

Course Content: Safeguarding Patient Privacy: Cultural Competency for Healthcare Providers

Introduction

There are 7 billion people in the world today who speak a staggering 6000+ languages. The world's population is becoming increasingly mobile with resultant blurring of traditional language, racial, and ethnic lines. Up to one-third of the United States population identified as being a racial or ethnic minority in the 2000 census. This is not unique to the United States; more than 50 countries have reported that greater than 15% of their population is accounted for by immigrants.

The increasing diversity of the nation brings opportunities and challenges for health care providers, health care systems, and policy makers to create and deliver culturally competent services. Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. A culturally competent health care system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities. Examples of strategies to move the health care system towards these goals include providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to patient care.

Early Conceptions of Cultural Competence

For decades, healthcare leaders and educators have recognized that cultural and linguistic barriers between healthcare providers and patients might interfere with the effective delivery of health services. Advocacy for greater attention to these barriers gave rise to programs and curricula bearing the monikers cross-cultural medicine, cultural sensitivity, transcultural nursing and multicultural counseling.

Programs largely focus on populations "whose health beliefs may be at variance with biomedical models." Although the principles underlying these programs were acknowledged to be universally applicable, the targeted groups included primarily immigrant populations with limited English proficiency and limited exposure to western cultural norms. Programs sought to bridge the "cultural distance" that existed between healthcare providers and these immigrant patients, focusing on the appropriate use of interpreters and "cultural brokers" and on learning the history and cultural norms of different minority populations.

Several frameworks and guidelines were proposed to help healthcare practitioners consider patients' cultural context and conduct cultural assessments. These models acknowledged that, while awareness of and respect for different cultural traditions were valued, familiarity with all cultural perspectives a healthcare provider might encounter in clinical practice was impractical.

Additionally, viewing patients as members of ethnic or cultural groups, rather than as individuals with unique experiences and perspectives, might lead providers to stereotype patients and make inappropriate assumptions about their beliefs and behaviors. To account for these concerns, approaches to cross-cultural healthcare incorporated a balance, between acquiring some background knowledge of the specific cultural groups encountered in clinical practice, and developing attitudes and skills that were not specific to any culture but were universally relevant.

Culture is focused on the ways groups of people understand their history, share their values and engage in similar behaviors while sharing a similar worldview. Culture is not necessarily equivalent to racial and

ethnic groups. It may reflect a similar socioeconomic background, religious background, sexual orientation or even occupation such as the military culture or nursing culture. People who share a cultural belief are organized into groups such as a family, or they could be grouped by other identifiers such as gender, age or common interests. Healthcare in the 21st century should and must be practiced in a culturally competent manner. Health-related cultural beliefs can be seamlessly integrated into the care of patients.

There are several nontraditional groups which have now been recognized as cultural groups in healthcare such as adolescents, deaf youth, street youth, gay and lesbian youth. These groups have shared values and make similar but non-homogeneous healthcare decisions. Failure of the healthcare provider to recognize the individual patient's identification with a group can negatively impact health outcomes. Sometimes healthcare providers may inadvertently use offensive language which can completely erode the patient's trust in the clinician's credibility ultimately leading to poor health outcomes and noncompliance.

The American Association of Colleges of Nursing established the Essentials of Baccalaureate Nursing Education in 2008 which led to a vast increase in cultural competency standards in nursing curricula nationwide. By 2008, more than 90% of US medical schools added cultural competency training to their curriculum. Pharmacy, nursing and dental schools also added cultural competency training to their curriculum.

The National Quality Forum defines cultural competency as "the ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family-centered, evidence-based, and equitable.

Cultural Norms

There are multiple cultures. The only way to identify patient's cultural concerns is to ask. The following are a few examples. There are certain cultural practices that healthcare providers should be aware of. For example, for Muslims, it is important to understand fasting during the holy month of Ramadan and being aware that children of certain ages may be allowed to participate in fasting. In addition, in some Muslim subcultures, it may be inappropriate to touch any female patients even a handshake.

Native Americans believe in "passive forbearance" which proposes the idea that individuals should be able to choose their path free of intervention from other family members. Different cultures ascribe varying importance to values; for example, Latino culture values "personalismo" which is defined as politeness in the face of adversity or stress. Machismo refers to strong masculine pride and dictates interactions with certain male Latino subgroups. Note that adherence to cultural beliefs relies heavily on the degree of acculturation and does not happen homogeneously within all cultural groups. For example, within the Latino cultural group, there are different national subgroups such as Cuban, Venezuelan, Mexican, etc.

Healthcare Practice and Cultural Competency

The perceived role of healthcare providers differs significantly between various cultures with some cultures viewing the healthcare provider as a trusted confidant who is expected to provide valuable advice as needed. Other cultures may view any advice provided as an intrusion. Thus, healthcare providers should adjust their practices based on the patient's background and expectations.

As the culture of medicine shifts from a more paternalistic view to one where patients are viewed as active participants in their own care, providers are encouraged to provide services tailored to the patient's individual values. At one time, stereotyping by healthcare providers was viewed as taboo in healthcare but as the culture in healthcare continues to evolve, identifying patients by a cultural group they identify with has been associated with improved health outcomes.

Empathy is an integral part of providing culturally competent healthcare, enabling providers to appreciate, perceive and respond to a patient's verbal and nonverbal cues.

Several studies have shown that healthcare provider nonverbal communication remains the best predictor of patient satisfaction. Research showed that if clinical providers were attentive to the patient's needs, appeared interested and made eye contact during a clinical encounter; a physician race did not matter on the participant's evaluations.

Cultural competency has been identified as one of the main strategies deployed to dispel disparities in healthcare. Cultural competency is the ability of the healthcare provider to effectively comprehend the language, actions and values of a specific religious, racial, ethnic and other social groups. Cultural competency has become a key aspect of health care policy and practice where it is now seen to enhance healthcare practices rather than detract from it.

The office of Minority Health of the US Department of Health and Human Services along with the Agency for Healthcare Research and Quality established the National Standards on Culturally Linguistically Appropriate Services (CLAS). The CLAS standards are a collection of guidelines, recommendations and mandates which are designed to eradicate ethnic and racial health disparities. The idea undergirding the CLAS standards is that better communication tailored to specific social, racial and ethnic groups eventually leading to improved health status.

Standards

The Principal Standard

Standard 1: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

Standard 3: Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

Standard 4: Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Standard 7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement and Accountability

Standard 9: Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.

