

INTRODUCTION

“YOU MAY NEED TO TREAT PEOPLE DIFFERENTLY TO TREAT PEOPLE EQUALLY.”

WHY BEING CULTURALLY COMPETENT IS IMPORTANT

Communication is the cornerstone of good quality care. Effective communication between clinicians and patients leads to more accurate diagnoses, increased adherence to treatment regimens, and, as a result, decreased medical liability and, most importantly, better patient care.

A breakdown in communication is the most common cause of errors that harm patients, according to a recent American Medical Association (AMA) report. Clearly, it's time to learn how to better communicate and interact with patients, especially with those from diverse cultural backgrounds. One of the best ways to do this is to practice culturally competent care.

When we encounter patients who are of a different “world,” with different beliefs, attitudes, and fears than our own, we must be able to make them feel comfortable in coming to and interacting with us. By responding with the key ingredients of sensitivity, compassion, and awareness, we can begin to practice culturally competent care. Imagine yourself in a foreign country surrounded by people speaking a language that you don't understand. Imagine further that you need help because of a health problem. Think of what a difference you would feel if you got a warm smile and an attitude of compassion and concern.

There are some who say they don't understand how cultural competence can benefit anyone. The truth is, culturally competent care can help you gain more patients, provide better care for your patients, and give you personal satisfaction, more income, and greater success.

How? When you open your arms to a broader diversity of patients, word gets around. If your patients are comfortable coming to you, they will return and recommend you to others. It's a win-win situation. Both you and your patients will benefit.

POPULATION CHANGES BRING LICENSING CHANGES

The importance and relevance of cultural competence is paramount in view of the rapid and explosive change in the demographics of our patient population. This is reflected by the recent legislative activity in those states that are most

affected by these population changes. New Jersey was the first state to pass a law that ties cultural competence education to medical licensure. California has also enacted legislation, which mandates the inclusion of cultural competence principles in all continuing medical education courses. The original proposed bill mandated 16 hours of Continuing Medical Education (CME) with licensure for all physicians. Arizona, Texas, New Mexico, and Illinois are also contemplating similar legislation.

Connecting cultural competence legislation to medical licensure is a reality. Such legislation will increase as surely as the diversity of the population increases. We feel that this guidebook can better prepare all clinicians who evaluate and treat patients for such mandates in the future. It is intended to help all those who are concerned about improving their skills in cultural competence.

RESIDENCY TRAINING PROGRAMS

Program directors in orthopaedic surgery residencies must meet requirements outlined by the Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committee (RRC) for Orthopaedic Surgery to be accredited. Satisfactory completion of an accredited residency program allows the graduate to sit for the certifying examination of the American Board of Orthopaedic Surgery (ABOS). These requirements are now grouped under six core competencies. Two of these competencies specifically address culturally competent care and diversity.

Under the core competency of patient care, residents are “expected to demonstrate the ability to practice culturally competent medicine” (www.acgme.org). Under the competency of professionalism, residents are expected to “demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities.”

With a growing number of state licensing boards now listing culturally competent care education as a prerequisite for licensure, programs need to offer this education to fully prepare a resident for practice in these states. In addition, the U.S. Department of Health and Human Services (HHS) Office for Minority Health has set standards for culturally and linguistically appropriate health care, and the main organization for accrediting hospitals, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is also considering incorporating cultural and linguistic competence requirements into hospital accreditation guidelines. Such guidelines are the “stick” that can be

used to mandate education regarding diversity and culturally competent care, giving regulatory bodies an opportunity to punish or prohibit from practicing those who do not comply.

However, a “carrot” exists that is more important and appeals more to our professional devotion to doing the best possible job for our patients. Our purpose as educators is to give residents the knowledge and skills to provide excellent care for their patients. Evidence is mounting that culturally competent care is optimal patient care and leads to better patient outcomes (mainly via enhanced adherence and compliance) and higher patient comfort level and satisfaction.

Residency directors now have the opportunity to redesign curricula and resident educational experiences to address these issues, and produce graduates who are culturally competent. This is especially important within academic medical centers, where many underrepresented minorities seek care.

Residents themselves feel the need for cultural competency. There are no current data regarding orthopaedic residents and culturally competent care, but a 2003 survey of residents from seven specialties published in *JAMA* found that 96% of residents felt cultural issues were important in providing care; up to 50% reported no culturally competent care education after medical school; and 20% to 25% reported concerns about dealing with immigrant patients and patients who had religious beliefs or cultural beliefs at odds with Western medicine.

