From the CEO

Cultural and Linguistic Competence in Health Care

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California has the most ethnically diverse population in the nation, with six of the top 10 ethnically diverse cities in the United States: Oakland, Long Beach, Los Angeles, San Jose, Sacramento and Fresno. Non-Latino whites are no longer the majority, and, according to the 2000 census, almost 40 percent of Californians speak a language other than English at home. Addressing the needs of the multicultural, non-English-speaking residents has created many challenges in all sectors of life, particularly in health care.

For the purposes of this article, cultural competency is defined as a set of integrated attitudes, knowledge and skills that enables health care professionals or organizations to care effectively for patients from diverse cultures, groups and communities. Linguistic competency is defined as the ability of a physician or surgeon to provide to patients who do not speak English or who have limited ability to speak English, direct communication in the patient's primary language.

Over the last 20 years, numerous studies have been conducted to identify the extent to which cultural and language barriers affect the provision of health care, particularly among the immigrant, non-English-speaking population. A 1998 study conducted by the Federal Office of Minority Health and the Agency for Healthcare Research and Quality examined how cultural competence affects health care delivery and health outcomes. Not surprisingly, the bottom line is that lack of attention to linguistic and cultural issues results in increased costs and lower quality of care for affected populations.

The findings resulted in the development of 14 national standards for culturally and linguistically appropriate services (CLAS) in health care. The first, that "Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language," is the foundation from which all other standards are based. The CLAS standards were published in the Federal Register in December 2000 and have become the basis for subsequent government and private sector activities to define, implement and evaluate cultural competence

activities among health care providers. (See http://www.ahrq.gov/fund/fr/fr122200.htm.)

Most efforts to date have focused on bridging linguistic barriers between patients and health care providers. The Federal Civil Rights Act of 1964 was the first law to set forth the rights of non-English-speaking residents. Title VI requires that any recipient of federal funds—including hospitals, nursing homes, managed care organizations and physicians—must make reasonable efforts to make their services accessible to limited-English-proficiency (LEP) patients. This also applies to any provider that receives Medicare or Medicaid payments.

Related California laws expand on federal requirements, perhaps the most applicable for anesthesiologists being the Kopp Act, passed in 1983. This law requires all general acute care hospitals to have language interpreters available at all times for patients whose population in the hospital's geographic region or census is 5 percent or more. In addition, Medi-Cal Managed Care and Healthy Families Plans must provide oral and written translation services for LEP patients whose numbers reach the geographic threshold set by the Department of Health Services and the Major Risk Medical Insurance Board. Most recently, the Department of Managed Health Care closed the public comment period and will issue regulations that will require health plans to provide language interpretive services.

Where Should Physicians Receive Cross-Cultural Training?

Cross-cultural competency has been recognized as a necessity in health care education and is starting to be included in some medical school curricula. In 2005, the Association of American Medical Colleges published Cultural Competence Education for Medical Students, which outlines needed curricula for medical schools and Tools for Assessing Cultural Competence Training—TACCT. The entire report can be found at http://www.aamc.org/.

Residency programs provide a rich setting for cross-cultural training. However, most programs lack the time and trained faculty to provide structured learning. A 2003 survey* of almost 3,500 residents in their final year of training showed that, although cross-cultural care was perceived to be important, there was little clinical time allotted during residency to address cultural issues, and there

*Joel S. Weissman, Ph.D.; Joseph Betancourt, M.D., MPH; Eric G. Campbell, Ph.D.; Elyse R. Park, Ph.D.; Minah Kim, Ph.D.; Brian Clarridge, Ph.D.; David Blumenthal, M.D.; Karen C. Lee, M.D., MPH; Angela W. Maina, B.S. *JAMA.* 2005;294:1058-1067. Sept. 7, 2005.

was little training, formal evaluation, or role modeling. Many believed "they were not prepared to provide specific components of cross-cultural care, including caring for patients with health beliefs at odds with Western medicine (25 percent), new immigrants (25 percent), and patients whose religious beliefs affect treatment (20 percent). In addition, 24 percent indicated that they lacked the skills to identify relevant cultural customs that impact medical care."

The latest training ground for cultural competency is in continuing medical education. In 2005, AB 1195/Coto was signed into law and requires continuing medical education providers based in California to include curriculum on cultural and linguistic competency in any CME program that has patient care components.

To see the statute, go to http://leginfo.ca.gov/pub/bill/asm/ ab_1151-1200/ab_1195_bill_20051004_chaptered.html.

This mandate does not require that physicians obtain a defined number of CME credits, but that CME providers provide relevant information on resources and information to help them care more effectively and cost-efficiently for patients with limited English proficiency and from diverse cultures. As an accredited CME provider, the CSA complies with the requirements by providing information on existing federal and state laws and regulations and is assembling a list of resources on various aspects of cultural and linguistic competency. In 2007, one-credit online CME modules will be developed as well.

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Half Dome

 This photograph was taken by Gordon Haddow, M.D., and is reprinted on the *CSA Bulletin* cover with his permission. This picture of Half Dome in Yosemite National Park was taken on the Mirror Pond Trail during the late winter of 2005. Dr. Haddow said, "Luckily the sun broke through on what had been, up to then, a very dull (and unphotogenic) day." The photo was taken with a Nikon camera and 200mm lens on Scala film..