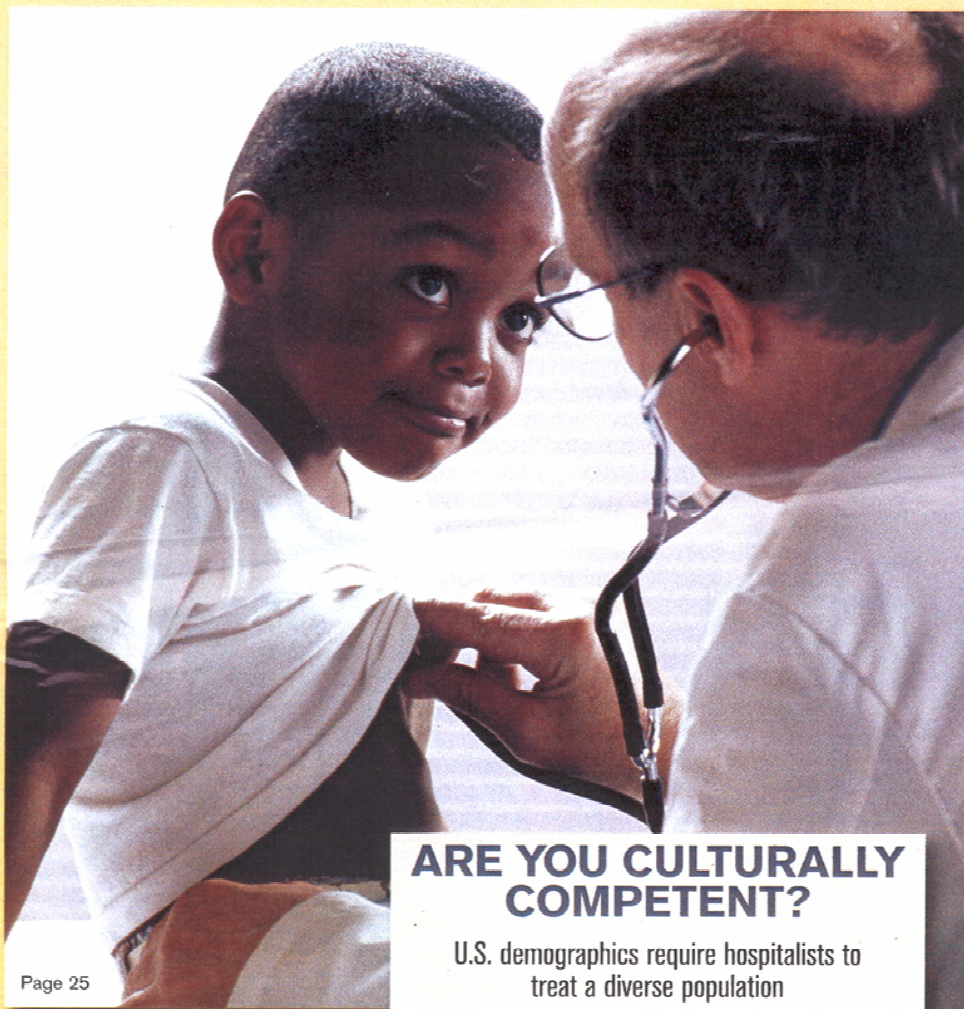


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Page 25

ARE YOU CULTURALLY COMPETENT?

U.S. demographics require hospitalists to treat a diverse population

By Gretchen Henkel

As the diversity of the U.S. population increases, so do the challenges for hospitalists, as they seek to deliver truly patient-centered care in the 21st century. The March 2002 Institute of Medicine report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," concluded that, while some care inequities can be attributed to access and linguistic barriers, healthcare providers themselves may contribute to disparities in care for their minority patients.¹

How can hospitalists ensure that they bridge the cultural divide between themselves and their patients from different racial, ethnic, and cultural backgrounds and avoid potential missteps in care delivery?

CONTINUED ON PAGE 25



Page 21

Feature Articles

STROKE COVERAGE

Magic Bullets13
An evidence-based review of antiplatelet strategies

The Hospitalist's Role in Stroke Management ...21
Training, protocols, communication

The Hospital of the Future ...16
The series begins

Columns & Departments

President's Column 5
SHM Point of View 6
Society Pages: News about SHM 8
What's Your Diagnosis? 12
Pediatric Special Section 28
In the Literature 33
Classified Connection 37



Page 58

On Service Note 58
Meet incoming Physician Editor Jamie Newman

ARE YOU CULTURALLY



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COMPETENT?

Changing U.S. demographics challenge hospitalists to communicate and treat diverse patient populations

■ By Gretchen Henkel

CONTINUED FROM PAGE 1

AN OPEN MIND

Experts in cultural competency interviewed for this article explained that hospitalists can readily acquire the knowledge and skills necessary to effectively provide patient-centered care for all their patients. (See "Resource List," p. 27.) But the most critical element in culturally competent healthcare delivery is the attitude with which the provider approaches his or her patients.