Medical schools have recognized the need for such education. Harvard Medical School has been a leader in this area, and produced a report in June 2006 that is a valuable resource for program directors and faculty—“Culturally Competent Care Education at Harvard Medical School: Background, History and Accomplishments. Bridging the Gap One Patient at a Time”—that is accessible at www.hms.harvard.edu/cccec.

This trend will extend to graduate medical education, and is the impetus for this guidebook. In addition to the “carrot” of providing knowledge and skills that enable orthopaedic surgeons to better care for their patients, these materials can also help avoid the “stick” of regulating agency penalties by providing a method of documenting culturally competent care education.

Perhaps of even greater importance is the so-called “hidden curriculum”—the behavior of attending faculty surgeons that residents witness on a daily basis. Much of the educational process of learning to be a surgeon occurs in a

master-apprentice setting, with the attending surgeon serving as a role model for the resident. Observing how attending surgeons communicate with patients and deal with patients from multicultural and multilingual backgrounds likely has a significant impact on how residents will interact with patients when they are on their own in practice. This is difficult to measure and quantify, but assessing and monitoring the hidden curriculum is a leadership issue in residency programs. As Albert Schweitzer remarked, “Example is not the most important thing in leadership—it is the only thing.”

The other issue related to culturally competent care in residency programs is the lack of diversity within our professional ranks. Orthopaedic surgery is a profession populated primarily by white males, with very few females and minority members compared to other areas of medicine, and especially related to our country’s population. In addition to the benefits to the patient, having a multicultural population of physicians provides cross-cultural education and interchange between peers, resulting in improved understanding of different cultures and their views that might influence health care decisions. The president of the Association of American Medical Colleges, Jordan Cohen, MD, has stated, “All patients, minority and non-minority alike, stand to benefit from a racially and ethnically diverse physician workforce. To the extent that diversity among physicians serves to reduce health care disparities, it serves to improve the quality of care for everyone.”

Residency program directors, chairs, and selection committees are the gatekeepers for our profession. Selection criteria for choosing applicants to interview and rank vary widely by department, but survey studies recognize audition rotations, grades in medical school, US Medical Licensing Examination board scores, and election to the Alpha Omega Alpha medical honor society as being commonly employed to sort through applicants. Augustus White, MD, PhD, has written eloquently about this process, and questions whether the current process results in selection of the best candidates for our profession, because grades and test scores do not always predict success in clinical medicine. He believes substantial changes are needed if we are to achieve humanitarian and pragmatic societal goals, and that increasing diversity and decreasing disparities will be crucial to our profession’s future success.

The goal of increasing diversity in orthopaedics is a controversial one. Many see it as implementation of a quota system that forsakes merit and qualifications as prerequisites for entry. But diversity has gained a strong foothold in many areas of our society outside of medicine, and hopefully the concept is not as objectionable as it once was. Diversity training and awareness is commonplace now in

business and educational environments, and the census changes clearly point to a need to address changing demographics in the United States. An underappreciated fact is that as medical schools become more diverse, orthopaedics will reach a smaller proportion of medical students if it remains a predominantly white, male specialty, and thus may miss out on attracting some of the best and brightest students.

Residency program directors and chairs will need to face diversity and culturally competent care issues in the near future, not only to meet regulatory and accrediting requirements, but more importantly to meet the health care needs of our multicultural, multilingual society.

LEARNING OBJECTIVES

By reading this guidebook completely, you will

- Learn the necessity for culturally competent care in orthopaedics through real-life patient case examples in a clinical setting.
- Achieve a better understanding of how cultural issues and needs can impact the patient/physician relationship and increase treatment adherence.
- Learn various communication techniques as they apply to different patient circumstances and cultures.
- Identify appropriate references in order to further research items regarding culturally competent care.

CME Accreditation

The American Academy of Orthopaedic Surgeons (AAOS) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The AAOS designates this educational activity for a maximum of 3 *AMA PRA Category 1 Credits*.™ Physicians should only claim credit commensurate with the extent of their participation in the activity. To claim CME for this activity, please visit www.aaos.org/challenge_cme.

HOW TO USE THIS GUIDEBOOK

The AAOS Cultural Competency Challenge CD-ROM presents diverse patient case scenarios and interactively tests users on how they might respond to specific cultural competency issues. Reaction to the CD-ROM has been so positive that we've created this guidebook to further explore the many issues of culturally competent care.

