of tolerance is a good start, it is a modest place to end. Cultural competence is more than tolerance, because the term "tolerance" implies limits to the mutuality of experience between two different people or groups, and instead settles for enduring the differences or not interfering with them.

In the health care sector, an industry that serves others, enduring others or not interfering with differences falls short of the necessary kind of engagement that will produce wellness. Understanding differences and giving up ethnocentric thinking builds relationships and saves lives.

The price of the democratic way of life is a growing appreciation of people's differences, not merely as tolerable, but as the essence of a rich and rewarding human experience. – Jerome Nathanson

While on the surface the idea of tolerance is a good start, it is a modest place to end.

Understanding Terminology

Culture – The thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups

In health care practices, providers should consider:

- How rights and protections are exercised
- What is considered to be a health problem
- How symptoms and health concerns are expressed
- Choices about who should provide treatment or education for a problem
- What type of treatment is considered acceptable

It is no longer sufficient to be technically competent, and not culturally competent. Treating consumers with respect is a great start, but not enough, since interactions with consumers can sometimes lead to misunderstandings.

If health care professionals compliment a Mexican child as a way to build rapport, the well-intentioned behaviors could indicate that the professional is "giving the child an evil eye." Compliments are thought to reflect envy and thus thoughts of ill will. The perceived damage can be neutralized by simply touching the child. Knowledge of Mexican culture helps to build rapport in a constructive way.

Beckoning a Korean person with an index finger could be regarded as insulting, since in the Philippines and Korea, the gesture is used to call dogs. Different reactions to the gestures will occur in correspondence to the degree to which acculturation or assimilation has occurred.

A lack of eye contact from a Vietnamese woman may not mean discomfort, but deference to authority. Many Asian cultures tend to be hierarchical.

None of these examples is useful to predict behavior, but rather to consider possibilities for finding meaning in situations. Rather than resort to guessing, a health care professional can first try to find out the country of origin and the number of years that the consumer has been living in the United States. Presumptions about country of origin can be embarrassing.

A Japanese woman was a source of curiosity for some American colleagues, who wanted to know how long she had lived in the U.S. She was born in the U.S., and her parents had survived internment during World War II, even though they, too, were American citizens.

The Language of Culture

Ethnocentrism - the tendency to look at the world primarily from the perspective of one's own culture. Ethnocentrism often entails the belief that one's own race or ethnic group is the most important and/or that some or all aspects of the culture are superior to those of other groups. Within this ideology, individuals will judge other groups in relation to their own particular ethnic group or culture, especially with regard to language, behavior, customs and religion.

Cultural competence is an ongoing process of discovery.

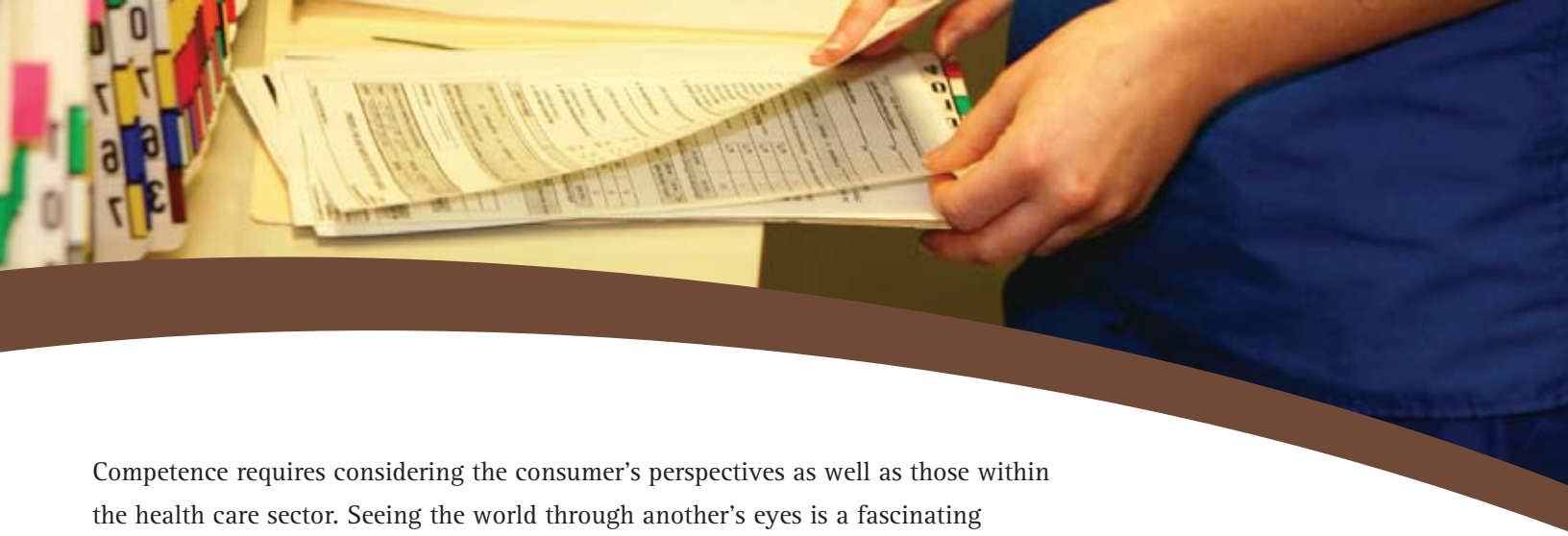
To become culturally competent, health care professionals must understand their own culture and biases, and become sensitive to and appreciate the differences of other cultures. Professionals must then begin to acquire knowledge of other cultures, followed by a commitment to apply the new understanding to interactions with people from other cultural groups.