"I don't think we can teach attitude," says Alicia Fernandez, MD, assistant clinical professor of medicine, Division of General Internal Medicine, University of California, San Francisco, a nationally known researcher on language barriers and former full-time hospitalist. "But I think that any doctor who's trying to do the best he or she can by their individual patients has the right attitude, which is to remain open to practicing patient-centered care."

Physicians must be able to approach each patient on his or her own terms, and to acknowledge that members of different racial and ethnic groups hold beliefs about health and illness that diverge from those of Western medicine.

"You really need to have the capacity to empathize, and turn off all of your own belief systems, in some cases, to listen," says Stacy Goldsholl, MD, a hospitalist based in Wilmington, N.C., and an SHM Board member.

Dr. Goldsholl recalls one situation involving a patient who was a Jehovah's Witness who entered the hospital with a gastrointestinal bleed. Because of religious proscriptions, the patient refused a blood transfusion.

"It was extremely difficult as a scientist-trained physician, to watch someone bleed to a hemoglobin of 5, knowing that a simple transfusion would save this patient," recalls Dr. Goldsholl.

The patient later underwent surgery without a transfusion and survived, but Dr. Goldsholl believes this case illustrates that delivering patient-centered care requires the practice not just of the science—but the art—of medicine.

"I think the real message is, you have to think outside of your own box," she offers. "In addition, the cultural issues become much more pronounced when you start to approach end-of-life issues that take on more of a cultural, ethnic, and spiritual dimension."

AWARENESS AND KNOWLEDGE

Mitchell D. Wilson, MD, believes "the average American tends to be very ethnocentric. We are not taught cultural awareness in recognizing our own inherent biases, so we are unable to take the next step and recognize that there is a gap between our culture and another person's culture that would require us to take a different approach."

Dr. Wilson is associate professor of medicine, medical director and physician advisor, Department of Clinical Care Management, University of North Carolina (UNC) Hospitals, and section chief of hospital medicine and medical director, FirstHealth of the Carolinas Hospitalist Services, UNC School of Medicine, Chapel Hill. He is also an SHM Board member.



Hospitalists face more difficulty with some cultural issues than primary care providers because we're thrust into a situation of an acute illness, whereas the primary care provider at least gets an opportunity to establish a relationship.

—Jack Percelay, MD

Dr. Wilson says that his own cultural awareness emanated from participation in a spirituality and medicine program for student doctors and nurses at the medical school where he trained and was later on faculty.

"I was able to function both as a small group facilitator and a large group panelist, and we used a case-based format for creating awareness of spirituality in medicine," he explains.

Dr. Wilson notes that he later drew on these experiences when, as a hospitalist at a regional medical center, he was called to admit a woman to the hospital from the emergency department. She was dressed in traditional Muslim clothing and spoke no English. Knowing that it is offensive for traditional Islamic women to be examined by a man, Dr. Wilson asked through the woman's friends who had accompanied the woman whether she would prefer a woman doctor and whether she would be comfortable at least with his taking her history. She answered "yes" to both questions.

Dr. Wilson prevailed upon a female doctor in a competing practice to perform the examination and also made a special effort to admit the patient to the female physician in his own group who would be working the next day.

"It's not that I've been trained in cultural awareness," he says, "but this case points out the importance of recognizing other traditions, so that you can deliver care that is effective and culturally sensitive."

EARNING TRUST

Maren Grainger-Monsen, MD, senior research scholar and director of the Biomedical Ethics in Film Program at the Stanford University Center for Biomedical Ethics (Calif.), has produced several award-winning films about patients

from different racial and ethnic groups and their interface with the healthcare delivery system. In the process of filming patients with their families, she has realized that as a physician she often mistook respect for trust.

Patients, she says, "would be respectful and polite and seeming to agree with me, but as I have worked on these films and spent time with families, I realize that they approach the physician and the hospital system with more caution and they wait to see if the people are trustworthy."

Jack Percelay, MD, chair, American Academy of Pediatrics Section on Hospital Medicine and SHM Board member, notes that "hospitalists face more difficulty with some cultural issues than primary care providers because we're thrust into a situation of an acute illness, whereas the primary care provider at least gets an opportunity to establish a relationship. In pediatric hospital medicine, we need to be very careful and cognizant of this, make sure we employ translation resources and social workers, and be hesitant to judge someone else's value system, while still advocating for the patient."

While it can be important to acquire a baseline of knowledge about dominant cultural and religious groups (especially if a group comprises a sizable percentage of patients seen at one's institution), Dr. Fernandez cautions against using a laundry list approach to cultural competency.

