Treating Immigrant Populations — Cultural Competence in Health Care

by Alice Kitchen

Delivering health care to non-English speaking immigrant populations requires knowledge and appreciation of the patient's culture. Acquiring the skills to bridge the two worlds calls for self-awareness by the practitioner and a commitment to cultural competence by the organization.

A Bosnian woman and her nine-year-old son arrived at a private practice office for the first time. Unable to speak English, the woman was severely distressed and frustrated because she could not relay her needs. Since the woman was doubled over and crying, the physician assumed the woman was in pain but felt helpless in his inability to communicate necessary questions. An interpreter was requested but no one was immediately available. The nine-year-old boy, under his mother's instruction, began to interpret with great hesitancy and discomfort. "She is bleeding . . . stomach hurts . . . ." The patient, her son, and the physician deliberated extensively to obtain an adequate history and physical. The physician waited for an available interpreter to relay the news of suspected endometriosis.

Demographics in the United States have been rapidly changing and health care must evolve in order to accommodate the resulting diversity and pluralism. Nationally, about 800,000 legal immigrants and 300,000 undocumented immigrants arrive in the United States each year (Lamberg 1996). Locally, of the 1.7 million residents in metropolitan Kansas City in 1998, roughly 96,000 were Hispanic, Asian, Pacific Islander or other (U.S. Bureau of Census and Claritas 1999). Since 1990, the metropolitan area has seen a dramatic influx of non-English speaking people. They are from Latino, Somalian, Vietnamese, and Arabic cultures, and speak various dialects of their respective primary languages. By the end of 2004, Hispanics, the fastest growing ethnic group in the United States, will outnumber the non-Hispanic black population as the nation's largest minority (Associated Press 1999).

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Many immigrants are not conversant in English or familiar with the dominant culture. Thus, linguistic and cultural barriers pose an ethical challenge to professionals who believe that the patient and his or her family must understand, participate in, and consent to medical care. Since physicians begin by developing rapport, gathering an oral history, and conducting a physical exam, it is obvious why patient care suffers when linguistic and cultural obstacles exist between the patient and practitioner.

A Haitian father, frantic about his daughter's medical condition, brought his daughter to the emergency department of an urban hospital. The physicians initially had no way of obtaining the patient's history or asking even simple questions. Are you in pain? Where does it hurt? Have you had a fever? Have you vomited? Fortunately, the social worker connected the hospital doctors to a French Creole-speaking community physician who knew the patient and was able to interpret for them in the middle of the night via telephone. The physicians then discovered that the child was a known patient of their oncology department.

The legal and regulatory standards for preventing substandard services comprise Title VI of the Civil Rights Act of 1964 and are applied in the Guidance Memorandum: Title VI Prohibition Against National Origin Discrimination — Person with Limited-English Proficiency (LEP). The requirement for equal access to health care necessitates effective communication, which practitioners must achieve by securing a skilled interpreter and developing cultural competence.

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Cultural competency is required to provide quality comprehensive health care. It is defined as a set of congruent behaviors, attitudes, and policies that permit a system and its professionals to incorporate the importance of culture at all levels and adapt to cultural differences (Cross et al. 1989). The continuum for cultural competence is broad. At the extreme end of ethical standards, we define cultural destructiveness as inflicting harm. The scale then progresses from cultural incapacity, cultural blindness, cultural precompetence, and cultural competence to cultural proficiency.

Beyond these legal and regulatory standards, most health care settings have a quality of care standard determined by the organization. Measuring cultural competency and inserting it in the individual quality of care treatment plan requires a deliberate effort. Several authors listed in the reference section have designed guides and measurement tools to address this need (e.g., Rauch et al.1993, and Cross et al. 1989).

Approaching Cultural Competency

Addressing the needs of patients with limited English proficiency goes well beyond the obvious first step of securing an interpreter who speaks and understands the language and culture of the patient. The process of multicultural development is threefold (Rauch et al. 1993). It requires self-awareness, knowledge, and skill.

Self-Awareness

The first step to cultural competence is self-awareness, which entails recognition of one's natural deficits and biases that result from being socialized within a particular culture. Most of us are limited by the values, customs, and behavior of our own culture. Judging another's culture by the standards and norms of one's own is called ethnocentricism. A medical student from Trinidad described this tendency " . . . as though some of us have culture, but the rest of you think you are beyond all that" (Hamilton 1996).

