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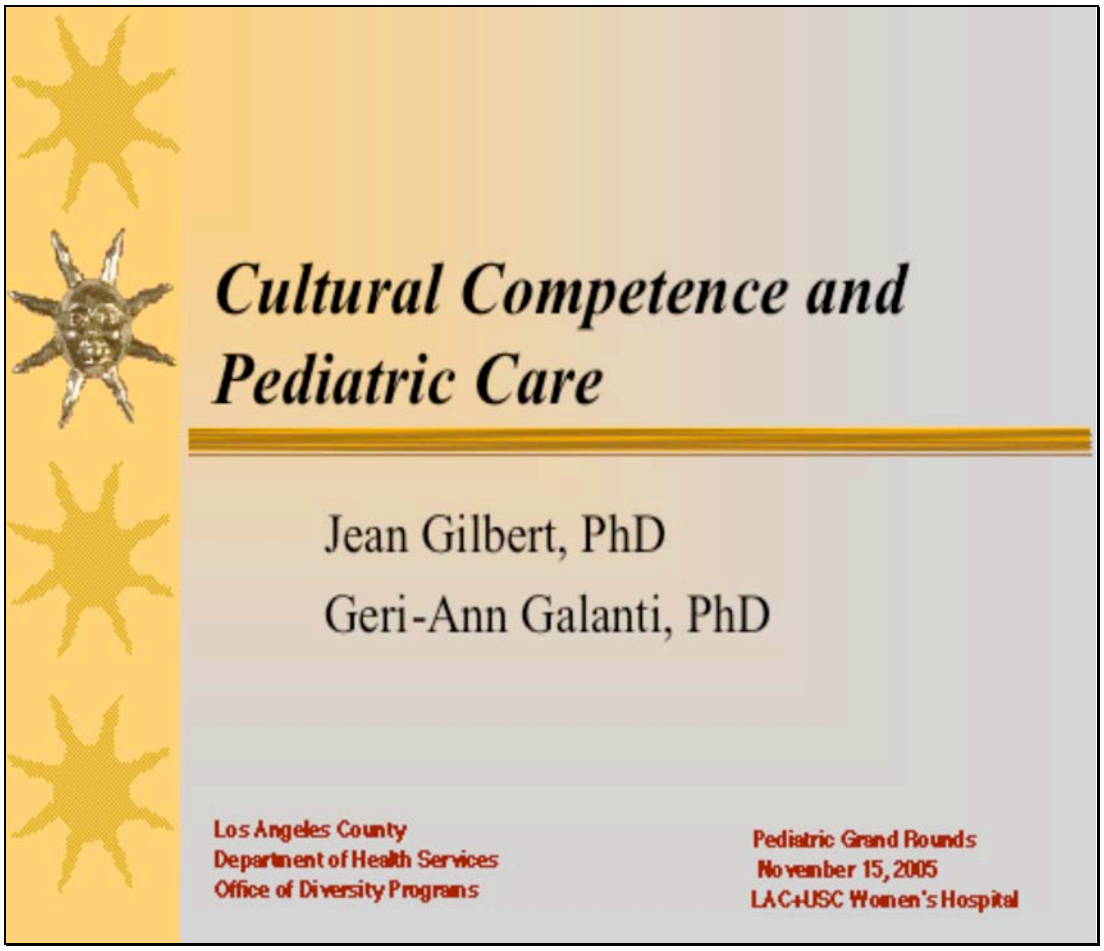
Cultural Competence and Pediatric Care
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LAC+USC Women's Hospital

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The American Association of Medical Colleges has just this year published recommendations for integrating cultural skills throughout medical skills and a guide for evaluating medical students on those skills.

In 1999, the American Academy of Pediatrics, in their journal (Vol. 103 (1), published the policy statement, Culturally *Effective Pediatric Care: Education and Training Issues*, a statement which defines culturally effective health care and describes its importance to pediatrics. The statement also defines cultural effectiveness, cultural sensitivity, and cultural competence and emphasizes the importance of these concepts for training in medical school, residency and continuing medical education curricula.

In 2003, the Los Angeles County DHHS adopted its own *Cultural and Linguistic Competency Standards* created with the help of a local and national group of experts in the field. These Standards outline the goals, policies, and activities that the county is working on to reflect national and state regulations for quality health care services for diverse patient populations.

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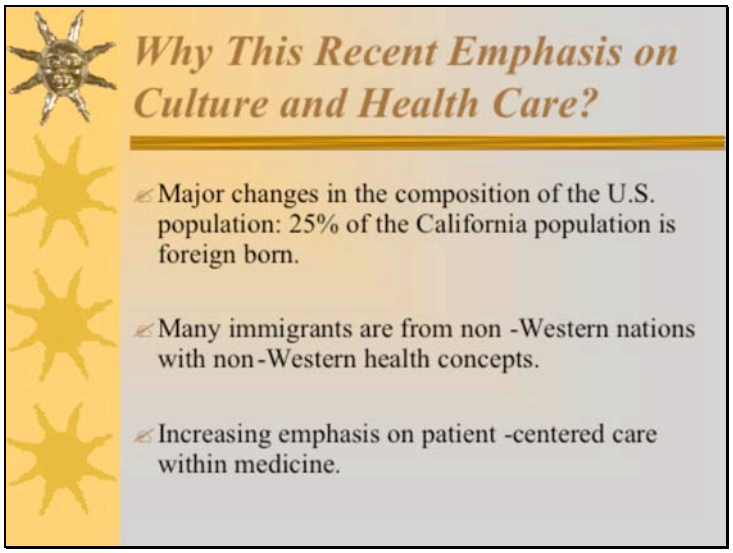

The U.S. is a nation of immigrants, but up until recently, and excepting African Americans, most of the immigrants came from European nations. There was even immigration legislation designed to keep it that way up until after World War II. Changes in immigration laws in 1965 and refugee resettlements have changed all that.