Standard 10: Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Standard 12: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

Standard 13: Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

Standard 14: Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

Standard 15: Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

LGBTQ Community

Bisexual: Someone who remains attracted to both genders.

Asexual: Someone who is not attracted to any gender. They typically do not identify with a specific sexual orientation.

Cisgendered: This is a person who recognizes their gender as the same gender they had assigned at birth.

Homosexual or Gay: Someone who is attracted to someone of the same gender.⁸

Intersex: Someone who is born with variations in sex characteristics that do not fall into the typical description of a male or female body. Bottom line, this refers to someone whose anatomy is not exclusively female or male.

Lesbian: This refers to a woman who is attracted to another woman.

Pansexual: A person who is attracted to people of any gender or sexual orientation.

Questioning: This refers to someone who is questioning their gender or sexual orientation.

Transgender: This refers to someone whose gender is different from their gender at birth.

LGBTQ: The abbreviation LGBTQ usually refers to the lesbian, gay, bisexual, transgender and questioning/queer people. However, it is commonly used to represent all gender or sexual minorities such as asexual or intersexual subgroups. The Q in the LGBTQ community can mean “queer” or “questioning,” and this refers to someone who is exploring their sexuality or gender identity.

Disparities in the LGBTQ Community

There are several studies which have documented the disparities in health care endeavors involving the lesbian, gay, bisexual, transgender and queer communities. It has been established that lesbian and bisexual women are less likely to receive standard preventive screenings for cervical, breast and colon cancer screenings.

Lesbian, gay, bisexual, transsexual and questioning communities have a growing stack of inequalities in healthcare delivery including sexual health, mental health and substance use. Clinical providers educated and competent in cultural awareness for the LGBTQ communities have now become a necessity to bridge the health inequalities affecting these communities.

LGBTQ-Sexual Health

The World Health Organization defines sexual health as a state of physical, mental and social well-being in relation to sexuality. Sexual wellness necessitates a respective and positive approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. There has been an increased prevalence of transgender diagnoses with most studies observing a higher male to female than the female to male ratio.

Sexual health is very intricate in the cultural, legal and socioeconomic and political fabric of communities which provide a context to the lives of the LGBTQ community. Until 1992, homosexuality was considered a mental illness at which time it was declassified by the World Health Organization.

People in the LGBTQ community may experience fear in disclosing their sexual orientation which can lead to higher rates of sexually transmitted diseases including human immunodeficiency virus (HIV) in patients who are gay, bisexual or men having sex with men especially in countries where their sexual choices are criminalized.

Unfortunately, some people in the LGBTQ community still get attacked if they display affection publicly, even in countries where there is anti-discrimination legislation in place. Overall, there are increased reports of bullying and poor access to healthcare among the LGBTQ communities, especially in poorer countries.

LGBTQ individuals report higher rates of suicide, anxiety, depression and drug or alcohol dependence. Men who only have sex with women are six times less likely to commit suicide compared to men who have sex with men. The cause for the increased health disparities among the LGBTQ community is multifactorial and complex.

Gender Dysphoria

Gender dysphoria is a relatively new medical term which attempts to name and explain the dysphoric symptoms that people in this community may experience. As patients in the transgender community transition both socially and medically, they experience a unique set of challenges that clinical providers must remain aware of, so they can provide appropriate support during their transition. There is a stark sparsity of research in transgender health and transgender communities.

Most of the research among the transgender population has been on patients transitioning from male to female transgender. There is a great need for gender affirmation in these trans-men and trans-women due to the stigma and discrimination they often face. There are specific challenges faced by the transgender population which may make them more vulnerable to certain ails. For example, transgender men who receive testosterone therapy may experience increased vaginal atrophy which can make them more susceptible to sexually transmitted diseases including HIV.

Lesbian and bisexual women typically have a lower incidence of sexually transmitted diseases compared to heterosexual women. However, there is a diverse group of women who identify as lesbian, and a thorough and appropriate sexual history must always be performed. Note that bisexual women are more likely to report having an increased number of sexual partners as well as an increased rate of chronic pain and cervical cancer.

Bacterial vaginosis has been shown in multiple studies to be more common among bisexual and lesbian women. Although human papillomavirus (HPV) related cancers have been shown to occur in women participating in female-to-female transmission of genital HPV with occurrences of cervical neoplasia. In spite of these facts, cervical cancer screening remains low among the lesbian and bisexual community. Homosexual men have an increased rate of HPV associated anal cancers compared to heterosexual men.

Cultural Competency for LGBTQ Members

It is imperative that clinicians create a safe environment for patients to feel comfortable providing their medical history and receiving necessary medical care. Electronic Medical Records which allow patients the ability to identify themselves as LGBTQ can cue clinical providers to the patient's potential needs and challenges. Clinician cultural competency can ameliorate the quality of patient interactions.

There have been continued reports of negative experiences by the LGBTQ community specifically as it relates to unequal healthcare treatment and homophobia. According to a 2010 study, a national survey of LGBT physicians, 65% of them reported hearing derogatory comments about LGBT patients from healthcare professionals. 34% of them reported witnessing discrimination in care against patients in the LGBT community.

A 2011 survey of transgender people noted that 19% of survey responders reported being refused medical care because of their gender identity.

The joint commission and the Institute of Medicine have both voiced that sexual orientation and gender identity should be included as part of the electronic medical record. Having this information in the electronic medical record is imperative for tracking and analyzing health disparities in the LGBTQ community at the population level.

Education of the medical community to become competent in the care of the LGBTQ community has been identified as the way forward in helping bridge the gap in the healthcare disparities affecting the LGBTQ community. There has been a push to include competencies in the medical and nursing curriculum which address issues surrounding sex, gender, sexuality, and other related topics.

Continuing medical education to nurses, physicians and other clinical providers on LGBTQ issues has become the best recourse given the sparsity of LGBTQ issues in the curriculum.

The Health Equality Index (HEI) is a benchmarking tool which was established in 2007 and is used to designate healthcare facilities in the United States which are leaders in LGBTQ healthcare equality.

At-Risk Population

Although chronic illnesses or disabilities may occur at any age, the likelihood that a person will experience any activity limitation due to a chronic condition increases with age. In 2000, 35 million people — more than 12 percent of the total population — were 65 years or older.

By 2050, it is expected that one in five Americans — 20 percent — will be elderly. The population will also become increasingly diverse. By 2050, racial and ethnic minorities will comprise 35 percent of the over 65 population. As the population at risk of chronic conditions becomes increasingly diverse, more attention to linguistic and cultural barriers to care will be necessary.