Ethnic – relates to large groups of people classified according to common traits or customs.

Race – Though many definitions exist, there is no established agreement on any scientific definition of race. The general belief among those in the scientific community is that race has no biological or natural basis. Yet, "racial" attitudes among health care providers have contributed to health disparities and distrust among different ethnic/racial groups.

Cultural and linguistic competence in health care – Health care services that are respectful of and responsive to cultural, linguistic, socioeconomic and gender-specific needs.

Cultural competence is an ongoing process of discovery. A health care professional or stakeholder is most recognized as competent when he recognizes his own biases and consistently refrains from imposing his views on other cultural groups.



Competence requires considering the consumer's perspectives as well as those within the health care sector. Seeing the world through another's eyes is a fascinating growth experience, because changes in attitudes set the stage for increasingly successful cross-cultural interactions.

Competence requires considering the consumer's perspectives as well as those within the health care sector.

Limited language proficiency – A level of skill and understanding in speaking, reading, writing or understanding a language different from the first language learned. Limitations exist for English speakers and speakers of other languages.

In some instances, individuals with limited English proficiency:

- Were not born in the United States or an English-speaking country
- Speak a native language other than English
- Live in a household where English is not the dominant language spoken
- Are Alaskan Natives or Native American Indians who come from environments where a language other than English is spoken, and that language has had an impact on their proficiency in English
- Have limited interaction with English speakers

Clients/Consumers/Patients – Individuals, including accompanying extended families – guardians, companions, grandparents – seeking physical or mental health care services.

Staff – Individuals employed by a health care organization, as well as contractors or those affiliated with the organization.

Conflicts among staff members can have a negative affect on the quality of care consumers receive. A nurse refused to provide a specific dosage of medication that a Japanese physician had prescribed to a consumer. She believed the dosage to be harmful. The physician was incensed that she refused his order "to his face." The physician would have preferred that she agree with him publicly and then reduce the dosage as she believed appropriate. Respect for authority is important in Asian cultures, but so is the avoidance of conflict.

A Nigerian male nurse assistant expressed resistance whenever a female nurse asked him to do something. Role expectations and significance in his culture prevented him from accepting direction from a woman, in spite of his recognition of her higher rank professionally.

Training for foreign-born staff can prevent misunderstandings and help people from other cultures to understand the culture of American health care organizations.

Stereotype – A generalized perception of first impressions based on behaviors presumed by a group of people and often based on outer appearance. Stereotypes, therefore, can instigate prejudice and false assumptions about entire groups of people, including the members of different ethnic groups, social classes, religious orders, the opposite sex, etc. A stereotype can be a conventional and oversimplified conception, opinion or image, based on the assumption that there are attributes that members of the "other group" have in common.

A danger in health care is assuming that all members of a group fit a similar pattern. A Chinese health care professional observed that a Mexican woman had suddenly developed a severe condition. She called the consumer's husband, even over the physician's objections. When the physician attempted to get the Mexican woman to sign the consent form, she refused. With little time to waste before surgery, the husband arrived to sign the consent form, and then the consumer was sent quickly to surgery.

A danger in health care is assuming that all members of a group fit a similar pattern.

The Chinese health care professional used generalization effectively. A generalization can be used to recognize a cultural tendency, but the health care professional should be *flexible* in an appraisal of the situation, since a generalization may prove to be inaccurate. A stereotype, on the other hand, is an *inflexible* assessment of a person that closes the door to possibilities, and tends to lead to erroneous assumptions and culturally destructive behaviors.

A Korean man was brought to an emergency room for treatment because he was unconscious. Large welts were on his chest causing considerable puzzlement from the health care professionals. Actually, the welts were the result of a practice called "coining." Heated and oiled coins are rubbed vigorously on the chest of a person who is ill in an attempt to draw the illness out of the body. In this case, the "cure" was more damaging than the illness, but unconsciously incompetent health care professionals could make matters worse.

Although learning more about specific cultures may be a laudable practice of health care professionals, they are often cautioned against falling into the traps of stereotyping cultural groups based on information they acquire about differences.

The ongoing learning process in developing cultural competence requires a combination of *valuing individual differences* and *intellectual curiosity*.

As health care providers learn more, they should ask questions to be certain that their knowledge is coupled with understanding. The more a health care provider knows about cultural practices of an individual, the better able he or she is to determine the correct treatment or service for the consumer.

Making the appropriate generalization, however, can be a useful tool that narrows the field of possibilities, and can have a significant impact on the quality of care. When an American health care provider interacts with a person who is culturally different, it is helpful to know that decisions about health care may be based on American health care values such as autonomy, independence and privacy. Other cultures may prefer the dependence on family and connection rather than privacy.

Worldview - Refers to the framework of ideas and beliefs through which an individual interprets the world and interacts with it.

Although learning more about specific cultures may be a laudable goal and practice of health care professionals, they are often cautioned against falling into the traps of stereotyping cultural groups based on information they acquire about differences.

Touch, Self-Care, and Relieving Pain

Health care professionals and stakeholders acquire knowledge of other cultures in order to develop an understanding of different beliefs and values. Three important areas to investigate are 1) touch, 2) self-care, and 3) relieving pain.

Rehabilitation nurses provide services over time to consumers who can be dramatically affected by practices involving touch, relieving pain and encouraging self-care.

Some questions to consider in preparation for working with consumers are:

- What is the comfort in touching others or being touched?
- Does the gender of the person touching the consumer make a difference?
- Will pain be expressed verbally or will the consumer accept the pain quietly?
- Is there a belief that addiction to pain medication should be avoided at all costs?
- Is there a belief that pain medication is essential to recovery?
- Is independence a strongly held value when it comes to self-care?
- Is it important that family members provide care for the consumer?
- Will the consumer practice self-care at home or will someone at home provide it?