The U.S. is beginning to more completely reflect the global community with all its cultural and linguistic diversity.

The emphasis on patient-centered care increases the focus on what the patient brings to the health care encounter in terms of personal context, perspectives and goals in an effort to involve the patient more completely in his/her own prevention and treatment options and goals.

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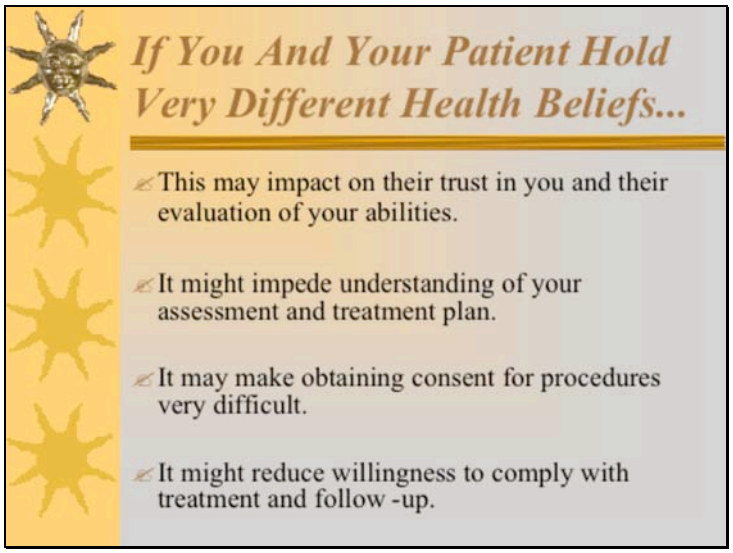

The clinician workforce and the patient population are becoming more culturally diverse at the same time that medicine is emphasizing patient-centered care. This diversity raises the potential for cultural misunderstandings, particularly in the emotion-laden circumstances of many patient/provider encounters. Finding common ground or common understandings in the midst of cultural diversity is critical in creating the rapport and trust necessary for consenting and follow-up on treatment regimens.

In cross-cultural situations, it's important for you to try to determine if your patient and you are seeing the situation differently in important ways.

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Keep in mind that your patient may expect you to behave in preconceived ways, based on their prior experiences here or in their countries of origin. In many countries, a physician is viewed as an authority, not to be questioned, so the idea of bringing or asking questions may need to be empathically encouraged many times. On the other hand, your patient may think you are lacking in some regards if you aren't familiar with a traditional disease or treatment modality that is familiar to them, though they probably won't say so!

Perceptions of good and bad health and the causes of illness are formed in a cultural and historical context. What may seem a problem to you (plumpness?) may not seem to be a problem to them.

Do you think an amulet is an effective preventive strategy? Some of your patients might think so.

A severe backache is an everyday fact of life to a farm worker, not a sign of something more problematic.

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We don't always think of these things as health-related, but they are important contextual factors into which health care is embedded.

Gender roles, for example, and sexuality: How a Somali woman views her genitals in relation to self and men is far removed from how your Mexican American mother views hers, and both are different from a middle-class Anglo. There are similarities and deep cultural differences.

A well-functioning family can make all the difference in how well a patient can carry out a treatment plan, but families are structured and function differently across cultures. What might be considered dysfunctional in one culture functions well in another because the accepted dynamics are different.

Groups differ in the patterning of diseases and understanding the epidemiological profiles of different ethnic groups may be useful.

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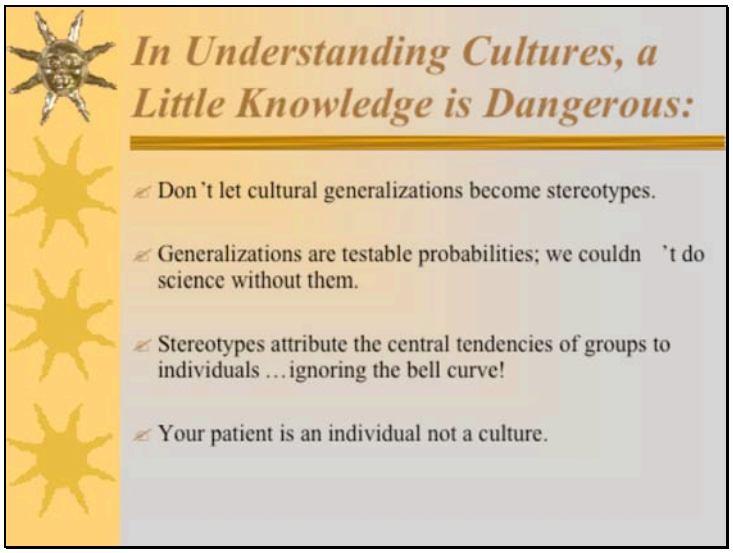

In attempting to understand cultures, I've found that people want to be given dependable cultural recipes: Vietnamese think this or do this about death; the Hmong believe that most illness involves soul loss, etc.

There are, in fact, core cultural beliefs and concepts, but in dealing with individual patients, you need to think of these, like all generalizations as probabilities.