Language and Communication Barriers

Of the more than 37 million adults in the U.S. who speak a language other than English, some 18 million people — 48 percent — report that they speak English less than “very well.” Language and communication barriers can affect the amount and quality of health care received. For example, Spanish-speaking Latinos are less likely than Whites to visit a physician or mental health provider, or receive preventive care, such as a mammography exam or influenza vaccination. Health service use may also be affected by the availability of interpreters. Among non-English speakers who needed an interpreter during a health care visit, less than half — 48 percent — report that they always or usually had one.

Language and communication problems may also lead to patient dissatisfaction, poor comprehension and adherence, and lower quality of care. Spanish-speaking Latinos are less satisfied with the care they receive and more likely to report overall problems with health care than are English speakers. The type of interpretation service provided to patients is an important factor in the level of satisfaction. In a study comparing various methods of interpretation, patients who use professional interpreters are equally as satisfied with the overall health care visit as patients who use bilingual providers. Patients who use family interpreters or non-professional interpreters, such as nurses, clerks, and technicians are less satisfied with their visit.

Low Literacy

The 1992 National Adult Literacy Survey found that 40 to 44 million Americans do not have the necessary literacy skills for daily functioning. The elderly typically have lower levels of literacy and have had less access to formal education than younger populations. Older patients with chronic diseases may need to make multiple and complex decisions about the management of their conditions. Racial and ethnic minorities are also more likely to have lower levels of literacy, often due to cultural and language barriers and differing educational opportunities. Low literacy may affect patients' ability to read and understand instructions on prescription or medicine bottles, health educational materials, and insurance forms, for example. Those with low literacy skills use more health services, and the resulting costs are estimated to be \$32 to \$58 billion — 3 to 6 percent — in additional health care expenditures.

Lack of Cultural Competence

People with chronic conditions require more health services, therefore increasing their interaction with the health care system. If the providers, organizations, and systems are not working together to provide culturally competent care, patients are at higher risk of having negative health consequences, receiving poor quality care, or being dissatisfied with their care. African Americans and other ethnic minorities report less partnership with physicians, less participation in medical decisions, and lower levels of satisfaction with care. The quality of patient-physician interactions is lower among non-White patients, particularly Latinos and Asian Americans. Lower quality patient-physician interactions are associated with lower overall satisfaction with health care.

African Americans, Latinos, and Asian Americans, are more likely than Whites to report that they believe they would have received better care if they had been of a different race or ethnicity. African Americans are more likely than other minority groups to feel that they were treated disrespectfully during a health care visit (e.g., they were spoken to rudely, talked down to, or ignored). Compared to other minority groups, Asian Americans are least likely to feel that their doctor understood their background and values and are most likely to report that their doctor looked down on them.

Ways to Provide Cultural Care

Individual values, beliefs, and behaviors about health and well-being are shaped by various factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation. Cultural competence in health care is broadly defined as the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system. The goal of culturally competent health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy. Some common strategies for improving the patient-provider interaction and institutionalizing changes in the health care system include:

1. Provide interpreter services
2. Recruit and retain minority staff
3. Provide training to increase cultural awareness, knowledge, and skills
4. Coordinate with traditional healers
5. Use community health workers
6. Incorporate culture-specific attitudes and values into health promotion tools
7. Include family and community members in health care decision making
8. Locate clinics in geographic areas that are easily accessible for certain populations

9. Expand hours of operation
10. Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials

Ways to Provide Cultural Care

Ongoing Learning Process

In order to increase the cultural competence of the health care delivery system, health professionals must be taught how to provide services in a culturally competent manner. Although many different types of training courses have been developed across the country, these efforts have not been standardized or incorporated into training for health professionals in any consistent manner. Training courses vary greatly in content and teaching method and may range from three-hour seminars to semester-long academic courses. Important to note, however, is that cultural competence is a process rather than a goal and is often developed in stages by building upon previous knowledge and experience.

Approaches that focus on increasing knowledge about various groups, typically through a list of common health beliefs, behaviors, and key “dos” and “don’ts,” provide a starting point for health professionals to learn more about the health practices of a particular group. This approach may lead to stereotyping and may ignore variation within a group, however. For example, the assumption that all Latino patients share similar health beliefs and behaviors ignores important differences between and within groups. Latinos could include first-generation immigrants from Guatemala and sixth-generation Mexican Americans in Texas. Even among Mexican Americans, differences such as generation, level of acculturation, citizenship or refugee status, circumstances of immigration, and the proportion of his or her life spent in the U.S. are important to recognize.

It is almost impossible to know everything about every culture. Therefore, training approaches that focus only on facts are limited, and are best combined with approaches that provide skills that are more universal. For example, skills such as communication and medical history-taking techniques can be applied to a wide diversity of clientele. Curiosity, empathy, respect, and humility are some basic attitudes that have the potential to help the clinical relationship and to yield useful information about the patient’s individual beliefs and preferences. An approach that focuses on inquiry, reflection, and analysis throughout the care process is most useful for acknowledging that culture is just one of many factors that influence an individual’s health beliefs and practices.

Guidelines from Professional Organizations

Many professional organizations representing a variety of health professionals, such as physicians, psychologists, social workers, family medicine doctors, and pediatricians have played an active role in promoting culturally competent practices through policies, research, and training efforts. For example, the American Medical Association provides information and resources on policies, publications, curriculum and training materials, and relevant activities of physician associations, medical specialty groups, and state medical societies.

Several organizations have instituted cultural competence guidelines for their memberships. For example, based on ten years of work, the Society of Teachers of Family Medicine has developed guidelines for curriculum material to teach cultural sensitivity and competence to family medicine residents and other health professionals.

These guidelines focus on enhancing attitudes in the following areas:

- Awareness of the influences that sociocultural factors have on patients, clinicians, and the clinical relationship.
- Acceptance of the physician's responsibility to understand the cultural aspects of health and illness
- Willingness to make clinical settings more accessible to patients
- Recognition of personal biases against people of different cultures
- Respect and tolerance for cultural differences
- Acceptance of the responsibility to combat racism, classism, ageism, sexism, homophobia, and other kinds of biases and discrimination that occur in health care settings.