Note that most nursing schools place a high value on both touch and self-care. The specialty of rehabilitation nursing supports these values.

Touch – Not all ethnic groups/cultures are comfortable with touch. There may be differences in preferences among Hispanics and Asians. Hispanics tend to be more comfortable with touch than Asians. The degree of comfort or discomfort is dependent upon the degree of acculturation of the consumer.

Among devout Muslim and orthodox Jewish consumers, touching between members of the opposite sex is forbidden, so same-sex health care providers are essential to the treatment process.

The culturally competent health care professional asks the consumer if she is comfortable being touched, and refrains from unnecessary touching if the consumer is uncomfortable.

Self-care – Many Americans value independence in the recovery process. For many other cultures, *interdependence* is more highly valued than independence. Therefore, self-care is considered culturally inappropriate, since the family members are responsible for the care of the consumer.

A Japanese man performed well during physical therapy sessions after a stroke, but insisted on allowing his wife to care for him completely when she visited him in the hospital. Although the health care professional was frustrated with his "lack of progress," his extended family was culturally obligated to care for him. Other cultural groups also value the care of the extended family, such as some Hispanics and African Americans.

Role expectations are clearly defined in some cultures, with a dominance given to men and fathers.

Another factor in self-care is the age of the consumer. Old age is regarded as a time for rest and reflection among some Asians, so younger family members are expected to provide care.

Role expectations are clearly defined in some cultures, with a dominance given to men and fathers. Because of the prominent roles of dominant family members and extended families, culturally competent health care professionals include the family in plans for extended care.

Relieving Pain – Different cultures have different ways of responding to pain. Because some consumers may be stoic in response to pain, while others may be more expressive, the culturally competent health care professional must pay close attention to nonverbal clues for cultures that value stoicism and will seek to fully understand the meaning of the more expressive responses.

It is important to determine the usual pattern of response, because any unusual pattern can provide useful information. Those who tend to be stoic may not request medication for pain. Often medication has to be offered several times before the

consumer will accept it. Some consumers fear that pain medication will lead to addiction, so they valiantly refuse, even when taking the medication could hasten recovery. When physicians give a range of dosage options for a consumer, some Filipino nurses may provide lower dosages of pain medications, even in hospice or palliative care, because of their perspectives on pain and addiction.

Conflicting values concerning touch, self-care and pain can lead to serious misunderstandings and ultimately a decrease in the quality of care.

Learning to be Culturally Competent

If it is to be, it must start with me.

- Cultural competence starts with self-awareness
- As a person gains knowledge, personal and professional growth occurs
- Knowledge is enhanced with specific skill development
- Contact with people who are culturally and linguistically different is essential to developing proficiency

Cultural Interaction

Seek first to understand, before being understood. – Steven Covey

Culture is like an onion that must be peeled in order to fully understand how a person solves problems. If health issues are a problem to be solved, the cultural rules and values provide insight into possibly the most successful approach to care.

Peeling the cultural onion begins with listening for cultural cues, such as 1) how the consumer views relationships with others, 2) the consumer's attitudes toward time: past, present and future, and 3) how the consumer gives emphasis to an internal or external environment.

Some consumers have strong family orientations that influence how and when they accept treatment or receive education. Specific family roles can also influence the nature of follow-through and compliance with prescribed treatments.

A consumer's concept of time and preferred emphasis on the past, present or future can determine how a diagnosis or prognosis is received. In hospice situations and palliative care, past-oriented family members may be unwilling to share a terminal prognosis with a dying member, but may prefer to focus on the vibrant past of the dying consumer.

Effective communication usually begins with active listening, or what could be called, listening for possibilities.

Future-oriented consumers may rely heavily on evolving medical technology to solve health problems, such as the newest research or medication. On the other hand, past-oriented consumers may be in favor of traditional remedies, including what American medical practice may regard as alternative approaches. Present-oriented consumers may not readily connect their present medical problem to life style choices of the past, but rather to their current, temporary difficulties.

After using listening, reflecting and inquiry skills in cultural interactions, the health care professional is then effectively positioned to share perspectives.

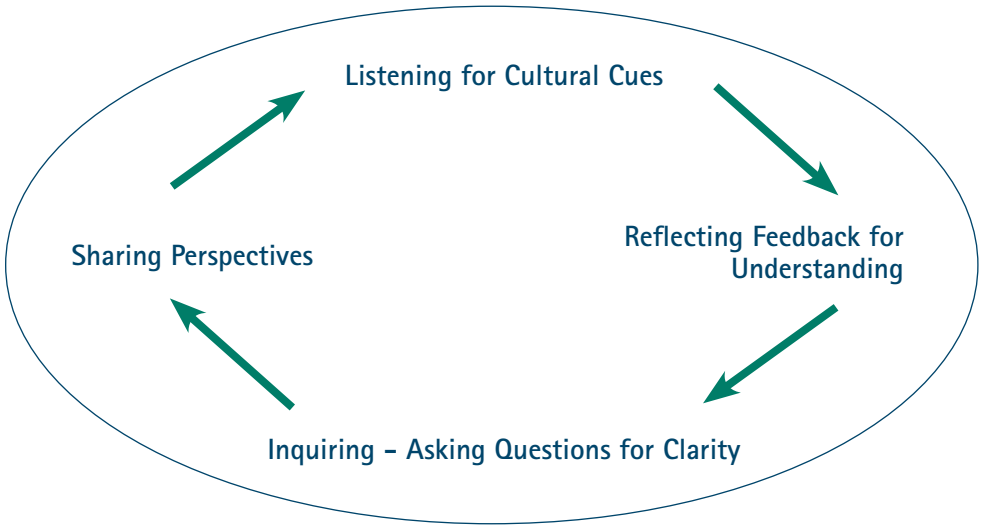
The importance of the internal and external environment can vary considerably. Citizens in Tokyo may wear face masks if they have a cold or virus, because they prefer not to spread their illness to others by breathing on them. Bikers in urban areas in the U.S. may wear masks because they do not want to be affected by the pollution that they may breathe in. In one case, the emphasis is given to the internal environment, while in the second case the emphasis is given to the external environment.