Science runs on inductive and deductive thinking, so we all deal with generalizations every day: African American men have a statistically significant higher prevalence of prostate cancer than the general population…but that doesn't mean that the fifty year old African American in your exam room has prostate cancer. It simply enhances the probability and you need to pay attention to that.

In the same way, as you learn about cultural beliefs, you have to see them as possibilities, not predictable individual characteristics.

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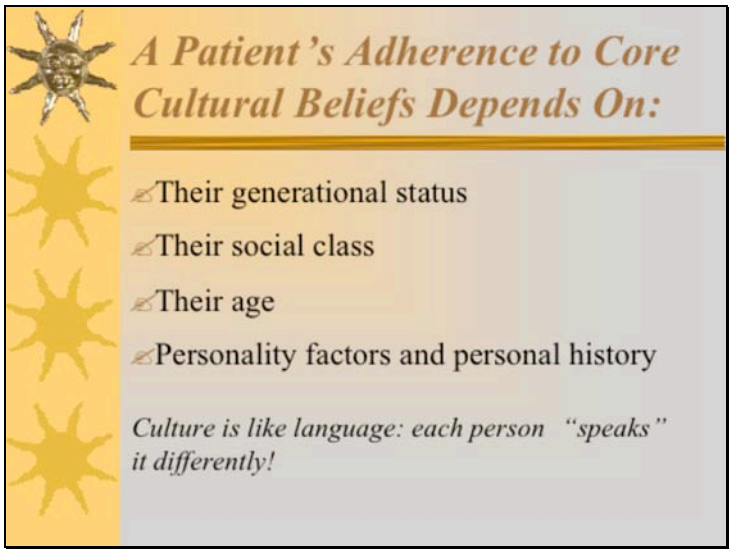

Persons born outside this country and those who speak little English are more likely to adhere to traditional cultural beliefs as are older people. More likely is the operative phrase here.

Middle-class folks all over the world tend to be less traditional in many of their beliefs, due to education, but there is a still lot of variation and surprises in the mixture of health beliefs.

And in any culture, each person's attitudes and beliefs are the result of the interaction between their personality and their life experiences. For example, witnessing what appears to be a serious illness cured by magical means can make an indelible impression on an easily influenced individual.

Frequently, I hear providers say, "Is the way my patient is behaving and expression of culture or their individual personality? I am most concerned about meeting the needs of the individual patient."

The answer to this question is: Probably both culture and personality are operative. Psychological studies have indicated that specific personality traits tend to cluster or factor out differently in different cultures. Still, statistics show that within cultures there are outliers and variations on these traits.

When you have seen enough patients from a specific culture, you will likely begin to see the interplay of personality and culture more clearly.

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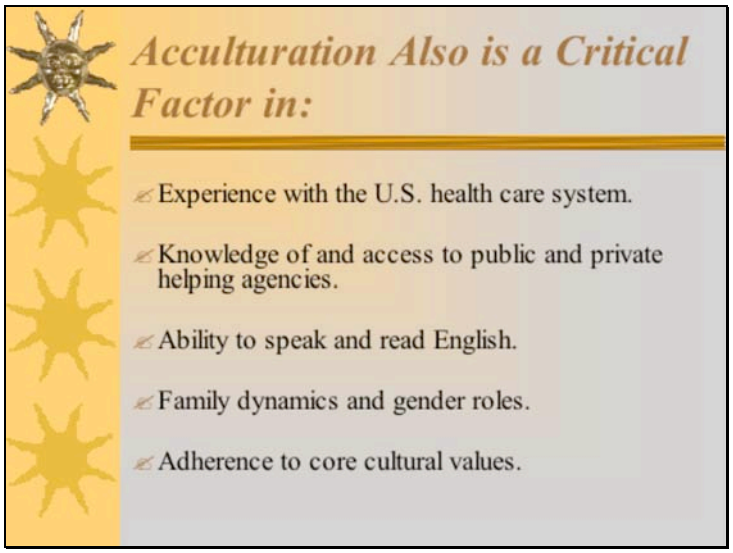

The American health care system, its structure, personnel, paths of access and regulations, is especially confusing to immigrants coming from countries whose systems are organized differently and who don't speak English. . It takes a long while and many experiences to understand the workings of both health care and other agencies that are non-existent or different in countries of origin. It is difficult, for example, for patients to follow instructions or directions if they don't understand the context for the directions or if the labels or signs don't make sense to them. Having translated materials is very helpful.

Acculturation occurs both rapidly and slowly.

Learning to use new instrumentalities, such as ATMs, supermarkets, fast food vendors, or even bronchial inhalers can occur in a matter of months; but adopting deeply felt culture mores such as family and gender roles often happens only across generations.

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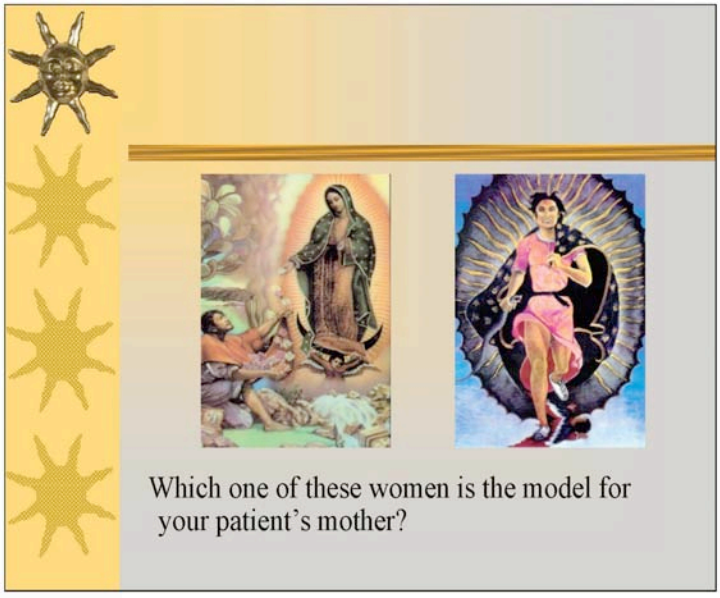
Which one of these women is the model for your patient's mother?