"It's helpful to know, for instance, that many Vietnamese here came as a result of the Vietnam War," she says. "On the other hand, it is not that helpful to say [something like], 'Don't shake hands with Vietnamese.' Our patients are forgiving of whether we shake hands or don't shake hands. They are less forgiving when we appear not to listen to them."

LOST IN TRANSLATION

Nearly 14% of people who live in the United States speak a language other than English in their homes, according to the U.S. Census Bureau's Census 2000 estimates.² When a person with limited English proficiency (LEP) enters the healthcare system, the potential for medical error increases if language barriers are not addressed. Indeed, healthcare institutions that receive federal healthcare dollars (Medicare, Medicaid) are obligated under Title VI of the Civil Rights Act of 1964 to provide access to interpreter services—free of charge—to LEP patients.

Those interviewed for this article advised that physicians should avail themselves of trained medical interpreters whenever possible. These professionals are trained to translate providers' and patients' communications verbatim—without editing—and are conversant with medical terminology.

However, such resources may not be available in rural hospitals. Such is the case for William D. Atchley, Jr., MD, medical director of the Hospitalist Service at Sentara Careplex Hospital in Hampton, Va., who recently used a cafeteria staff person to translate while he examined and admitted a Mexico-born patient with rhabdomyolysis that resulted from heat exhaustion. Dr. Atchley, an SHM Board member, has also used family members as translators. He notes, though, that "trying to get an understanding of what is going on can be difficult at times because the one family member who may act as a translator may not have as good a command of English [as a trained medical interpreter]. You are always fearful that something could get lost in translation."

Even large institutions that have medical interpreters on staff may not have 24-hour coverage. In that case, telephone interpreters through AT&T's Language Line service can be another option (www.language-line.com). Physicians can also work with ad-hoc interpreters, defined as family members or friends who act as interpreters, but are not professionally trained, says Dr. Fernandez.

"It can pay off to first take a few minutes to explain to these interpreters that you want them to repeat everything they hear as much word for word as they can," she explains. "Tell them that you will give them time to participate in the conversation—as a family member—later on. First, you want them to play this narrow role as interpreter, and later you will let them add information as the family member because their contribution is also

valuable."

Young people, including teenage children, should not be used to interpret unless the situation is immediately life-threatening. "There has been a lot of research," says Dr. Fernandez, "showing that [using children as interpreters] distorts family roles and makes the children uncomfortable."

For example, says Dr. Grainger-Monsen, it would be completely inappropriate for a child to translate while a physician asks his mother about her past sexual history or vaginal bleeding.

THE TIME IT TAKES

At San Francisco General Hospital, where Dr. Fernandez is an attending physician, there are 140 languages spoken each month. She says the variety of patient backgrounds presents a challenge even for someone like herself, who has conducted extensive research on barriers to minority healthcare. She admits that she sometimes experiences an "internal groan" when she notices that the next patient in her busy clinic day is someone who speaks a language that she doesn't. Like many of the hospitalists interviewed for this article, Dr. Fernandez notes that because using medical interpreters is time-consuming, she experiences initial resistance to the process.

A 2004 Canadian study examined the relationship between length of stay and LEP in the ambulatory care setting. It found that LEP patients stayed in the hospital longer for conditions, such as unstable coronary syndromes and chest pain, stroke, diabetes, and elective hip replacement.³

Issues about cultural competency are "fairly complex," notes Alpesh Amin, MD, MBA, FACP, executive director Hospitalist Program and vice chair for clinical affairs, Department of Medicine at the University of California, Irvine, and SHM Board member. Sorting through issues surrounding patients' beliefs toward healthcare, as well as their family values and dynamics, "takes time to resolve, and if I really want to understand your personal beliefs, I've got to be willing to sit down and talk about it. But, I'm not going to get paid for that time. This is not a



➤ In her work producing films about patients from different cultures interacting with the healthcare system, Dr. Grainger-Monsen realized that as a physician she often mistook respect for trust.

goal was to keep this individual alive, because he was so important as a figure in the clan. I learned that their culture had a profound impact on their expectations of me as a physician and a provider—how I conducted myself in terms of family and clan communications, what resources I brought to bear to try and stabilize and improve his health, and how I worked with specialists. I also learned that although some clan and family members were fluent in English, even modest miscommunications, if I were to use them as translators, could result in significant setbacks."

Prior to his current position with Cogent Healthcare, Dr. Holman managed a group of 30 hospitalists at HealthPartners Medical Group in Minnesota and in partnership with the Center for International Health developed a cultural competency curriculum for their group and for the University of Minnesota residents in training at Regions Hospital in St. Paul.

"When you are busy working in the hospital, you need to be able to quickly access some resources to be able to give you a 'just in time' amount of information and awareness" with which to approach your patient, he says.