Commitment to Cultural Competence

Health systems are beginning to adopt comprehensive strategies to respond to the needs of racial and ethnic minorities for numerous reasons. First, there are increasingly more state and federal guidelines that encourage or mandate greater responsiveness of health systems to the growing population diversity. Second, these strategies may be seen as essential to meeting the federal government's Healthy People 2010 goal of eliminating racial and ethnic health disparities. Third, many health systems are finding that developing and implementing cultural competence strategies are a good business practice to increase the interest and participation of both providers and patients in their health plans among racial and ethnic minority populations.

In addition to increasing the cultural competence of health care providers, organizational accommodations and policies that reduce administrative and linguistic barriers to health care are also important. Policies that strive to achieve cultural competence throughout the organization must address issues on all levels, from the organization's top management to clinicians to office staff to billing and administrative staff. Organizational policies that address language and literacy barriers have been among the most successful efforts.

Bilingual and Bicultural Services

Traditionally, community health centers that serve the Asian American or Latino communities have the most fully developed linguistic capabilities. For example, Asian Counseling and Referral Services (ACRS) in Seattle is a community-based mental health organization that effectively addresses language needs. They try to provide bilingual and bicultural clinicians that match the client's background. When this is not possible, ACRS provides trained staff to act as co-providers with a licensed mental health professional. These trained individuals act not only as interpreters, but also help provide a cultural context for the client's beliefs and practices.

Stemming from 30 years of experience in this arena, ACRS has developed a training curriculum, "Building Bridges: Mental Health Interpreter Training for Interpreters of Southeast Asian Languages." This curriculum will be used as a model for a national mental health interpreter training project to address the needs of limited-English speaking people. This national project includes training for interpreters, trainers, and health providers, as well as a mental health interpreter certification process.

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Within the Latino community, the use of promotoras, also known as peer educators, is becoming increasingly popular. Promotoras are generally ordinary people from hard-to-reach populations who act as bridges between their community and the complicated world of health care. They learn about health care principles from doctors or non-profit groups and share their knowledge with their communities. The peer education model is not only cost-effective, but also has been shown to be more effective in terms of reaching populations who find the information more credible coming from someone with a familiar background.

Assessing Literacy Levels

Methods employed to assess literacy levels include the use of screening instruments that test for certain skills related to functional literacy or less formal tools that allow health care professionals to determine a person's comfort level with various modes of communication. For example, at the To Help Everyone (T.H.E.) Clinic in Los Angeles, nurses and health care professionals speak individually with patients when they arrive at the health clinic to determine whether the patient prefers to learn by using written materials, pictures, verbal counseling, or some other technique. This method of assessment allows the patient to identify their own learning style preference without having to take a literacy test; it also reduces feelings of fear or humiliation that may occur when singled out.

Communication

Education and training in cultural differences and skills should be included in initial training and continuing education. Healthcare workers need to identify the impact of policy, procedure on patient care and advocate for patients' cultural needs.

Healthcare organizations should provide cultural resources to meet the needs of a diverse population. The organization must focus recruitment and retention on gaining a multicultural workforce. The workforce should be like the cultures of people who live in the community where the organization is located.

Communication is of vital importance in cultural competence. Communication within a culture is socially based and often complicated. It includes a variation of the culture, which can often be misunderstood. Misunderstandings can lead to incorrect assumptions, stereotyping, prejudice, and issues with cultural boundaries. When communicating with patients from different cultures, it is important to keep in mind the culture's normal actions. The differences that exist when two cultures communicate can confuse meanings in the messages that are sent and how the messages are understood. The communication between two different cultures is called cross-cultural communication.

Cross-cultural communication includes:

- Respect and appreciation for another language
- Ability to observe and communicate without judgment
- Recognize cultural barriers
- Encourage expression
- Speak slowly and clearly without slang
- Show empathy
- Ability to correct misunderstandings

Good communication skills include:

- Actively listening
- Pay attention to non-verbal cues
- Pay attention to perceptions of time, space, touch, expressions, and silence

Understand how the patient perceives the situation and health treatments

Communication and Language Assistance

Healthcare worker's nonverbal communication has the most impact on patient satisfaction. If healthcare workers were attentive to the patient's needs, appeared interested, and made eye contact during care, a healthcare worker's race did not matter on the patients' evaluations.

Health organizations that receive federal funding are required to meet standards that improve communication. Some of the standards are:

- Care should be correct for different cultural health beliefs and actions, preferred languages, health knowledge, and other communication needs.
- Leaders and the workforce should have the correct culture and language for the people in the service area.
- Educate the workforce in culture and language as well as correct policies and actions.
- Offer language assistance to patients at no cost to them.
- Inform all patients about language assistance in their preferred language, verbally and in writing.
- Make sure individuals providing language assistance are capable. Avoid using untrained individuals or minors as interpreters.
- Provide easy-to-understand print material and signs in the languages commonly used by the people in the service area.

Cultural Competence and Patient Safety

Disparities in healthcare extend to the patient safety arena. For example, a study that looked at hospitals across the country found that patients with limited English proficiency were more likely to be harmed than their English-proficient counterparts when they experienced adverse events, and that harm was more likely to be severe. These findings extend to pediatric populations, such as the study that found that hospitalized Latino children are more likely to experience an adverse event than non-Latino white children.

Patient safety events that can result from the failure to address culture, language, and health literacy include diagnostics errors, missed screenings, unexpected negative responses to medication, harmful

treatment interactions from simultaneous use of traditional medicines, healthcare-associated infections, adverse birth outcomes, inappropriate care transitions, and inadequate patient adherence to provider recommendations and follow-up visits. For example, lack of understanding that a hospitalized Asian woman would only communicate when a male family member was present, led to a delay in obtaining consent for a necessary surgery. With growing diversity in patient populations across the country, the risk increases that differences between patients and providers will contribute to missed care opportunities and safety events.

In addition to affecting medical errors and harms directly, cultural competence can have a powerful effect on another driver of patient safety outcomes – patient engagement. Cultural and linguistic competence strategies, such as provision of language assistance and the use of cultural brokers, can promote effective communication with diverse patients that is critical to engage them as collaborative partners in their care. Other interventions, such as cultural competence training, can increase understanding of what the patient is experiencing and give providers skills to bridge cultural differences and foster increased trust.

The Need for Cultural Competence

Differences between healthcare providers and patients can affect communication. This can, in turn, impact both clinicians' and patients' decisions about treatment. For example, a clinician may misinterpret a patient's silence as a lack of interest in receiving care. As a result, the clinician may not order a diagnostic test, when in fact the patient's response reflected their notion of respectful behavior.