With so many differences in perceptions and cultural rules or values, interacting with consumers who are culturally different becomes particularly important in the helping process. Effective communication usually begins with active listening, or what could be called, listening for possibilities. If a health care professional develops sharpened listening skills, cultural cues regarding relationships, attitudes toward time and emphasis on the environment can be useful in the treatment or educational process. Whenever possible, health care professionals should prepare for a cultural encounter with some brief research on the culture of the consumer. Such resources as *EthnoMed* and *CultureGrams* can be consulted to gain a cursory understanding of different cultures before interacting with a consumer.

Letting the consumer know that he is understood and that his perspective is included in the problem-solving process goes a long way toward building trusting relationships. Using the skill of reflecting an understanding of the consumer's point of view, by repeating in one's own words what the consumer has shared, is a powerful assurance for the consumer.

After using listening, reflecting and inquiry skills in cultural interactions, the health care professional is then effectively positioned to share perspectives.

Figure 3: Active Listening



Arthur Kleinman, Ph.D. (1978) developed the Explanatory Model, which outlines a culturally sensitive approach to asking about a health problem. The model guides the health care professional in asking questions to gain clarity and demonstrates respect for the consumer's interpretation of her experience. This interview protocol offers a collaborative approach to problem solving that is characteristic of a culturally competent health care professional.

Figure 4: Explanatory Model

1. What do you call your problem?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does the problem do to you? How does it work?
5. How severe is it? How long do you think you will have it?
6. What do you fear most about this problem?
7. What are the chief problems your sickness has caused you?
8. Anyone else with the same problem?
9. What have you done so far to treat your illness?
10. What treatments do you think you should receive? What important results do you hope to receive from the treatment?
11. Who else can help you?

For health educators, Berlin and Fowkes (1983) proposed a slightly different model. The LEARN model is also inclusive and collaborative, beginning with listening to the consumer. Whenever educational efforts begin with a statement of the problem from educators, without the benefit of hearing the consumers' perceptions of the problem, the consumer is likely to resist. Resistance may show up as seeming compliance, with

little or no follow-through, or consumers may deny "factual data" as not true for them. Denial of the facts or reasons for the spread of infections has in some cases led to the persistence of HIV/AIDS and other diseases.

Caution should be taken in less than perfect interpretation situations where family members are used.

After the educator has the ear of the consumer, the educator's perception of the problem can be shared. During the exchange of ideas, differences and similarities will surface. Reconciling those differences and acknowledging similarities helps consumers to accept the changes that may be required to improve their quality of life or to solve their health problems.

Culturally competent health educators recommend treatment options and negotiate with the consumer to form an agreement. Educators should be certain to manage the expectations of the consumer by describing the pros and cons of treatment options, taking into account the relationship orientation, attitude toward time and emphasis on the environment of the consumer. The cultural lens of the consumer continually influences the outcome of treatment decisions.

Figure 5: Berlin and Fowkes' LEARN model:

L earn to listen to the client's perception of the problem
E xplain your perception of the problem
A cknowledge and discuss differences/similarities
R ecommend treatment
N egotiate treatment

Berlin and Fowkes prescribes a model of interaction that leads to negotiation of treatment options with full respect for the consumer's perspectives, while maintaining the professional expertise that is critical to quality care. Both the Explanatory and the LEARN models demonstrate respect for the consumer and see the cultural lenses of the consumer as critical to the treatment outcome.

Working with Interpreters: Translation* is Not Enough

When consumers have limited command of the English language, challenges can arise that can have dire consequences. Many health care organizations hire interpreters to bridge the gap in understanding. Caution should be taken in less than perfect interpretation situations where family members are used.

Cultural rules or expectations can interfere with interpretations of medical issues. Sometimes a consumer is shielded from the truth about her condition, because the family member does not want to upset her. At times, Latino women can be modest about revealing private or personal information to a health care professional if their children are interpreting. A further complication is that a family interpreter is

emotionally affected by the information shared. Sometimes a consumer's cultural history can cause resistance to treatment, such as the story of a Mexican woman who refuses to receive an epidural procedure because her spouse tells her she is not a real mother if she does not experience pain during childbirth.

Excellent interpreters are bilingual, bicultural and understand the English medical vocabulary. They generally are comfortable in a medical setting and understand the significance of the health problem. Confidentiality is guarded. An interpreter assumes multiple roles: translator of the language, culture broker and consumer (patient) advocate, conveying both expectations and concerns.

Excellent interpreters are bilingual, bicultural and understand the English medical vocabulary.

Some factors are significant in interpretation:

1. Qualified interpreters should be used
2. The use of family members is discouraged
3. Avoid using young children as interpreters
4. Avoid using untrained workers to interpret
5. Minimize the use of telephone language lines for interpretation

** Note: Technically, translation is written communication and interpretation is verbal communication, but the terms are often used interchangeably.*

Caretakers' Responsibilities Cross-Culturally

Even though a competent interpreter may be used, the caretaker/health care professional has specific responsibilities that must be considered:

- Get background information and set goals before entering the exam room.
- Learn a few phrases of greeting and introduction in the native language. This behavior conveys respect and willingness to learn about the culture.
- Agree on an interpreting approach; use the interpreter as a resource.
- Tell the consumer that the interpreter will translate everything that is said, so there will be a stop after every few sentences; control the pace of your conversation.
- Listen without interrupting.

