Dear Dr. Jeff:

We recently received a questionnaire from a managed care company prior to signing a contract with them. In addition to questions regarding availability of services, such as intravenous infusions and transitional care, they asked us to confirm that our facility possesses “cultural competence.” We weren’t sure what this was, much less how it could be measured. We checked “yes” anyway. Any suggestions or thoughts?

Dr. Jeff responds: When I applied to medical school in the 1970s, the MCAT contained a separately scored section for general information. My acceptance was aided by my extraordinary volume of what Bob Dylan in “Tombstone Blues” called “useless and pointless knowledge.” I was pleased that my ability to identify Sibelius as a native of Finland and facility in dividing Shakespeare’s plays into comedies, tragedies, and histories was seen as an enhancement to my potential as a physician. Indeed, physicians, along with lawyers and the clergy, have been traditionally counted among the community leaders who support cultural activities. Although I would argue that expanding a physician’s knowledge and experience base beyond the narrow requirements of science and mathematics may produce practitioners better able to communicate with patients and each other, this section of questions was eliminated from the MCAT in 1977. Your knowledge of the arts and literature is not what the insurance company values. “Cultural competence” is simply the new buzz phrase for the slippery concept of providing appropriate care to a diverse patient population. The website of the National Center for Cultural Competence at Georgetown acknowledges that there is no one accepted definition of cultural competence, even though the words have entered state and federal legislation, academic publications, and foundation and corporate expectation lists. The Department of Health and Human Services has used at least six different, albeit related, definitions for different programs.

The phrase goes back to 1990. When Risa Lavizzo-Mourey, MD, (now president and chief executive officer of the Robert Wood Johnson Foundation) and Elizabeth Mackenzie, PhD, from the University of Pennsylvania Medical School division of geriatrics, wrote an article for the Annals of Internal Medicine (Cultural competence: essential measurements of quality for managed care organizations. Ann Intern Med 1996;124:519–21) describing cultural competence as “an essential measurement of quality for managed care organizations.” The authors wrote that cultural competence represents the integration of three population-specific issues: culturally based health beliefs and values; variable disease incidence and prevalence; and treatment efficacy. Or, according to the National Medical Association, “Cultural Competence (Health) is the application of cultural knowledge, behavior, and interpersonal and clinical skills that enhances a provider’s effectiveness in managing patient care.”

Competence in Practice

Confusing as these definitions may appear at first, the key point is that they go beyond cultural “awareness” and cultural “sensitivity” to address how this knowledge and sensitivity are used to address and improve patient care.

Providers of Medicare Part A services are required by law to offer translation services to individuals with limited English proficiency (LEP). These services must include spoken language translation for the LEP individual and translation of written materials into all the languages likely to be needed for LEP individuals in the geographic area served. In my experience, this requirement is routinely ignored. Even if the facility has contracted with a telephonic translation service, it is rarely used. Family members often act as translators, even when the discussion content is obviously inappropriate. I have overheard 10-year-old grandchildren translating questions about bowel habits for their grandparents. Problems with substance abuse, noncompliance with medical instructions, or complaints related to genitalia are unlikely to receive appropriate translations and answers, and the potential HIPAA violations involved are obvious. Frequently, the language barrier is simply ignored. Charts of cognitively intact residents often simply copy the history of present illness from a hospital transfer note with the review of systems crossed out and “unable to obtain” inserted. Under these circumstances, residents who are calling out or moaning in a language other than English are unlikely to have their problems addressed appropriately.

The Only Way To Know Is To Ask

Of course, before translation services can be used, it is vital to obtain an accurate account of the LEP resident’s primary language. I worked for many years at a nursing home of the edge of New York’s Chinatown. We frequently admitted residents from hospitals with transfer notes describing them as “Chinese-speaking.” Although the major dialects of Chinese are written with the same ideograms, the spoken languages are entirely different. After a minute of attempted conversation, facility translators would often report that they could not understand a single word the patient said. Younger Chinese usually spoke Mandarin, while the majority of older residents spoke Cantonese, which had been commonly used in Chinatown. Some older immigrants born in rural China spoke Tosaenese, while a new wave of immigrants in the last decade arrived speaking primarily Fukienese. When the hospitals described them as “Chinese-speaking” they simply revealed that they had not truly spoken to them at all.

Cultural competence is the opposite of stereotyping. A resident with the last name Lopez could be like Jennifer Lopez, who was born in New York City, or like Nancy Lopez, the golfer, who was born in New Mexico, or the resident could be Puerto Rican, Filipina, Spanish, Mexican, Central American, a Sephardic Jew, British (Sue Lopez, manager of the Welsh national soccer team), French (gold medal fencer Nicolas Lopez), Basque, Catalan, or even Swedish, like Martin Lopez, the heavy metal drummer. When spelled “Lopes,” the name might be Portuguese or Brazilian. And, of course, it could be the married name for someone from virtually any culture. Obviously, cultural backgrounds cannot be identified simply by language or names or superficial physical characteristics. In a well-known Seinfeld episode (“The Wizard”), Elaine believes incorrectly that her tan-skinned boyfriend is African-American, while he thinks she is Hispanic because she has dark curly hair and keeps taking him to Spanish restaurants. Even knowing a resident’s ethnicity and country of origin may not correctly identify their cultural background. For example, I treated an elderly lady with an Irish name who was active in her local, heavily Irish parish, but who was actually Hispanic. Another elderly patient, born in Ireland with an Irish last name and living in a traditionally Irish residential development, surprised the staff of our nursing home when she asked the kitchen to prepare grits for her daily breakfast. Her family had moved to the South when she was a baby and she grew up as a traditional Virginian. The only way to know is to ask. These questions should be part of a social history, which is all too often limited to tobacco and alcohol use. The social history should encompass the various social and cultural aspects of a patient’s past that may underlie the current illness and the patient’s response to that illness.

Respecting Cultural Beliefs

Medical anthropology draws on the social, biologic, linguistic, and cultural factors that influence the distribution and experience of disease and healing. For example, the cultural belief of many ethnic groups in theories of yin and yang lead many elders to refuse cold liquids, since they believe that old age is associated with an excess of cold (yin) elements. Facility hydration programs need to address these beliefs with warm liquids that residents may more readily accept. Of course, chicken soup works for everyone, but afternoon tea or a bedside Thermos can be a substitute for a bedside water pitcher. Similarly, limenits producing a local sense of warmth may provide such patients better relief from musculoskeletal pain than standard oral analgesics. Many cultures have traditional foods that the sick associate with healing. For some residents, they are a more acceptable choice than canned nutritional supplements.

The well-founded fear in many social and ethnic groups that they will not receive appropriate medical attention has made some patients and families reluctant to execute advance directives limiting invasive procedures. A culturally competent medical facility should be prepared to recognize and address these concerns, and emphasize that advance directives give a resident control over their own care. Naming a health care proxy is an ideal first step for such residents to assert control over their health choices rather than simply endure unwanted invasive procedures. In the 29 years since the Lavizzo-Mourey and Mackenzie article, few attempts have been made to integrate their concerns into medical care. Rehospitalization statistics, for example, don’t reveal if the facility addressed resident and family concerns. “Noncompliance” is typically seen as a patient characteristic impeding care, whereas families insisting against our advice that a resident be returned to the hospital are “problem families” rather than system failures. Of course, not all rehospitalizations are preventable, and not all problematic residents and families can have their concerns addressed. But a frank examination of your cultural competence regarding the actual patients you see could be the beginning of an ideal quality improvement project.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board. Read this and other columns at www.caringfortheages.com under “Columns.”