It may be easy to forget that while western medicine places a heavy emphasis on the science of the body, the function of organs and cells, and the relationship between microbes and disease, other cultures approach signs and symptoms of illness from different perspectives. Some Hispanics believe that "hot" and "cold" elements, are present in practices, food, diseases, and medications. Some Asians believe that the lack of balance between yin and yang is the cause of illness. Many cultures are

accustomed to herbal remedies instead of prescribed medications. Individuals in those cultures may find prescriptions especially confusing. Why are some medications taken everyday and some only when one is sick? If one pill works, would twice as many pills be twice as effective? People who are accustomed to using herbal remedies may not understand the concept of using precise dosages.

A Vietnamese woman once refused to take antibiotics for conjunctivitis until all herbal remedies had failed. In addition, she was dedicated to her work as a tie-maker and struggled with finding time to visit a doctor. She suffered for a month before she told her doctor that she couldn't "see." Although these situations may frustrate practitioners accustomed to Western medicine, physicians must be sensitive to the patient's beliefs. A physician can warn his or her patient against the abuse of illicit drugs, but one cannot expect a patient to deny cultural practices, even if the results are harmful. Health care professionals can start building a patient's trust by learning about the patient's customs then providing information on one's own practices.

Self-awareness can be acquired in many ways; self-report questionnaires, related cultural awareness tools, supervision, reading, consultation, diversity grand rounds, and continuing education can give staff insight into the knowledge and experience they need. This knowledge can guide the employee evaluation process. Human Resource personnel are well advised to ensure that their institutional staff evaluation forms include questions and standards related to cultural competence.

A structured guide to embrace this task can be found in *Diversity Competence: A Learning Guide* (Rauch et al. 1993). Health care providers seeking to achieve competence must remember that their patients often assume that the practitioner lacks appreciation for their culture based on prior negative experiences. Both patient and medical staff need to overcome the reluctance to ask each other questions or admit they don't understand. Dialogue needs to be followed with clarification. What did I prescribe for you? How are you going to take the medication? How often will you take the medication?

Knowledge

Since knowledge entails recognition and appreciation of specific cultural differences, it is closely tied to self-awareness. It is knowledge that allows one to value another culture.

In a pediatric physical therapy setting, a young Vietnamese child had what looked like circular burns on her back. A staff member noted these marks, suspected child abuse, and reported it. However, one therapist of Vietnamese descent recognized the marks as a sign of "coining," the practice of placing a heated coin on an ill child's neck, spine, back, or ribs to diminish pain, restore appetite, draw out fever, or strengthen a weak stomach.

Cross-cultural communication can be difficult and even frustrating for both the patient and the health care professional. Knowledge, however, can facilitate the establishment of the relationship necessary for culturally competent health care. This facet of cultural competence can ensure a better understanding of the patient's needs and help gain his or her confidence and adherence to the treatment plan.

Many of the methods noted here for gaining competence are more cognitive than experiential. Attitude and behavior assessments often create discomfort and defensiveness, and misguided approaches in this area can result in counterproductive responses. Descriptions of behaviors for each section of the competency continuum from cultural destructiveness to cultural proficiency will make the evaluation process more objective.

Measurable indicators are valuable for both the employee and supervisor. At my hospital, for example, to improve the practitioner's awareness of "age level differences" tools were created for measuring staff on Age Specific Competency after a site visit from the Joint Commission on the

Accreditation of Healthcare Organizations (JCAHO). This tool helped staff improve their ability to recognize the various developmental growth levels in children and to adjust their communication and interactions based on this knowledge. This same method can be used to evaluate staff skills and knowledge levels and their need for further training.

Time pressures in the health care setting also hinder one from developing a level of trust from which to build an ongoing patient/physician relationship. However, establishing rapport can save time in the long run. Experiencing other cultures can be accomplished through lectures, grand rounds, journal articles, consults on cases, and questioning colleagues who are knowledgeable about a particular culture. Experiencing the culture in the *shoes of the other* means participating in their community in natural ways (e.g., through music, food, theater, meetings, and religious events).

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In addition to knowledge of the basic sciences, health care professionals must learn practicalities. Physicians understand that certain disorders have an increased incidence in specific populations: tuberculosis is more common in people from developing countries; hypertension is more common in African Americans; gastric carcinoma is more common in the Japanese. However, without ongoing awareness, one may not consider the environment that an immigrant has come from. Refugees may be more likely to have psychological complications. Patients from developing countries may not be accustomed to making appointments.