- Watch the consumer, not the interpreter, and be certain to add gestures.
- Do not think "out loud" since the thoughts may confuse the consumer.
- Avoid the use of jargon or words and expressions that may be misunderstood.
- Reinforce verbal interaction with visual aids – brochures, posters, models.
- Repeat important information more than once and ask the consumer to repeat what was said (back-interpretation).
- Always give a reason for the treatment or procedure; provide all the information about diagnosis, testing and treatment.
- Be certain that the consumer understands how to consume medications or use educational resources by asking them to repeat exactly what was suggested; confirm understanding and agreement.
- Be cautious about suggesting that a consumer make a will, even for dying patients or those with terminal illnesses; in some cases such a suggestion would be tantamount to wishing death for a consumer.
- Avoid saying "You must..." Instead, teach consumers to look at options and allow them to decide.

The Influence of Culture and Language

The success of programs and services offered by nonprofit organizations may be influenced by a number of factors.

- Health, healing and wellness belief systems
- How illness, disease and their causes are perceived by the consumer and the provider
- The behaviors of consumers who are seeking health care and their attitudes toward health care providers
- The delivery of services by the provider who looks at the world through her or his own set of values, which can compromise access and quality service for clients/consumers from other cultures

The differences in worldview can contribute to the resistance to care and disparities that exist in quality and access.

Differences in Worldviews

A glimpse at the contrast between the traditional American worldview and that of others who now live in the U.S. shows the extent to which different cultural perspectives may potentially have an impact on how health care is perceived. Among members of co-cultures such as Native Americans, African Americans and Hispanics, differences in cultural experiences and perspectives have contributed to stereotypes and disparities in treatment.

Figure 6: Cultural Perspectives on Health

AMERICANS	OTHERS
• Make it Better	• Accept with Grace
• Control Over Nature	• Balance Harmony with Nature
• Action	• Wait and See
• Intervene Now/Early	• Cautious Deliberation
• Strong, Aggressive Measures	• Gentle Approach
• Recent Approach is Best	• Take Life As It Comes
• Treat Everyone the Same	• Recognize Differences

Strategies to Improve Cultural Competence

A number of strategies can improve cultural competence:

- Interpreter services from qualified providers
- Recruitment and retention policies for staff
- Ongoing training for staff
- Coordination with traditional healers
- Use of community workers
- Culturally sensitive health promotion and marketing
- Family and community member participation
- Immersion into another culture to learn cultural rules
- Administrative and organizational accommodations, such as providing for visitors or extended families

Purnell (2002) developed a comprehensive model of cultural competence that clearly acknowledges differences in perspectives. Each component of his model raises questions about how to use the perspectives to increase competence, by realizing the uniqueness of a consumer's life experience and worldview.

Figure 7: Purnell Model of Cultural Competence

- **Communication**

  What is the dominant language? How are the following expressed: volume and tone of voice, spatial distance, eye contact, facial expressions, greetings, time orientation, names, and touch?

- **Family Roles and Organization**

  What are the role expectations? What are the gender roles? How are the elderly regarded? To what extent is the extended family involved? Are there alternative lifestyles to be considered?

- **Workforce Issues**

  What is the degree of acculturation? What are the co-cultures (formerly sub-cultures) of which the person is a member? What are the possible language barriers?

- **Biology/Biocultural Differences**

  What biological variations may affect treatment or prevention? What are concerns about drug metabolism or allergies?

- **High–Risk Behaviors**

  Does the person consume alcohol or use tobacco products? What is the extent of physical activity? What are safety concerns?

- **Nutrition**

  How is food regarded? What are the food rituals?

- **Pregnancy**

  Are there fertility practices? What are the views toward pregnancy?

- **Death Rituals**

  How does the person regard death? What is the ritual bereavement process?

- **Spirituality**

  What are the religious practices? How does the person link spirituality, health and life?

- **Health Care Practices**

  What are traditional practices? What is the consumer's perceived responsibility for health? Does the person self-medicate? How is pain handled?

- **Overview and Heritage**

  How does the person view education and work? What are the family origins? What are the consumer's geographic origins?

Lessons in Intercultural Communication: Reject Easy Assumptions

Assumptions can be dangerous, leading the naïve into cultural traps. Intercultural communication requires openness to possibly being surprised by new information.

1. Don't assume sameness. Seeing no differences is like "disappearing" a person.
2. Normal behavior may be cultural.
3. Behaviors have different meanings.
4. What a person intends may not be what is understood.
5. Competence requires moving beyond simple acceptance or tolerance.
6. People have perfectly logical explanations for their behaviors, but their cultural logic may not be understood.

When English is Not the First Language

Compassion, empathy and patience are necessary attitudes and behaviors when a provider is working with a consumer who has limited English language proficiency. Below are suggestions for sensitive, effective interactions.