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Cultural Competence begins with good communication skills. Probably the overriding issue is basic communication, when you and the patient/family don't speak the same language. We'll get to issues surrounding working with an interpreter in a bit. But first, let's look at some other communication skills.

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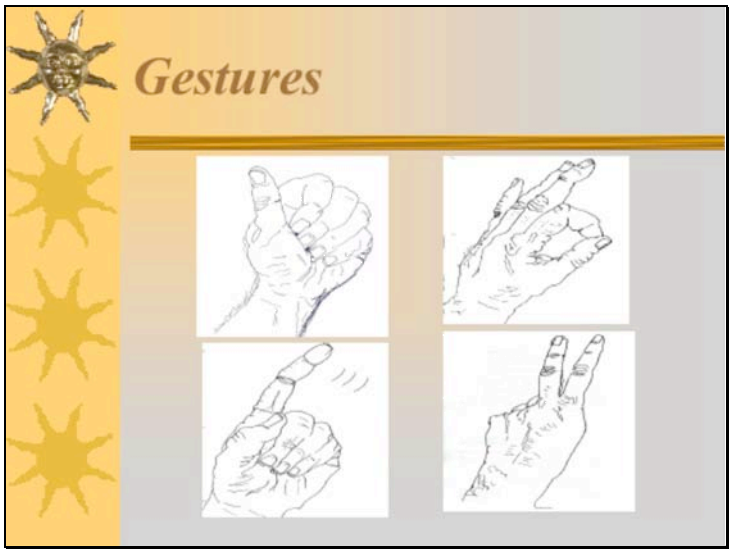

The simplest things can cause communication to go awry. Take for example, gestures. You want to indicate to a parent who doesn't speak English that her child's test results came back indicating that the child is doing well. You give a thumbs up. If the parent happens to be from Iran, you've just given them the equivalent of the middle finger! Or, instead, you give them what you believe is the gesture indicating that everything is "okay." If they are from Brazil or Afghanistan, you just made a crude sexual proposition! Perhaps one day you're treating the child of parents who recently arrived from the Philippines. You beckon them over to you with your index finger, and then wonder why you get a dirty look and lose whatever rapport you had developed with them. The reason is that you essentially just called them a dog! If you make a V with your index and middle finger, that may mean peace or victory to you, depending on how old you are. In British speaking countries, however, (Great Britain, South Africa, New Zealand, Australia), if you show the back of your hand, you've just insulted them … remember what thumbs up means in Iran?

If you're referring to the height of a Mexican child, you must use the bottom edge of your hand (by the pinkie), parallel to the floor. If you put your palm parallel to the floor, it indicates that you're talking about farm animals, and could be perceived as insulting.

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Gestures aren't the only potential source of non-verbal miscommunication. Eye contact -- or lack thereof -- is another common source of misunderstanding. The two people in the photo look similar, but their body language might reflect very different things. If an Anglo or African American avoids eye contact, it usually indicates that they are uncomfortable, or hiding something, or perhaps even lying. In Asian cultures, however, it can be a sign of respect. Asian cultures are hierarchical, and to look someone directly in the eye implies that you're equals. However, you're all physicians, and thus owed tremendous respect, which they might demonstrate by avoiding direct eye contact. This is most likely when you're an older male physician and you're talking to a younger, unacculturated woman. In any case, don't assume that avoiding eye contact means the same thing in all cultures. In some Middle Eastern cultures, if a woman looks a man directly in the eye that could be taken as a sexual invitation. In some Native American cultures, the eyes are seen as the window to the soul. If you look someone directly in the eye, they could steal your soul. Or you could steal theirs, so they will avoid eye contact. The bottom line is that if a patient or family member is avoiding direct eye contact, you

should consider among the possible explanations ones that might be appropriate for their culture.

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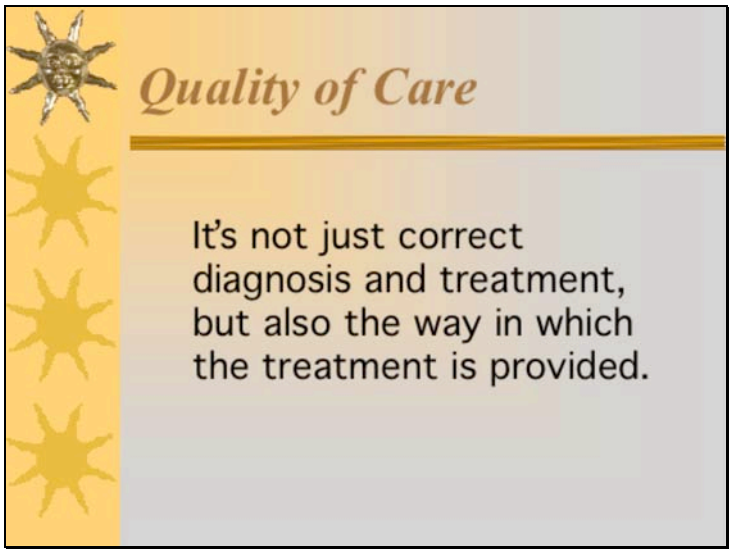

When you're looking at quality of care, remember: It's not just correct diagnosis and treatment, but also the way in which the treatment is provided.