A Somalian man had suffered from right knee pain for years. The physician diagnosed the patient with arthritis and treated him with traditional anti-inflammatory medications. Since the pain persisted under a variety of medications, the physician finally ordered a CT of the patient's leg. They discovered that shrapnel, acquired in Somalia years ago, had been causing the man's pain. Such obstructive complexities occur in the treatment of immigrant populations, creating difficulties for the provider and the patient.

On the other hand, as we develop appreciation for a particular culture, we need to strike a balance between viewing everyone in the culture through stereotypical characteristics and denying individuals within the ethnic group their unique differences. Cultural proficiency is the point at which one recognizes cultural norms, values, and tendencies but also respects individual differences.

Skill

Skill is interwoven in the concepts of self-awareness and knowledge. It is the ability to ask the right questions and engage the patient in communicating his or her cultural values concerning health care (with or without an interpreter). Many health care professionals know that skill is only acquired when knowledge is put into practice.

A face-to-face encounter with a patient can begin with asking the patient about his or her previous experience with health care providers; what is expected from this visit; and how does he or she want to be addressed (e.g., by last name, first name, or title). During this introduction, one should note nonverbal preferences such as eye contact, physical closeness, and touch. Pay attention to body language, hand motions, emotional expressiveness, or silence, as these behaviors also convey cultural values and norms. Seek to understand which English words are particularly sensitive, taboo, not easily interpreted, not used in polite company, or have altogether different meanings in another language.

Some groups prefer that their physicians and nurses dress casually while others expect the more

identifiable look of the professional white coat or uniform. Some populations have strong feelings about being asked to disrobe, to being touched, or to making direct eye contact. Some Middle Eastern women may refuse to see a male physician. Some Southeast Asians may find discussion of family planning on a first visit offensive. Patients not accustomed to making appointments may arrive at a private practice at any time, expecting to be seen. If the provider learns about these cultural variations, he or she can accommodate the patient's needs and educate the patient on American practices.

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Most groups rely primarily on their own culture's approach to health care and medicine. Providing information on the different aspects of diseases and disabilities is useful to the practitioner's relationship with the patient. Using knowledge of the patient's cultural values and beliefs is likewise helpful.

In addition, western measurement guides should not be used definitively with ethnic groups inadequately sampled in the design of the tool. The growth chart of the National Center for Health Statistics, for example, may accurately reflect the height and weight curves of the majority of Americans but not people of some other ethnic backgrounds (Hamilton 1996).

One can practice screening protocol for specific populations by obtaining the recommended guidelines. The American Board of Family Practice guidelines for screening Latin Americans include tests for intestinal parasites, Leprosy, Hepatitis B and a host of other disorders (Weissman 1994). Likewise, Hoang and Erikson have developed guidelines for Southeast Asian refugees and Nelson et al. provides screening protocol for evaluating a vulnerable population (both are cited in Moore 1997).

Finally, one does not have to accommodate all the practices of various cultures. For example, one must respond to spousal or child abuse and explain the ramifications of such actions. In the case of female genital mutilation practiced by some Middle Eastern, Asian, and African communities, one can inform the patient that its practice is illegal in the United States and physically harmful (American Academy of Pediatrics 1998). Health care professionals must be sensitive to this cultural practice and educate the patient on the specific health effects without indicating their own emotional views.

The Immigrant

The hospital can be a frightening place for anyone. As patients, we are in a vulnerable position because we have to ask strangers to help us. We are asked to undress and respond to an innumerable amount of intimate questions. Are you coughing anything up? What color is it? When was your last bowel movement? When was your last period? Are you sexually active? How many partners? Do you smoke, drink, or use any drugs? What is your living situation? What is your occupation? What illnesses run in your family? Is anyone deceased? What did they die of? Does this hurt? May I do a rectal exam? May I do a breast exam? . . . Imagine being asked these questions in a foreign language surrounded by a foreign culture.

A middle-aged woman entered a family practice office for the first time. She was pale with black hair in long naturally spiraled curls. She entered the examining room and sat half-way on the bed with one leg still touching the floor. Her teeth were tightly clenched, showing barely tolerable discomfort.

She was from Mexico but lived in a small town in the Midwest. She told the doctor of her extreme incessant pain. She could hardly walk, dress herself, sleep, sit, stand, eat, or cook without having severe pain throughout her body. She had been to

numerous neurologists and physical therapists but her diagnosis remained simply as chronic muscle pain. The family practitioner, an immigrant from the Philippines, told her to go home . . . to Mexico.