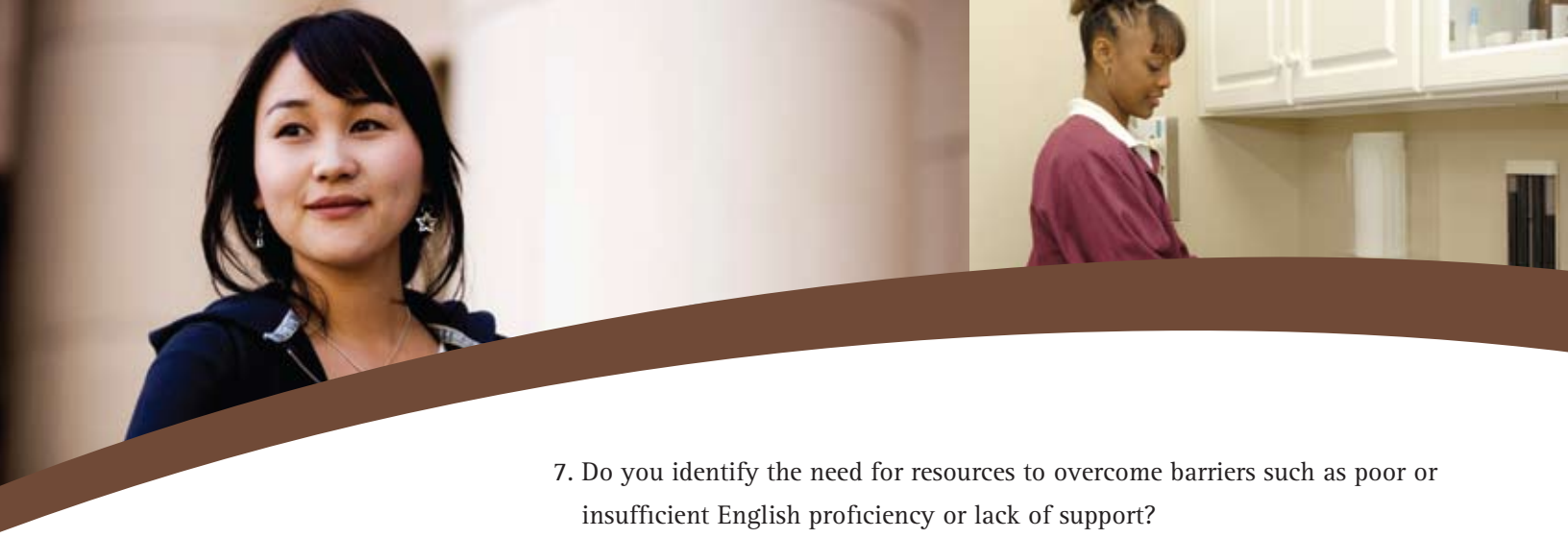
- Avoid using jargon, slang, idiomatic expressions, jokes and colloquialisms unless there is certainty that they will be understood.
- Avoid using long sentences or negative wording; simple grammar is safest and easier for all.
- English language competency cannot be equated with level of intelligence. Very intelligent people may have difficulty learning a new language as an adult.
- Speak slowly and clearly. Invite feedback on whether or not the communication is clear.
- Don't expect "yes" to always mean yes, or "no" to always mean no. If there are doubts, rephrase the statement. Ask questions for greater clarity.

Assumptions can be dangerous, leading the naïve into cultural traps.

Self-Assessment: Ask Yourself These Questions about Consumer-Centered Care

Techniques to provide culturally sensitive care are readily available in the literature, but a self-assessment asks the health care professional to look at his or her own biases honestly.

1. Do you react adversely to a person's accent?
2. Are you open and curious about different cultures and other ways of doing things?
3. Do you respect different practices and perspectives without judgment?
4. Do you recognize that consumers require quality care regardless of their cultural or linguistic background?
5. Do you actively accommodate consumers' choices about their care?
6. Do you assume that you know what a consumer wants or needs?



7. Do you identify the need for resources to overcome barriers such as poor or insufficient English proficiency or lack of support?
8. Do you identify sources of social support such as community organizations for consumers?

Culturally Competent Marketing and Public Relations

The message to be conveyed to consumers is that the organization includes their cultural perspectives in policies, practices and processes. The web site and marketing materials should contain images that reflect the community and describe the commitment to including others. Be certain that marketing materials are offered in the language of the consumer whenever possible and that they "speak" to the consumer about the core message of the organization. Competent health promotion should show healthy images and contrast the images with unhealthy alternatives, but the contrast should be sensitive to the consumer's worldview.

Culturally Competent Executive Leadership

Health care providers must possess the ability and knowledge to communicate and to understand health behaviors that are influenced by culture. Cross, Bazron, Dennis and Isaacs (1989) list five elements that contribute to an organization's ability to increase cultural competence.

1. Valuing the diversity of clients and the community
2. Having the capacity for cultural self-assessment
3. Being conscious of the dynamics inherent when cultures interact
4. Having institutionalized cultural knowledge
5. Having developed adaptations of service delivery reflecting an understanding of cultural diversity

These five elements should be evident throughout the organization, within policymaking, administration and practice. Attitudes that support diversity and cultural competence should be demonstrated throughout the organization in decisions about choices of treatment or education, in an environment of mutual respect and in the quality of care for consumers.

Developing culturally competent programs is an ongoing process. Re-evaluation is central to progress, since how things get done is dependent upon the dynamics within both the organization and community served. Changes in demographics require changes in approaches to providing services.

Culturally Competent Boards

A board's strategic direction should include a vision for addressing culturally focused health care within the organization. A strategic approach implies that there is a focus on improvement and a marshalling of resources and programs to build competence. The power of the visioning process is that the strategic direction highlights strengths of the organization, acknowledges a need for a redirection of organizational energies and establishes a commitment to measurable or observable results. Resources and assets are then part of programs and service delivery and evaluated on the basis of outcomes and long-term impacts.

Changes in demographics require changes in approaches to providing services.

Collaborations and other innovative approaches to resolve health disparities and issues of cultural sensitivity, for instance, are more likely to occur with a board's commitment. An engaged board identifies best practices and real solutions to close the gap in quality of service and supports programs to address the lack of cultural competence and sensitivity.