When healthcare providers fail to recognize the differences between them and their patients, they may inadvertently deliver lower-quality care. Cultivating skills that improve cross-cultural communication can play an important role in delivering equitable care.

Additionally, building teams with healthcare professionals who reflect the diversity of the patient populations served can also improve cross-cultural communication. Diverse teams have a wider cultural knowledge base that they can share with one another. This makes them likely to respond with empathy to the unique cultural needs of patients.

Language accessibility is also key. Language barriers keep patients from accurately describing their symptoms and providers from explaining diagnoses. Language barriers can also create unsafe and inappropriate situations in other ways.

For instance, clinicians may rely on children to serve as interpreters, putting young people in the position of telling a parent they have cancer. As another example, clinicians may rely on abusive spouses to interpret for their battered partners. Both situations pose significant problems.

Cultural Competence with Cultural Humility

Healthcare providers strive to develop a multicultural orientation to deliver culturally sensitive care and improve communication. However, even when healthcare professionals have a meaningful understanding of a culture, they still can't predict the behaviors and attitudes of their patients simply based on their cultural backgrounds. That's because people are unique, and their behavior and beliefs might not always reflect those of their cultures.

Given this, healthcare professionals must focus on building cultural competence and cultural humility. Cultural humility recognizes the limits of people's knowledge of others. It also acknowledges that even

people who have cultivated their cultural awareness can still have unintentional, unconscious biases about cultures other than their own.

Cultural humility involves an ongoing process of self-evaluation. Through exploration of and reflecting on their own beliefs and behaviors, healthcare professionals can improve their awareness of implicit biases and foster an approach to patients characterized by openness and curiosity about each new patient.

Goals of Cultural Competence

Cultural competence aims to break down barriers that get in the way of patients' receiving the care they need. It also strives to ensure improved understanding between patients and their providers. The growing diversity in the U.S. population demands that the healthcare community expand its ability to address patient needs. Cultural competence offers a pathway and a framework to reach the goal of better health for all patients. Culturally and linguistically appropriate services, or CLAS, respond to individual preferences and needs of each patient. They also help improve health outcomes and decrease health disparities.

According to the U.S. Department of Health and Human Services Office of Minority Health, the principal standard of CLAS involves delivering equitable care that is:

- Effective
- Understandable
- Respectful

Improved Patient Outcomes

Cultural competence improves communication, which keeps patients safer. Clear communication allows healthcare providers to collect accurate medical information. It also encourages active dialogues in which patients and providers can ask questions, correct misunderstandings, and build trust. Studies have shown that the absence of culturally competent care can lead to preventable mistakes and adverse events.

For example, a recent study in Hospital Pediatrics that examined patient safety in hospitals across the U.S. suggests that patients lacking English language proficiency experience more adverse safety events during hospitalization than fluent English language speakers. The events they experience tend to be more severe as well.

Improved Patient Experiences

Healthcare environments that show an awareness of and respect for differences create more satisfying experiences for patients. When providers adjust treatments to meet patient needs and preferences, patients notice, and their overall experience improves. The Plos One review found that Black men rated providers' behaviors and attitudes significantly higher after the clinic gave its providers cultural competence training.

Another recent study published in the Journal of Sport Rehabilitation found cultural competence positively affects how patients experience health care. In addition to raising patient satisfaction, it increases the likelihood that patients will follow medical advice. The more culturally competent patients find their providers to be, the better their experiences. The study also indicated that patients treated by providers who could speak their language felt more satisfied as well.

If a healthcare provider uses medical jargon unfamiliar to a patient or makes assumptions about a patient because they use public health insurance, the patient may likely feel frustrated. Conversely, if clinicians show nonjudgmental openness in response to differences, actively listen, and make efforts to verify patients have understood them, their patients are more likely to feel satisfied with their care.

Promote Awareness

Promoting awareness and education plays a key role in improving cultural competence in health care. To develop cultural competence, healthcare professionals need to identify their beliefs and build an awareness of their culture. This gives them a basis to improve their cross-cultural awareness.

Cross-cultural awareness makes healthcare providers more open to unfamiliar attitudes, practices, or behaviors. It also improves collaboration with patients and helps them respond with flexibility. Benefits of cross-cultural awareness include:

- Improved rapport
- Tailored treatment plans
- Improved patient attendance and compliance

Diverse Team Member

Recruiting and retaining team members who accurately reflect the populations they serve gives healthcare organizations a clear advantage in their efforts to deliver culturally competent health care. When patients encounter team members who look like them, speak their language, and share their culture, they tend to feel more welcome. Healthcare providers who share cultural similarities with their patients often have a greater capacity to communicate with them, understand their perspectives, and anticipate their needs. Diverse team members can also share their insights with their colleagues, deepening everyone's capacity to deliver culturally competent care.

Putting Cultural Competence Into Action

To put cultural competence into action, healthcare organizations must create an institutional framework that:

- Demonstrates culturally competent practices
- Cultivates cross-cultural awareness and communication
- Maintains a diverse workforce

Cultural competence demands an ongoing commitment and multipronged approach. Healthcare organizations must build an infrastructure that supports activities and protocols that ensure culturally competent practices. Additionally, organizations must weather pushback from staff members who may perceive cultural competence as limited to racial and ethnic diversity and already consider themselves culturally competent. In such cases, healthcare organizations can implement educational programs that broaden definitions of cultural competence.

Benefits of Cultural Competence

Business benefits include enhancing the efficiency of care services, increasing the market share of the organization, decreasing barriers that slow progress, helping to meet legal and regulatory guidelines, and incorporating different perspectives, ideas, and strategies into the decision-making progress. Health

benefits include reducing care disparities in patient population, enhancing preventive care, improving collection of patient data, and reducing the number of medical errors, treatments, and medical visits. Social benefits include increasing trust, promoting community member inclusion, involving the community in health issues, assisting patients and families in their care, promoting patient and family health responsibility, and increasing mutual respect and understanding for patients and the organization.

- Collect race, ethnicity, and language preference data.
- Identify and report disparities.
- Provide culturally and linguistically competent care.
- Develop culturally competent disease management programs.
- Increase diversity and minority workforce pipelines.
- Involve the community.
- Make cultural competency an institutional priority.

Interpersonal Interactions

The ability or preparedness of healthcare providers to engage in effective interactions with patients depends in large part on the providers' knowledge, attitudes, skills and behaviors. While the features of patient centeredness and cultural competence are not intended to be a comprehensive account of all important facets, they are representative of the respective traditions.