➤ The most critical element in culturally competent healthcare delivery is the attitude with which the provider approaches his or her patients.

reimbursable expense for the physician."

Still, taking time to explore a patient's preferences could also shorten length of stay if, for instance, the patient indicated that prescribed management indicated after an expensive test would not be his choice of care, says Dr. Amin.

Understanding what beliefs and experiences patients bring to the table, as well as their past health behaviors, does involve a time investment, agrees Minn.-based Russell Holman, MD, national medical director for Cogent Healthcare, Inc. and SHM Board member. But that investment "can only help efficiency," he maintains. "We've invested ourselves tremendously in terms of identifying what are best practices for a patient with heart failure, or pneumonia, or heart attack, but the cultural competency dimension of healthcare has been largely overlooked."

Training in cultural competency is piecemeal at best, notes Dr. Holman, and often acquired on the job. He recalls a situation in which he learned first-hand the profound effect that culture has on health. While working with a Hmong man who was in a coma and on a ventilator, Dr. Holman initially attempted to seek decision-making from the patient's wife.

"I found out that was not the appropriate decision-making process for their culture," says Dr. Holman. The discussion was initiated in the patient's room, and was moved to a lecture-style classroom to accommodate the 37 members of the man's clan who came to discuss his condition.

"The fascinating thing to me was that the patient's wife and the other women sat in the back of the classroom and did not speak the entire time," explains Dr. Holman. "The decisions were largely conducted by the clan elders. I also found out that my patient was the clan leader, and the elders had very clear goals in mind. The

AGENTS FOR CHANGE?

In addition to Title VI compliance, hospitals are now surveyed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and are evaluated on their ability to provide language services.

"This is a changing area," notes Dr. Fernandez, "and I think it is important for hospitalists to be on the forefront of that change, part of the process that says, 'Yes, we need to be able to provide more efficient, more patient-centered, and safer care.' Language barriers, as one example, are inefficient, are dangerous, and are clearly associated with increased medical error."

Dr. Percelay believes that dealing with patients from different backgrounds involves using "common sense, being respectful and legitimately curious, and avoiding shortcuts in terms of translation issues. I think if people have an inherent respect for diversity, and are open to it, it can enrich your practice."

Dr. Fernandez agrees. "Practicing medicine in a patient-centered way is ultimately a more rewarding way to work and live," she says. "There also needs to be reform at a national level that allows physicians and hospitalists to be appropriately compensated for much of the conversation and bedside work that we do." **TH**

Writer Gretchen Henkel lives in California and writes regularly about healthcare.

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Resource List

Tools to help improve your cultural competency skills

• **"Worlds Apart," a 47-minute video** produced by Maren Grainger-Monsen, MD, director of the Bioethics and Film Program at the Stanford Center for Biomedical Ethics. It follows four patients (an Afghani-Muslim man with stomach cancer, a young African-American man on dialysis for renal disease, a Laotian girl who needs an open-chest procedure to repair a hole in her heart muscle, and a Puerto-Rican-American woman with depression and diabetes) as they navigate their way through the healthcare system.

The stories are told from each patient's perspective and include filming of physician-patient encounters, as well as scenes at patients' homes and places of worship. A study guide designed by Harvard University cross-cultural medicine educators accompanies the film, and is downloadable free (the video must be bought) from the distributor, Fanlight Productions (www.fanlight.com) or (800) 937-4113.

• **Ethnic-specific curriculum modules** created by the Collaborative on Ethnogeriatric Education and edited by Gwen Yeo, PhD, can be downloaded in Adobe Acrobat from the Web site of Stanford University Medical Center's Geriatric Education Center. Health beliefs and cultural traditions from 12 ethnic groups (including African-American, Korean, Filipino, and Pakistani) are explained, and tied to geriatric and end-of-life issues (www.stanford.edu/group/ethnoger/efiles.html).

• **Age through Ethnic Lenses: Caring for the Elderly in a Multicultural Society**, a book edited by Laura Katz Olson, professor of political science at Lehigh University, features chapters on a variety of socioreligious groups, populations from European origins, as well as rural elderly (2001, Rowman & Littlefield Publishers, Lanham, Maryland; www.rowmanlittlefield.com). Also available through www.amazon.com and www.bn.com.

• **The U.S. Department of Health and Human Services' Office of Minority Health** offers a wealth of links to agencies and reports regarding minority health access and health disparities: www.omhrc.gov.

• **The National Center for Cultural Competence** at Georgetown University, Washington, D.C., offers guiding principles, systems of care, and training modules for developing and improving cultural and linguistic competence: <http://gucchd.georgetown.edu>.

• **The Center for Cross-Cultural Health** (www.crosshealth.com), at the International Institute of Minnesota, offers information, training, research and consulting to develop culturally competent individuals, organizations and systems.—*GH*