One way to address identified gaps is a systemic approach to delivering services. A systems approach to cultural competence implies that all stakeholders are engaged in health improvement and health disparities reduction. After the board looks at what is causing or contributing to health disparities and the lack of cultural competence, priorities can be set by considering the strengths and talents that can be used for the greatest impact. Resources in the community and strengths of the staff and executive leadership can be taken into account in setting the strategic direction for the organization.

Building an Inclusive Board

Health care boards recruit talented, experienced professionals. But, the recruitment process is not necessarily strategic in that people of color and women are in a minority, as are different perspectives, social relationships and problem-solving or innovation skills. Even though much has been written about diversity in health care organizations' boards, people of color still represent less than 10%.

1. To what extent should the board represent the community it serves?
2. Does the board participate in community events, including organizational fundraising events?
3. Does the board composition include different races, genders, ethnicities, languages, socioeconomic levels?
4. Does the board include people who are familiar with the population served?
5. Does the board recognize health disparities among different cultural groups?
6. Does the board recognize the need to develop cultural competency?
7. Do board members periodically discuss their own biases and how to address them?
8. Does the board celebrate successes in the organization related to inclusiveness?

Developing competence takes time.

Culturally Competent Staff

Consumers may receive direct care from health care professionals in an examining room, but administrative staff and health educators provide, through community outreach, access to valuable information for prevention. The relationship developed through excellent consumer relations can build confidence in the organization among consumers, and can influence the impact of the organization's services. Below are some considerations in developing culturally competent staff.

Recruitment and Training

One recommendation of the publication entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* was to "increase the proportion of underrepresented minorities in the health care workforce." Often, critical requirements such as fluency in a language other than English forces an organization to hire from an underrepresented group. When a representative person is not available for language interpretation, the quality of service is compromised. An organization can plan to hire staff who represent the community and who possess skills that are necessary to provide culturally effective services. Since it's not always feasible to hire "diverse" staff, existing staff need ongoing training to be able to provide services and to grow professionally.

Cross-cultural education and training improves the health care professional's ability to understand, communicate with and care for consumers. Ongoing training can also decrease the likelihood of disparate treatment based on a consumer's race, language or culture. Even though health care professionals may think they are culturally competent, developing competence takes time, so resources must be committed to a long-term process.

Special Populations and Considerations

Rural Nursing

Underserved populations in rural areas require strategic allocations of resources and sensitivity to their life experiences. Health care providers may have erroneous perceptions of people living in rural areas, particularly their lifestyles, health habits and culture. Rural life varies from region to region, so an understanding of the local community is essential. Culture is a dynamic process, with people moving in and out of various regions and cultures throughout their lives.

Community-based health promotion and prevention programs are becoming increasingly prominent because they ensure community participation and increase the capacity of the local communities to engage in prevention activities. U.S. Government health agencies and the Centers for Disease Control and Prevention recommend a focus on community-based prevention. One way in which disparities caused by tobacco-related health issues are addressed is through approaches such as using lay health advisors. These advisors mitigate the trust issues that can sometimes interfere with the delivery of care.

36 percent of Hispanics said they distrust the U.S. health care system.

African Americans

In 2001, a national survey found that 35 percent of African Americans distrust the health care system. The survey also noted that 65 percent of African Americans were afraid of being mistreated in the health care system in the future. Based on historical factors of discrimination, segregation and medical experimentation, African American consumers may be distrustful of health care providers. As new generations emerge in the African American community, the historical experiences such as the Tuskegee experiment or exclusion from quality care will be less prominent in the root system of the community. But current perceptions require that health care professionals recognize the active nature of history in intercultural interactions.

Hispanics/Latinos

In a national survey of Hispanics in 2001, 36 percent of Hispanics said they distrust the U.S. health care system. Undocumented workers are particularly leery of contact with health systems, for obvious reasons. In the same study, 58 percent of Hispanics, compared to 22 percent of whites, said they were afraid of being treated

unfairly in the future. The distrust can be responsible for wariness about following recommendations, undergoing invasive procedures or participating in clinical research.

Although a myth exists that Hispanics and other immigrants place considerable burdens on emergency room resources in regions where they live and work, Hispanics come to the U.S. for employment, not health care. Non-citizens tend to request fewer health care interventions than citizens, and tend to use the emergency room less often than citizens.

An important note about Hispanics is that there are considerable variations within the group. Puerto Ricans, Mexicans, Cubans, Dominicans, etc. have different cultural rules. Hispanics are linked primarily by language, even though meanings and use of specific Spanish words may differ among the different nationalities or regions.

Angel Randolph of the North Georgia AIDS Alliance works to provide prevention information to the population of Hall County, and has worked with Gwinnett County in outreach efforts. The dramatic increase in the Hispanic population of Hall County has necessitated an emphasis on language and cultural competence in her work. Interpreters are a must in order to ensure that prevention information is understood. Through the use of bilingual volunteers the organization has been able to reach out to thousands of residents and workers in the region.

Knowing the nuances of social behaviors can build confidence.

Asians

In high context cultures such as Asian cultures, rules of engagement and propriety are nuanced. One known rule is that first generation Asians may express a preference for hierarchical relationships. It is therefore considered inappropriate for a young person to tell an older person what to do. If a home health worker is assigned to care for an Asian consumer, communication with the consumer could present difficulties. Since the eldest male is considered to be at the top of the hierarchy, instructions may have to be conveyed through that family member.

Ritual social behaviors can often be misunderstood. According to cultural rules, for example, when a Chinese person is offered food, the food is rejected until the third offer. To accept sooner is considered rude. When home visits are made, food may be offered. Knowing the nuances of social behaviors can build confidence.