Our guidebook expands the scope of the Cultural Competency Challenge CD-ROM for group situations as well as more intensive personal learning experiences. Patient

scenarios, tip sheets, annotated references, and a recommended reading section are included to encourage understanding of the principles of cultural competence in the health care setting.

This guidebook has many potential uses as well as users. It can be a personal self-assessment tool or an enhancement to the CD-ROM experience. It can be a good teaching tool for clinicians, residents-in-training, and medical students in different settings, such as grand rounds, journal clubs, or informal discussion groups. It can also be used in the training of front and back office staff—everyone who interacts with patients.

Guidelines, Not Rules

Before you begin, it's important to keep several things in mind:

- This guidebook is not all-encompassing and encyclopedic in reference to culturally competent care issues. It cannot possibly cover all aspects of cultural competence. No book can. Culture is too complex and changeable to define.
- This guidebook contains guidelines, recommendations, and tips. It is not intended to be used as a “rule book.” More extensive resources are available, as evidenced in the list of reference materials. Hopefully this guidebook will foster discussion through which the reader can gain a higher level of awareness and sensitivity regarding these important issues.
- Never assume that an individual who comes from an ethnic culture shares the traits of that ethnicity or culture. This assumption borders on stereotyping. Every patient should be treated as an individual, not defined by race, gender, or religion. We must realize that each population group also contains many diverse groups within it.
- In the chapters on different population groups, you will find many generalizations. They are offered only as a starting point, as a way to begin to learn something about others, and to begin a discussion. In no way are they meant to be used as hard and fast definitions or descriptions for every member of a group. Some observers suggest that generalizing about diverse populations, even with the intention of improving health care, could be interpreted as more stereotyping. But stereotyping is not a way to improve understanding—stereotyping blocks understanding. We hope to encourage learning.
- As used in this guidebook, culture refers to the customary beliefs and social forms of a racial, religious, or social group. Ethnic/ethnicity refers to a group of people who are classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background. Race refers to a group possessing dis-

tinct traits transmissible by descent. It is important to distinguish ethnic, linguistic, cultural, and racial characteristics from each other and not to correlate racial characteristics such as skin or hair color with either language preference or cultural habits.

- Regarding language and acculturation, don't assume that Asian-Americans, Hispanic/Latino Americans, and recent immigrants can't speak English or aren't acculturated. At the same time, it is important to ascertain the language skills of all your patients as soon as possible.

In addition, some topics/issues appear repeatedly and require some explanation:

Patient intake questionnaire

You may want to consider including certain points in your patient intake questionnaire, such as:

- Asking questions regarding religion or any potentially sensitive cultural issues that the patient wants his/her health care provider to be aware of. For example, it may be practical to ask if the patient would object to blood transfusions in an emergency, as some people do for religious reasons.
- Asking patients what term they would use or prefer to describe their own ethnic background.
- Using gender-neutral questions to ask about personal information. For example, ask about significant partner rather than husband/wife.

Comprehension check

A comprehension check is a technique to get your patients to explain in their own words what you plan to do for them or to describe what they understand your recommendations are. It's used to determine whether your patients understand what you've told them.

Using interpreters

It is generally a good idea to access and utilize interpreters whenever necessary to accurately communicate issues and recommendations to your patients with limited proficiency in English. There is a significant liability risk if a patient with limited English doesn't understand your recommendations or a procedure, as a result of inadequate translation. Options include using a certified interpreter, hospital- or health care system-provided interpreters, or AT&T Interpretive Services. Hiring a bilingual or multi-lingual staff person is another strong option if your patient base warrants it. Using a patient's family member for translation probably occurs most frequently, but is not ideal. Some patients may hesitate to tell all their medical problems to a family member and some cultures resist fully open medical discussions between generations or genders. Look into whether any community organizations make interpreter

services available. Using educational materials available in other languages is also a good option.

Physicians should take into consideration the legal requirements for having access to an interpretive service for patients with limited fluency in English.

Under certain circumstances, a physician practice may be required under Title VI of the Civil Rights Act of 1964 to provide language assistance to patients who have limited English proficiency (LEP). Language assistance typically means providing an oral interpreter and/or written translation services at no cost to the patient. To assist in complying with Title VI, the US Department of Health and Human Services has issued guidelines ("Guidelines") that urge physicians to consider the following factors in determining when language assistance is required for LEP patients:

- the number and frequency of LEP patients treated in the practice;
- the importance of the services provided to LEP patients; and
- the physician's resources.