"I've worked so hard all my life, Doctor. I don't know why I still have to prove myself. It's not bad here, Doctor, but I just don't like the attitude, you know?"

"I know. I know what you mean. That's why you have to go home for a while and be with your family. Eat their food and talk their language. It will be good for you."

"I know, Doctor, but I don't have the money right now."

"Yeah, that's a problem . . . Do you have anyone to cook Mexican food for you?"

"I eat Chinese food all the time," she said, smiling.

"Chinese?"

"Yeah, we go eat at this Chinese restaurant everyday. The owner is Chinese but the cook is Mexican. We walk in like it's our home."

"At least you're eating, right?"

"Yes, Doctor. At least I'm eating."

With cultural competence, this physician was able to identify the woman's true pathology so that they could proceed with effective treatment. Fortunately, the woman also found sympathy from a fellow immigrant who was also happy to "at least be eating." A young child explained the plight of immigrants to her pediatrician. "We came from Iraq. My parents brought us here so we can have a better life."

The Interpreter

Anthropologists have done considerable work in the area of language and communication across cultures. Ethnographic interviewing is discussed at length in the *Diversity Competence: Learning Guide*. There is no substitute for this knowledge.

The entry-level practitioner should be mindful of the following:

- Not all interpreters are equally qualified. Seek those who are familiar with medical terms or teach them the terms.
- Interpreters may be called on to translate on three different levels within each language: technical, standard, and slang.
- A conscious decision needs to be made as to whether one wants a line-by-line translation or a summary.
- Untrained interpreters may not be aware of the ethical standards in health care settings; that is, they may not know the inappropriateness of injecting their own words, opinions, or conclusions.
- Many English words do not have equivalents in another language; many concepts and phrases are not translatable; and inflection, directness or indirectness, and choice of words all play a part in communication.
- Language and behavior are closely related; the way a culture uses language often expresses its cultural values or orientation.

There are many approaches to finding interpreters. One can, for example, hire bilingual staff, seek out interpreter agencies, and consider long-distance telephone services for those hard-to-find languages or services needed on demand. How do you determine an interpreter's qualifications? How do you assess his or her knowledge of medical terminology? How will you know if they overstep their bounds or violate ethical standards? When seeking an interpreter, consider the medical issues and the culture. Gender preference should be considered, (especially in cases of rape, incest, and sexual abuse) when the patient is less likely to share information with an interpreter of the opposite sex.

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How do you know if you are being understood? If you are uncertain, ask for a replay of what you said to determine if the meaning was communicated. On issues of gender, find out who makes decisions about health care services, courtship patterns, sex, marriage, childbirth, child rearing, and the role of the extended family.

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For example, a female Arabic patient presented with a medical problem related to childbearing. She brought a male interpreter with her. Although, American culture recognizes women as having equal status to men, cultural norms may dictate that male decision making is standard in the Arabic culture. Ethically, should one always seek same sex interpreters in these circumstances? What should one do if no female interpreter is available?

The Culturally Competent Institution

In addition to developing personal cultural competence, we need to shape our organizations to become culturally competent. To accomplish this task, institutions must take the same steps their staff followed individually.

Obtaining cultural competence is an unending process. Institutional commitment is essential at every level. The process includes integrating the learning process in all aspects of patient care and administrative decision making; for example, we must incorporate cultural competence standards into staff education, hiring, staffing, budget and management decisions, and community involvement. The process can work well only if there is commitment at the executive level and a multidisciplinary team leading the charge. Techniques include *diversity grand rounds* for the medical staff, adapting routine employee orientation to cultural learning, and frequent educational tips on e-mail. Newsletters and organizational magazines can serve to strengthen an ongoing awareness of the importance of cultural learning. Cultural competence means no longer treating patients the only way we know how, but in the most effective way we can.

How do we know that we are culturally competent? We engage in a lifelong commitment to learning. We exchange cultural values and norms with patients, trade information with colleagues and benefit from their experience, seek expert knowledge or legal counsel when questions arise about how to proceed, and refer cases to institutional ethics committees in situations of ethical dispute. Providing health care services to non-English speaking populations requires that providers develop competencies not routinely included in medical school curricula and the allied professions. Standards of competence need to be established, training needs to be provided, and these standards need to be measured and shared.

Acceptance and appreciation of differences, along with the ongoing institutional commitment to education and skill development are the keys to achieving cultural competence. Only then, can the health care delivery system be truly responsive to its patients and their families in a manner that embodies respect and communicates clearly across cultures.

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