Negative reactions to learned behaviors can create conflicts even among staff. A misunderstanding about Filipino nurses is that they are sometimes considered cold and unfeeling, even by co-workers, since their training emphasizes the technical aspects of nursing, with little attention to the psychosocial aspects. Health care workers from other countries should be coached regarding expectations within the American system, just as American health care workers must broaden their cultural perspectives.

Gender Differences

Gender equality has been a goal in the U.S. since the women's movement of the 1970's, and earlier for African American women in the U.S. In many countries, men are still considered head of the family and therefore responsible for major decisions. Conflicts may arise when there is an expectation that women can make decisions about their own health or the health of their children.

Gender roles and expectations also influence the perceptions about the quality of care. A female Muslim consumer may object to invasive procedures performed by a male physician. A Muslim male may insist on covering a woman completely, even during an operation, particularly when the surgeon is male. Or, Muslim women may demand that all of their health care providers are women.

In some cultures, the assumption that the mother is equally empowered to sign a consent form for a child may be incorrect. Because the male has dominance, if the role expectation is ignored, health treatments or discussions can be delayed.

Lesbian, Gay, Bisexual and Transgender Consumers

Health disparities among gay, lesbian, bisexual and transgendered consumers are similar to the general population, but attitudes toward the population can interfere with the quality of care. Within the population issues about sexual identity, gender identity and sexual health behavior can be important in treatment or education. The following strategies can create an environment that encourages the LGBT community to share information with health care professionals.

- Post a statement that ensures non-discrimination.
- Display print materials that show same-sex couples.
- Provide materials that respond to LGBT health concerns.

Health care professionals must recognize their own views of the death experience, and their own cultural biases.

Dying Patients

Health care professionals must recognize their own views of the death experience, and their own cultural biases. Religion may be a source of comfort for dying patients, so how the person chooses to express beliefs at life's end must be respected. Koreans or Mexicans and African Americans will receive advance directives differently. African Americans are more likely to believe that patients should be informed if they have metastatic cancer, for example, and should know their options about life support treatments. Koreans and Mexicans may not want to know. Often the consumer's family members are the best source of information about what is appropriate, or sometimes the information can be gathered directly from the consumer. Advance directives can vary among groups, so health care providers should be careful not to make general assumptions.

Consider the following:

- Recognize the consumer's need for closeness or distance
- Acknowledge the consumer's decisions about the use of pain medications
- Recognize the need for contact with family members of all ages
- Avoid interpreting all behavior as stemming from the terminal illness

Homeless Consumers

Homelessness continues to be a national challenge, with a difficult economy causing more and more people to become homeless. Public health challenges are exacerbated with the steady increases in homelessness. Historically, data collected on homeless persons have been concentrated in urban areas. Less known is information about rural homelessness. Culturally competent providers must understand the causes of homelessness, such as unemployment, domestic violence, mental illness, poverty, etc., and learn responsive health care approaches for the homeless population.

Mobile clinics that visit shelters, free prescriptions, comprehensive mental and physical care, and a nonjudgmental attitude are responsive services, but the growing size of the homeless population will require innovative strategies to provide care.

The growing size of the homeless population will require innovative strategies to provide care.

Consumers with Hearing Loss

The use of interpreters with culturally different consumers who have hearing loss is particularly challenging, since consistency in the use of interpreters is essential for continuity of services. Service to deaf consumers includes the use of interpreters as cultural brokers and reducers of complexity in the treatment approach. Staff must be sensitive to the needs of the consumer and responsive to the cultural expectations of the extended family or primary caretaker in the family system. Primary care, follow-up and consistency are important aspects of successful interventions, particularly with services to children.

Debbie Brilling of the Auditory-Verbal Center encounters consumers who rely on herbal remedies until they are found to be ineffective. Since early intervention is critical to the success of treatment, some cultural practices can be frustrating. Uses of alternative healing practices are based on traditional beliefs as well as spiritual and cultural values.

Differences in child-rearing practices and behaviors can present challenges in providing uninterrupted care, while demanding parents may question authority, follow-up requirements or the treatment process. Working successfully with the family system is essential to treatment, and therefore requires patience and sensitivity.

Medical Informatics

The intersection of the computer, information science and health care has produced resources, devices and methods that can improve the gathering, storage, retrieval and use of health information. Unless trust is built with consumers, the gathering of useful data can be an incomplete or inaccurate process. Electronic medical records, clinical guidelines, medical terms and broad communication systems require trained staff for optimal use. The relevance for consumers is clear: cultural incompetence can create serious challenges in managing information.

Closing the Gap: Conclusion

Successful efforts to achieve cultural competence require an HUMANE approach, a process Phillip E. Jackson proposes. Mr. Jackson is branch head for hospital corpsmen assignments at the Navy Personnel Command in Millington, Tennessee.

Figure 8: Jackson's HUMANE Approach

H ire a diverse workforce
U nderstand the communities served
M ake cultural competence a business priority
A dopt cultural and linguistic approaches to health care practices
N urture a service-learning archetype
E valuate progress and continue to develop

Developing cultural competence requires an organizational development approach that starts with individual, group and organizational assessments, and continues with developing a strategic direction and actions for improvement. As an organization grows and increases competence, the organization must assess progress in order to continually improve. Learning cultural differences can be challenging, but a strong intention to learn can begin to reduce the complexity.

Learning cultural differences can be challenging, but a strong intention to learn can begin to reduce the complexity.

Resources and Tools

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The National Center for Cultural Competence (NCCC).

Our Mission:

Our mission is to advance the health of all Georgians and to expand access to affordable, quality healthcare for underserved individuals and communities.

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