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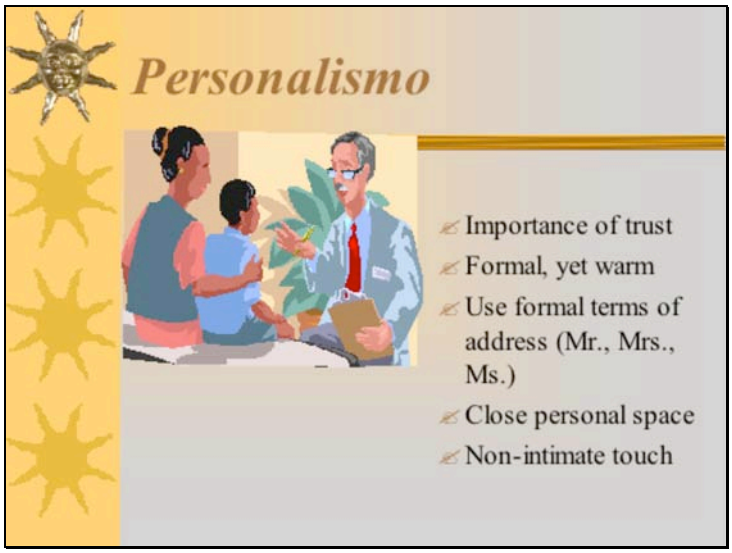

One of the dimensions along which there is cultural variation is that of the expected nature of the relationship between the physician and the patient. In this country, the relationship is generally expected to be a professional one, focused on the health concerns of the patient. In many other cultures, however, it is considered important to have a personal relationship with a physician. Patients are more likely to comply with your recommendations when your relationship makes it almost a matter of a personal favor. Although you might see a "no nonsense, all business" approach as professional, this can cause patients to lose trust in you, and greatly decrease the chances of compliance. There is even a term in Spanish, "Personalismo" that describes the type of relationship expected in that culture. The health care provider can improve communication with his or her Hispanic patient by making friendly conversation, asking about the patient's family and interests before discussing purely health-related issues. When speaking to your patient's parents, use formal terms of address. Touch them occasionally in a non-intimate way. Stand close. When you shake hands, hold it slightly longer than is customary among Anglo Americans. Project the feeling that this is someone you care about on a personal level, not just a professional one. Be formal, yet warm, at least early in the relationship. Over time, formality may decrease, and warmth increase. The time it takes will be compensated for in increased rapport and trust and ultimately compliance.

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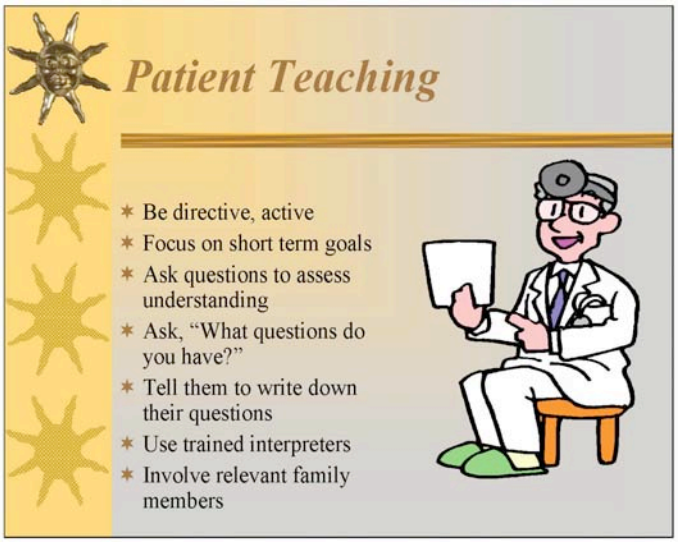

While written instructions (on medications, treatments, etc.) are important, patient teaching that is directive, active, and visual will usually be most effective. Most poor people have a present time orientation, meaning that they tend to focus on the present, rather than the future. You'll have more success with them if you focus on short term goals, rather than long term ones.

Many patients – or parents in this case— won't be very assertive. When you ask them questions, they often won't elaborate on responses. They will pretend to understand what you're saying, when in fact, they don't. This can have a huge impact on compliance. That's why it's so important to have them repeat back instructions, and for you to ask questions to make sure they really understand them. Furthermore, they won't ask questions unless prompted to. It's common to ask patients at the end of a visit, "Do you have any questions," but you may get a better response if you rephrase that and ask, "What questions do you have?" Imply that of course they must have questions; anyone would. It's also a good idea to remind them to write down any additional questions they may have after you leave, so they can ask you next time.

We can't stress enough the importance of using interpreters. Trained, professional interpreters. Someone at another hospital in Los Angeles told me of the time the patient, a 12 year old Hispanic boy was asked by his physician to interpret for his parents that he had a cancerous tumor and that his leg would have to be amputated. That is not appropriate, as I'm sure you would agree. Children are never appropriate interpreters. We'll be discussing more about interpreters a bit later.

I also want to mention that compliance (adherence) is likely to be higher if you involve the appropriate family members in patient teaching … something I'll be discussing in a moment.

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On the subject of compliance/adherence, there are a number of reasons why a patient may not follow through.