At the core of both patient centeredness and cultural competence is the ability of the healthcare provider to see the patient as a unique person; to maintain unconditional positive regard; to build effective rapport; to use the bio-psychosocial model; to explore patient beliefs, values and meaning of illness; and to find common ground regarding treatment plans. The patient-centered model additionally includes a detailed set of knowledge and skills that healthcare providers should possess in order to accomplish these tasks, such as understanding the stages and functions of a medical interview and attending to patients' physical comfort. While such detail is generally not explicit in accounts of cultural competence, most of these additional characteristics of patient-centered care might be endorsed as traits of a culturally competent provider.

Patient centeredness has not been directly responsive to racial and ethnic disparities in healthcare, but it has the theoretical potential to reduce such disparities because it addresses some of the hypothesized mechanisms by which patient race/ethnicity impacts healthcare providers. For example, provider decision-making appears in some cases to be biased by patient race. Since patient-centered care aims to equalize power between patients and providers, it is possible that disparities in clinical decisions would be reduced by increasing patient involvement. Providers also display differential interpersonal behavior, characterized by more affective distance (less warmth, empathy, respect), when interacting with people of color.

In addition to the core features that cultural competence shares with patient centeredness, it has been suggested that the culturally competent healthcare provider exhibits other, distinct qualities, such as understanding the meaning and importance of culture, and effectively using interpreter services when needed. Just as proponents of cultural competence might embrace most aspects of patient centeredness, it is likely that proponents of patient centeredness would also embrace these additional features of cultural competence. Because cultural context and effective communication are relevant to the care of patients in general, not only people of color, cultural competence has the capacity to enhance patient centeredness and improve quality for all patients.

Developing Leadership Skills

Advanced practice nurses need to have strong leadership skills to promote and encourage culturally competent health care. They also need acumen in other core competencies, such as communication and problem-solving. To fully demonstrate that they understand the importance of cultural competence in health care, nurses should develop certain leadership skills. Cultural awareness refers to the process of self-examination that allows health care leaders to understand their own cultural backgrounds and address any biases they may have toward individuals from other cultures. Cultural knowledge involves the ongoing process of health care professionals seeking to better understand the languages, cultures, and belief systems of their patients. Cultural skills consist of doctors and nurses being able to examine patients according to a culturally based assessment and collect culturally relevant data. Cultural encounter is the process of a health care professional interacting with a patient from a culturally diverse background. Cultural desire revolves around the willingness of health care professionals to engage in cultural encounters with cultural awareness.

Problem-Solving Skills

The importance of nursing leaders communicating their commitment to creating a culturally competent health care environment cannot be emphasized enough. The importance of communication extends to successful mediation when problems related to cultural misunderstandings arise. Researchers have found that role-modeling helps nursing leaders promote cultural competence. However, the context of exchanges between nurses and patients, as well as individual characteristics of nurses, demonstrates the importance of communication and relationship building.

Nurses' problem-solving skills are enhanced when they understand the social, economic, and cultural backgrounds of their patients because many problems in health care settings can be traced back to miscommunication or misunderstandings between patients and nursing staff. They should be able to demonstrate firsthand knowledge regarding how and why cultural competence is important in health care.

How Advanced Practice Nurses Can Gain Essential Cultural Skills

Addressing the health care needs of underserved communities requires that nurses recognize and adapt to the social, ethnic, and linguistic needs of the people in these communities. The ANA specifies that RNs at all education levels should demonstrate certain competencies. For example, all RNs should have the following competencies:

- "Participates in lifelong learning to understand the cultural preferences, worldview, choices, and decision-making processes of diverse consumers."
- "Communicates with appropriate language and behaviors, including the use of medical interpreters and translators in accordance with consumer preferences."
- "Educates nurse colleagues and other professionals about cultural similarities and differences of health care consumers, families, groups, communities, and populations."

Impact on Cost and Access

Health disparities directly and indirectly cost the U.S. economy \$309 billion annually. It is estimated that approximately 30% of direct medical costs for Blacks, Hispanics, and Asians are unnecessary costs resulting from health disparities, and indirect costs include lost work productivity and premature death.

Some examples of current health disparities experienced by minority populations that impact health outcomes include:

Adults with disabilities are more likely to be obese, smoke, have high blood pressure, and be inactive than adults without disabilities. They are also three times more likely to have heart disease, stroke, diabetes, or cancer. Bisexual adults are almost twice as likely to fail to obtain needed medical care due to costs compared to straight adults. Non-Hispanic black infants are significantly more likely than non-Hispanic white and Hispanic infants to be born pre-term and/or at a low birth weight, the two leading causes of mortality among black infants.

Less educated, low-income, and minority populations are less likely to have health coverage, negatively impacting their ability to access and afford care.

Incorporating Cultural Competency In Emerging Care Delivery Models

Non-traditional providers. Non-traditional providers (e.g., retail clinics) can supplement traditional health care providers and help mitigate the negative impacts of localized physician shortages. They are generally more cost-effective, have extended hours, and are conveniently located, increasing accessibility. Despite increased use of non-traditional providers, minority populations still frequently turn to more costly care. For example, a survey of parents/caregivers utilizing the emergency department for their children's non-urgent care needs showed that they were more likely to be Latino and foreign-born and almost half were low-income, and/or lacking health insurance themselves, even though almost all the children had insurance and a primary care physician (PCP).

Non-traditional providers could increase appropriate use by minority populations through culturally competent outreach and care delivery and serve as a referral source to traditional PCPs for ongoing health care delivery and management.

Integrated care delivery. There are efforts underway to more fully integrate medical, behavioral, and pharmacological care for optimal treatment planning and outcomes. Many cultures have different views of care, particularly when it comes to discussing mental health and accepting treatment, which may make them less likely to seek

treatment or disclose critical information to their care provider. Moreover, low health literacy may be one factor that influences whether individuals adhere to medications. Therefore, it is important that any integrated care approach has the flexibility to be personalized to offer culturally competent care to individuals.

What Health Care Providers Can Do

Health care providers can help eliminate health disparities by recognizing that the best possible care for one population may not be the best option for another. By taking steps to improve their cultural agility, they will be better equipped to serve each of their patients, regardless of race, ethnicity, culture, gender or sexual orientation or other individual factors. Some ways they can do this are to:

- Identify training needs by taking a cultural competency assessment and addressing any identified opportunities to reduce personal bias and increase knowledge and cross-cultural communication skills that will help build trust, engagement and positive relationships with patients.
- Create a welcoming office environment with a culturally diverse staff reflective of the community served or provide staff with cultural competency resources and training.