The Guidelines suggest that a physician document his/her analysis of these factors because providing language assistance to patients is largely dependent on the specific facts of the individual practice. If a physician concludes that language assistance is required, then the physician should develop an LEP implementation plan that should:

- identify LEP patients who need language assistance;
- determine appropriate methods of language assistance;
- provide for staff training;
- notify LEP patients; and
- monitor and update the LEP plan.

The Guidelines list some of the possible methods for providing language assistance, including hiring bilingual staff, contracting with interpreters, using telephone interpreter lines, using community volunteers, and using family or friends of the LEP patient. The physician must, however, inform LEP patients that they are not required to use family or friends and that they have the option of having the physician provide an interpreter free of charge.

It should be noted that the Guidelines probably do not apply to physicians who are enrolled only in Medicare Part B and receive no other federal funds. The Guidelines also likely do not apply to disabled patients because the Americans with Disabilities Act has different obligations for providing assistance for patients with disabilities. Finally, Title VI sets only the minimum obligations regarding LEP

patients; states may impose additional obligations for physicians.

The above summary is for informational purposes and is not intended as legal advice. You should consult a qualified attorney for details since state laws may vary. For the complete text of the HHS Guidelines, please go to <http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.html>.

In essence, this guidebook, together with the Cultural Competency Challenge CD-ROM, should enable you to better provide your patients with culturally competent care. We hope that it will be used not only by orthopaedic surgeons, but also by all physicians. Clinical practitioners of all types, residents, and medical students, as well as allied health professionals, nurses, and office staff can all gain more insight and success through cultural competency. But the bottom line is that the overall winner from our efforts will be our patients.

CONTRIBUTORS

The contributors to this guidebook are all knowledgeable and experienced in the concepts of culturally competent care. They have all participated in educational endeavors such as symposia, instructional course lectures, or publications regarding all of these principles.

BIBLIOGRAPHY

AMA Ethical Force Program report: "Improving Communication—Improving Care." From online press release of June 19, 2006. The report is available at <http://www.ama-assn.org/ama/pub/category/16245.html>. Accessed December 6, 2006.

Gregg J, Saha S: Losing culture on the way to competence: The use and misuse of culture in medical education. *Acad Med* 2006;81:542-547. Discusses how culture works in conjunction with individual, social, geographic, and economic factors and the need for a more holistic, complex approach to cultural competence and health disparities.

Jimenez R: Culturally competent patient encounter tips: Enhance communications with your Hispanic and Latino patients. *AAOS Online Service Bulletin*, October 2002. <http://www2.aaos.org/aaos/archives/bulletin/oct02/comm.htm>. Accessed December 6, 2006.

Ludmerer, K: *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. New York, NY, Oxford University Press, 1999. Kenneth Ludmerer discusses the importance of the hidden curriculum in his history of graduate medical education in the U.S.

Multicultural Caring: A Guide to Cultural Competence for Kaiser Permanente Health Professionals. Oakland, CA, Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department, 2000.

Poon AW, Gray KV, Franco GC, Cerruti DM, Schreck MA, Delgado ED: Cultural competence: Serving Latino patients. *J Pediatr Orthop* 2003;23:546-549.

Ross H: Is your hospital culturally competent? *Health Leaders News*, Sept 28, 2005. http://www.healthleadersmedia.com/view_feature.cfm?content_id=72222. In discussing the topic, Ross lists the benefits to hospitals of practicing cultural competence.

U.S. Department of Health and Human Services: Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. <http://usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.html>. Accessed January 10, 2007.

Weiss B: Cultural competence: Caring for Latino patients. *Med Econ* 2004;81:34-40. <http://www.memag.com/memag/cotent/printContentPopup.jsp?id=108876>. Accessed December 6, 2006. Weiss discusses various aspects of health care for Latino patients.

Weissman JS, Betencourt J, Campbell EG, et al: Resident physicians' preparedness to provide cross-cultural care. *JAMA* 2005;294:1058-67. The survey found that residents' self-reported preparedness to deliver cross-cultural care lags well behind preparedness in other clinical and technical areas. Cross-cultural care was perceived to be important, but there was little training, formal evaluation, or role modeling for these issues.

White AA 3rd: Resident selection: Are we putting the cart before the horse? *Clin Orthop Relat Res* 2002;399:255-259. White recommends looking beyond grade and test scores for qualities that enable residents to communicate better and become more culturally competent.