- In some cultures, particularly Asian cultures, respect for authority may inhibit them from disagreeing. Instead, they will agree, but not follow-through.
- Another is that they didn't understand your instructions. You may have assumed they understood how to take a medication, when they didn't. In Mexico, for example, poultices are commonly used. A powdered medication might be mixed and applied to a wound site directly, rather than taken orally. In China, herbs are boiled and taken all at once; pills, make be taken all at once as well. It's important to explain why you want them to take the pills spaced out, over several days. Make sure your instructions are clearly understood.
- Another reason might be that your recommendations make no sense given their understanding of their condition … something we'll be discussing shortly.
- Finally, many times patients will have concerns about a medication or treatment based on knowledge of someone else's experience.

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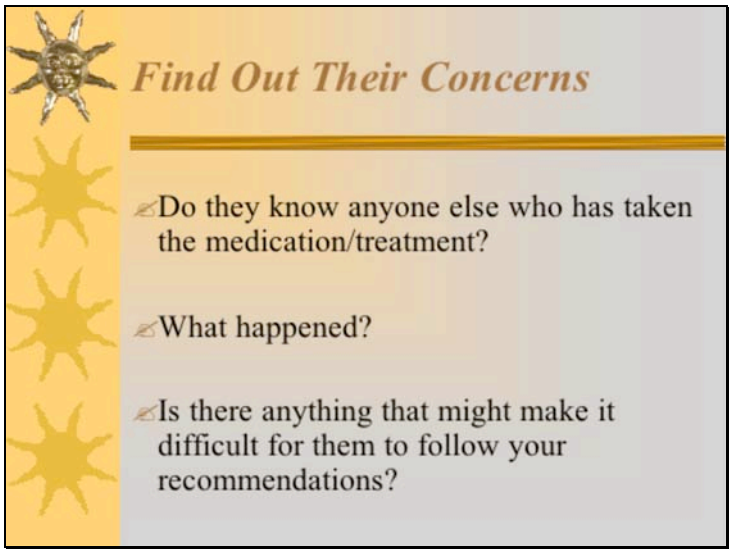

One way to deal with this is to ask them about their concerns. Do they know anyone else who has taken the medication/treatment? What happened? In this way, you can ascertain and allay their fears.

You might also want to see if there are any factors which might impede their following your recommendations. For example, if a child is diabetic, you might recommend a complete change in diet. However, the mother might not feel it is possible to stop cooking the foods that her hard working husband enjoys. There are usually compromises that can be made, but if you don't know what the barriers are, the patient is likely to just not follow through.

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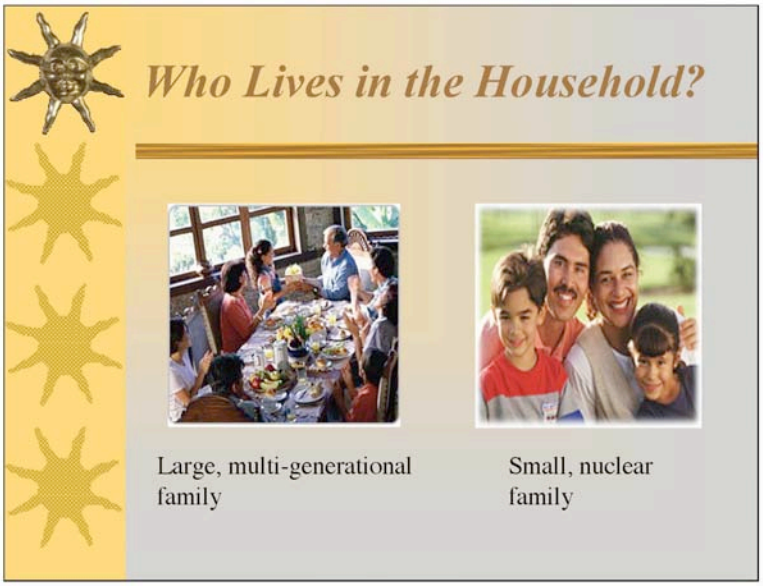

Another dimension that varies across and within cultures is the composition of the household. The traditional pattern for Latinos is to live in multigenerational households. While this may not always be the case, it's important to find out who the child lives with. Since the success of any follow-up treatment will depend upon the cooperation of the members of the household, it's important to identify who they are.

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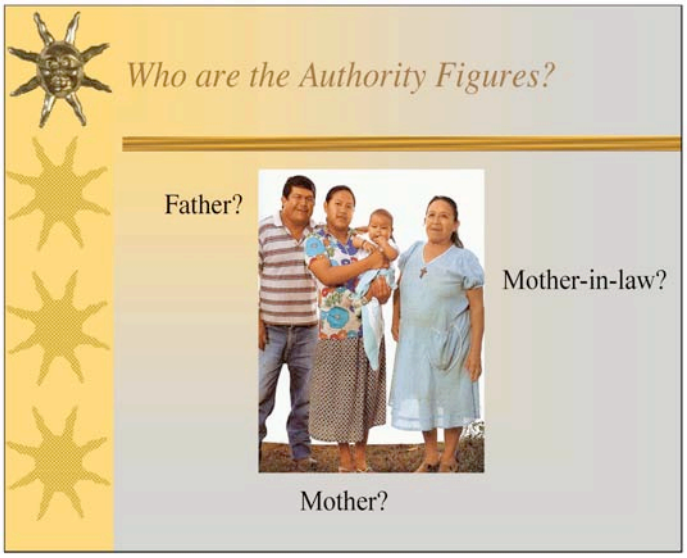

This raises the issue of who has the authority. After more than 3 decades since the Women's Movement, I like to think that men and women have equal authority in this country. However, it is not unusual in Latino, Asian, and Middle Eastern families for the man hold the position of authority.