- Establish language services policies and procedures to provide professional interpreter services and/or hire bilingual staff certified as medical interpreters; provide frequently-used patient instructions and health education materials at the right level of literacy and in the most common languages of the community served.
- Indicate in patient records whether a patient requires special services, such as interpreter services, so that each time the patient visits he/she experiences the same seamless experience as any other patient.
- Collaborate with community-based organizations/other providers on solutions to improve population health.

What Employers Can Do

Employers can also take steps to build cultural competency and improve health outcomes for all their employees by:

- Expanding their human resources leadership team to include experts in cultural competency and diversity
- Instituting multicultural staff representatives to support onsite health services, such as health fairs and open enrollment
- Seeking feedback from diverse groups of employees about their experiences as health care customers
- Providing materials and benefits information that are culturally competent, e.g., culturally adapted or language-specific
- Proactively gathering the demographic data of their workforce to measure and take action on health trends
- Collaborating with their health plan to better engage employees in their health

Culturally Competent Organization

Before a health care organization becomes culturally competent, leaders must understand the local community and the role the organization plays within the community. Steps to becoming culturally competent include (1) analyzing data and microtargeting surveys to improve service for the local community, (2) communicating survey findings to determine priorities and (3) educating staff and aligning programming and resources to meet community needs.

Education Principles

Becoming a culturally competent organization requires a thorough understanding of the principles that characterize cultural competence. First, staff needs to understand the factors that are pushing hospitals and care systems to become culturally competent. Hospital staff also needs to recognize and understand the cultural and clinical dynamics in interactions with patients. Becoming culturally competent involves developing and acquiring the skills needed to identify and assist patients from diverse cultures. With the necessary skills and mindset, staff can quickly identify the services required by a patient, thereby increasing positive health outcomes.

Staff Education

An effective educational or training program for cultural competence correlates with a lasting awareness and understanding by hospital staff. Although there are several approaches to educate staff, a successful educational program includes:

1. Cultural assessment
2. Multiple training methods
3. Ongoing education and
4. Measurement and tracking

The Impact of Unconscious Bias and Stereotypes

Healthcare providers may contribute to disparities in healthcare through three mechanisms:

1. Lack of recognition of nonverbal clues when dealing with patients of different cultural backgrounds
2. Biases
3. Stereotypes

People form preconceived associations between objects, which are often brought into the patient encounter. Research on clinical reasoning has demonstrated that experienced clinicians inform medical decision making through pattern recognition. Given the increasing time constraints on patient-provider encounters, clinicians may make assumptions about the clinical presentation of patients of different backgrounds and/or assumptions with regard to the treatment decisions using patterns that include patient demographics of race, ethnicity, or gender.

Evidence suggests that:

Providers stereotype patients on the basis of race, class, gender, age, physical disabilities, and sexual orientation; These stereotypes influence interpretation of patient's symptoms as well as providers' clinical decisions; and stereotyping occurs unconsciously. It is important to note that although overt expressions of bias have decreased over the years, a subtler form of unconscious bias exists even among self-defined, open-minded individuals.

Strategies to Address Unconscious Bias

Several strategies are available for providers to reduce the effects of unconscious bias:

Awareness training of bias and stereotypes and their effect on clinical decision making: Evidence suggests that when providers become more aware of the impact of bias and stereotypes on their medical decision making, the heightened awareness itself can reduce the impact. Self-reflection practices: Self-reflection involves providers contemplating their assumptions during a clinical encounter.

Individuation vs categorization: Individuation involves seeing patients for their individual traits as opposed to seeing patients for the groups they belong to (categorization). Evidence shows that attempting to see patients for their individual qualities suppresses the stereotypes that are associated with certain groups, thereby improving the clinical encounter.

Perspective-taking and affective empathy: Considering events and circumstances from the patient's perspective also suppresses activation of stereotypes. Once the provider has considered the patient's perspective, affective empathy may occur, which includes feelings of understanding/empathy for the patient's circumstances.

Partnership building: Lastly, providers are encouraged to build partnerships with patients. Race and gender are cues by which individuals often establish in-group, out-group associations. In other words, stereotype activation is reduced when others are viewed as being of the same group as the person making the assessment. Hence, if providers and patients are able to see themselves as members of the same team, the impact of stereotypes may be decreased. Taken together, these strategies have been shown to decrease stereotype activation and improve patient satisfaction, adherence, and ultimately outcomes.

Differences in Verbal Communication Styles

Differences in verbal and nonverbal communication styles can be a barrier to an effective clinical encounter. Minority patients may feel more comfortable with a form of communication referred to as setting talk, in which the discussion centers on topics of immediate context, such as the surrounding environment, the clothes one is wearing, or daily or life activities. In contrast, healthcare providers may feel very comfortable with a form of communication referred to as categorical talk, in which one may openly inquire about another person's age, occupation, place of residence, and other information, which may be perceived to be private and personal to the patient. Minority patients may also be distrustful of the healthcare system, which can be due to personal experience or to the experiences of people they know.

When different communication styles and comfort levels occur within the patient-provider encounter, and if the justification for personal questioning is not readily understood, patients may feel interrogated. For example, if the provider begins by discussing sexual orientation, sexual behavior, or substance use, the patient may believe that the provider has preformed opinions, and if the provider has not established trust, the patient may feel interrogated and become offended.

Some illnesses, symptoms, and behaviors may be stigmatized in certain cultural groups, and this can affect the patient's desire to discuss them. Following are some examples:

In some communities, depression is stigmatized. In such groups, patients with depression may report physical symptoms to their provider, such as fatigue and weight loss. Some cultural groups stigmatize sexual orientation or substance use, including alcohol and tobacco, or both, so that patients in these cultures may not disclose their sexual orientation to their provider or they may deny alcohol or tobacco use.

In some communities, certain symptoms may be considered private and inappropriate to be discussed openly; thus, it is difficult for patients to talk about these subjects. For example, some patients may

believe that it is inappropriate to discuss genitourinary complaints, or they may fear that the provider would interpret a symptom as resulting from promiscuous behavior.

Differences in Nonverbal Communication Styles

Differences in nonverbal communication styles can lead to significant misunderstandings between patients and providers. When interacting with patients of different cultural backgrounds, healthcare providers may encounter nonverbal expressions of symptoms that differ from what he or she expects. Hence, clinicians who are less familiar with a certain culture may miss the significance and meaning of these nonverbal cues, resulting in less accurate interpretation of the patient's symptoms. For example, 2 patients of different cultural backgrounds may have very different expressions of pain. Some patients may express pain passionately with animated gestures, emotions, and facial expressions, whereas others, who may be experiencing the same level of pain, appear stoic and reserved. If a provider is familiar with a patient's cultural background, it is more likely that the provider will correctly interpret the nonverbal cues.

Differences in Expectations of Treatment and Outcomes

Patients may have different expectations of treatment, care, and outcomes of the proposed treatment plan. Providers are often unaware of the cultural factors that affect decision making and adherence to treatment. Hence, providers who have not elicited the patient's understanding of treatment within his or her cultural context may draw their own --incorrect-- conclusions to determine why the patient has made certain treatment decisions. For example, approximately 40% of the US population uses complimentary and alternative medicine (CAM), either alone or combined with medically prescribed treatments. However, few patients disclose such use to their providers. One reason may be that patients using CAM may expect the clinician not to respect this treatment choice. In one study, 70% of patients reported that their providers did not ask about their use of CAM; lack of inquiry into use of such treatments may lead to poor patient adherence to recommended therapy.

Differences in expected treatment outcomes can also affect patient decision making and compliance. In certain cultures, women may believe that surgical resection for breast cancer may increase the risk for metastasis and may decline this treatment. These women may have witnessed another woman in their community with breast cancer undergo surgery for an aggressive tumor, only to have the malignancy spread later on. Similarly, some cultural groups believe that dialysis hastens death after having observed other community members with renal disease die soon after agreeing to the procedure. These 2 examples demonstrate how the same scenario may have completely different meanings for the patient and clinician. To the clinician, the link between metastasis and surgical resection may be explained as being due to late presentation for care or an aggressive tumor, whereas the patient perceives that the procedure played a causative role. Similarly, in the case of dialysis, the patient may believe that his or her community member should have declined dialysis because dialysis was soon followed by death. However, the clinician realizes that a delay in initiating dialysis increases the risk for mortality. Left unexplored, these differences in expectations of treatment outcomes may lead to poor patient compliance.

Strategies to Improve Patient-Provider Communication

Explore expectations of the encounter. Providers are encouraged to explore patients' expectations of the clinical encounter, while teaching patients the norms and expectations of Western medicine -- which include the provider's own expectations for the encounter. Providers should encourage patients to ask questions openly and to become actively involved in treatment decisions. Evidence supports that more

expressive patients are more involved in treatment decisions and that better patient-provider communication encourages patients to become more involved.

Openly discuss interpretation of nonverbal cues. When a provider is uncertain how to interpret nonverbal cues, he or she should explicitly explore the uncertainty with the patient. For example, if a patient does not establish eye contact or ask many questions, the clinician might encourage the patient to express him- or herself and ask about the patient's perspectives. The provider may ask the patient what he or she is thinking at that moment and provide supportive encouragement to share the perspective. Use models of cross-cultural communication. Several models of cross-cultural communication are available to improve the provider's ability to elicit a patient's understanding of his or her illness and treatment preferences during the clinical encounter.

Use the principles of shared decision making. The principles of shared decision making include respecting the patient's treatment preferences, encouraging active participation in decision making, and assisting patients in aligning their values and preferences with the options available and their expressed expectations for treatment outcomes. The treatment chosen by means of shared decision making may differ from the treatment that is routinely recommended.

Nurses Providing Culturally Competent Care

Cultural Awareness. First and foremost, nurses must perform a self-examination to gain insight into their own beliefs and values. The journal *Critical Care Nurse* offers an assessment tool to guide the process.

Cultural Knowledge. Then nurses seek out information to expand their knowledge base of different ethnic groups. Resources include journal articles, textbooks, workshops, and continuing education courses.

Cultural Skill. Cultural skill involves collecting relevant cultural information. It is insensitive to assume a person's cultural preferences based on appearance, country of origin or religion. Instead, nurses should ask questions and seek information in a professional manner.

Cultural Encounter. This is the process of engaging with patients from culturally diverse backgrounds, as this exposure increases the nurse's cultural competence.

Cultural Desire. Nurses must find the motivation to become culturally aware by remaining open-minded to learning and being accepting of others.

Summary

It's not just a catchphrase. Cultural competency refers to the ability of healthcare providers to recognize and respect patients with diverse values, beliefs, behaviors and linguistic needs. The National Institutes of Health (NIH) describes it as "the combination of a body of knowledge, a body of belief and a body of behavior" because it requires healthcare professionals to understand cultural differences and respond accordingly. The intersection of knowledge, beliefs, and behavior is where patient care can be affected.

The American Hospital Association says that "a culturally competent healthcare system is one that acknowledges the value of culture, incorporates the assessment of cross-cultural relations, recognizes

the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs.” It may sound like a tall order, but each of these action items is achievable. More importantly, they are necessary for healthcare systems to meet the demand of a diverse population. A successful recruitment strategy invites human resources and other hiring staff to present a culturally mixed set of eligible candidates. To retain a diverse workforce, an organization must incorporate cultural attitudes and messages in internal communications leading to increased trust in the workplace. Because each minority group is composed of subcultures, it is impossible to train employees in-depth about all cultures. A more successful approach is to educate healthcare providers on traditional beliefs and behaviors among the cultures most commonly served by that organization. Consistent training expands a staff’s knowledge base so that they can provide the most culturally appropriate treatment options.

Not all cultures accept Western medicine as their primary source of healthcare. Therefore, it is necessary to understand the role of traditional healers and coordinate with them to provide adequate patient care. This allows patients to follow their treatment program within their cultural parameters, which leads to patient satisfaction and improved health. Culturally competent healthcare offers numerous benefits for healthcare organizations and professionals. The social benefits are many and include more mutual respect between patients and healthcare workers, more trust, and greater patient empowerment and responsibility for their own healthcare needs. If patients feel understood and listened to by healthcare providers, they have been shown to be more able to participate in preventative healthcare. They are less likely to miss their appointments, and this, in turn, reduces the chance of medical errors occurring with improved health outcomes for the patient.

It couldn’t be more important for healthcare professionals and the organizations that they work in to focus on becoming more culturally competent so that every patient that they serve can enjoy the same level of patient care and the same excellent outcomes that they could expect if they were not from a diverse cultural background. Luckily, the importance of cultural competence is becoming better recognized within the healthcare profession today and more organizations are now taking steps to address this need within their workforce and settings.