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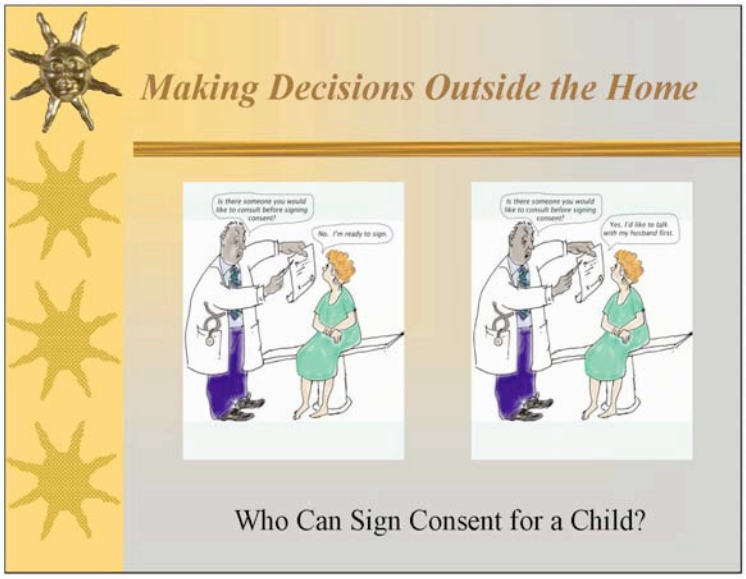

When it comes to making decisions outside the home, the husband and father will often be accorded that responsibility. This can be an issue when it comes to signing consent for a procedure to be performed on a child. The mother might not feel empowered to make major health care decisions for her child. You may just have to wait until the husband or another family member arrives. What if the situation is urgent, and you can't reach the father? Sometimes there's something you can do. There was a case at another LA hospital where a young female resident needed to get permission for an LP. The mother refused, wanting to wait for her husband to make the decision. Rather than wait, the resident went to an attending. The mother still refused. They went to an older attending. She still refused. They finally got her to agree when they had a 75 year old male physician talk to her. Residents shouldn't take it personally if they're young, especially if they're female – patients may not trust you to make decisions.

How will you know who will be signing consent for a child? Ask. When a child is admitted, talk to the parents. Find out whom you will need to talk with to get consent. In some families, either parent will say they can make the decision, in others, it may be the

father, or perhaps less often, the mother. But if you know in advance, it could end up saving a lot of time.

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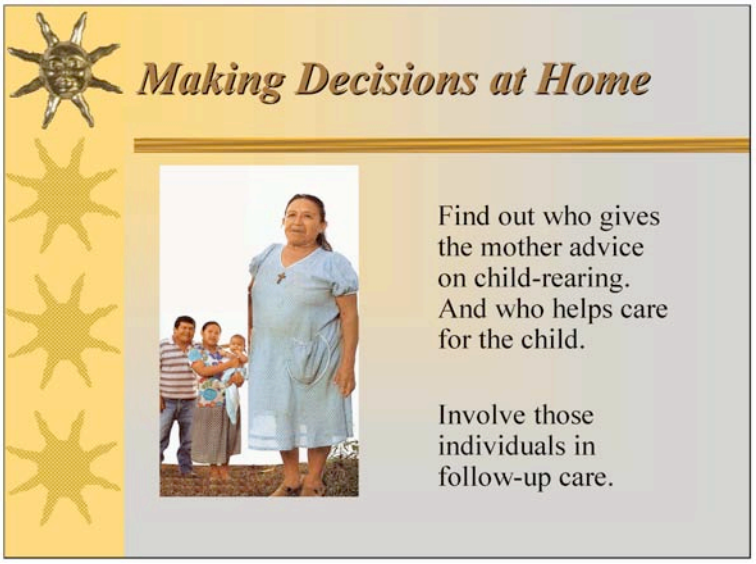

While men are often the authority figures outside the home, the situation may be very different within the home. Women are often in charge of the day to day care of the children, as well as responsible for their healthcare. But the child's mother may not always be that woman. Often times the child's grandmother will be the major influence within the household. Ask the mother who gives her advice about her child. Does that individual live in the house with them? If so, try to include that person in any follow-up care. If possible, try to involve all family members in patient teaching and make sure they all understand the importance of what you're recommending. Since older siblings are often responsible for child care, they should also be included in any teaching.

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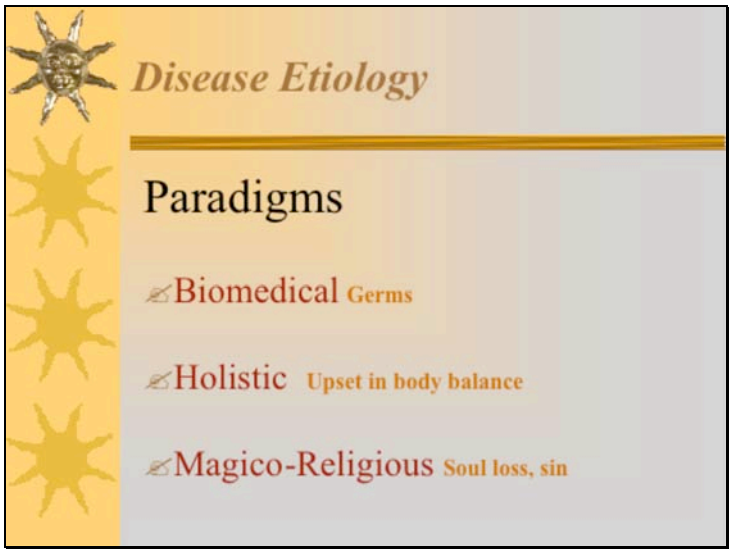

A major concern for most physicians is a patient's lack of adherence to medical recommendations. As I mentioned earlier, one reason for that might be that your treatment makes no sense in the context of their understanding of disease. You've all been trained in the biomedical paradigm. Germs -- viruses and bacteria -- are seen as a major source of disease. The proper treatment thus involves destroying the germs through the use of such tools as antibiotics.

However, some of your patients may hold a different model of disease. They may follow the holistic paradigm and understand disease in terms of an upset in body balance. According to this model, illness can result from such things as strong emotional states, or a dietary imbalance. This is usually conceptualized in terms of hot & cold within Latin American countries, or yin and yang within Asian countries. A medication that was once used to successfully treat a "hot" condition will often be considered "cold," and thus inappropriate for cold conditions.

A third common paradigm is the Magico-Religious paradigm. Health & illness are thought to be the result of outside forces, whether through the ill will of another, or through the will of God. This view is often held by people who feel as if they have little

control over their lives or their health and can be exacerbated by such factors as poverty or prejudice … which probably describes most of your patients. A classic example is the case of Lia, a young Hmong child and the subject of the book, "The Spirit Catches You and You Fall Down" by Anne Fadiman. Despite the well-intentioned expertise of the physicians caring for this young girl with epilepsy, everything goes wrong, in part because the physicians view of her disease -- epilepsy -- is so different from the family's understanding of her condition, which is called, not epilepsy, but "the spirit catches you, and you fall down." It is a sign that the individual may have the power to become a shaman, to perceive things others cannot see, as well as enter into trance states in which they can journey to the other world and heal people. The seizures are seen as a calling as much as an illness. So you can imagine the mixed feelings the parents had regarding treatment.

Again, if you want to improve the chances of adherence, you need to understand how your patients view their illness, and speak to them from that context. How will you know how the patient views their illness? Ask. What do you think is wrong? What do you think caused it? And I want to emphasize the importance of your tone and attitude when you ask these questions. They can't just be another item on the checklist. Most patients will be reluctant to share information they think might be met with ridicule. You need to ask with real curiosity and no judgment.

And keep in mind that many people adhere to multiple paradigms, so just because a patient wants antibiotics, doesn't mean they're not going to pray in the hopes that God will heal them.

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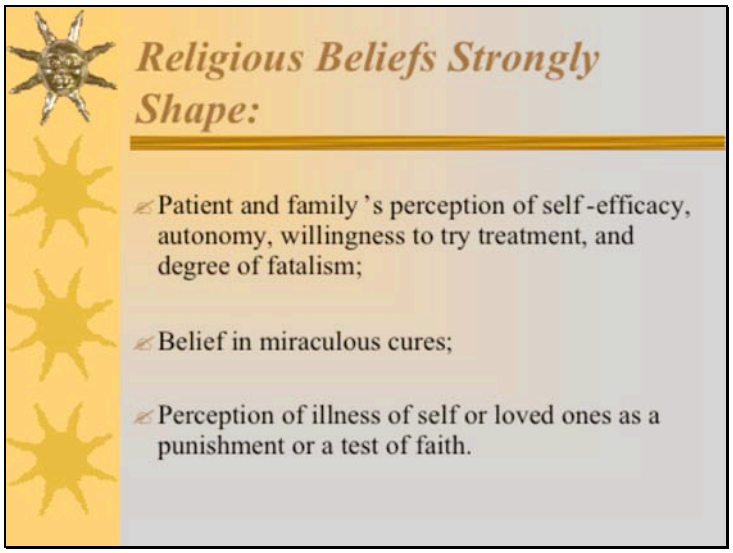

Illness and suffering have been part of the human experience throughout our species' history. And we are a species that is impelled toward assessing the meaning of our experiences and our existence. Every culture erects a philosophic framework into which existence, suffering, and death acquire a cultural logic…and this is most clearly found in religion.

The impulse toward fatalism is deep and strong, whether it is expressed as the will of God, as in Christianity, or the mechanisms of Karma, as in Buddhism and Hinduism. Reflecting on most of human history, we can see why this is so…not much could be done about illness and suffering, and death is still inevitable.

While in the Western cultures that has changed somewhat, in many cultures from which our immigrants are drawn, resignation is still the most sensible response to severe illness or disability. This can greatly impede a patient's or family members' ability to adopt a belief in their ability to change what they see as an inevitable train of events. It may be necessary to confront this fatalism with a concrete listing of steps that need to be carried out, by the clinician or by the patient/caretakers, with clear benchmarks for incremental positive effects along the way.

The hope for miraculous cures is founded in a similar world view. Just as an inevitable sequence of events cannot be stopped by those afflicted, a reversal is possible through the intervention of supernatural beings, such as saints or the Virgin (or an avatar of Buddha) that can intercede with the power that set the events in motion in the first place. Miracles are believed to happen though prayer or penance. The history of many religions contains reference to many miraculous cures. The Terry Schivo case, with which we are painfully familiar, is a reminder that the hope of miracles still is strong among much of the population.

Some patients or members of a patient's close family may regard illness, accident, or disability as a punishment for their perceived moral failings and may secretly carry this burden or belief, unwilling to discuss the failings that they believe caused the suffering. They may take on specific tasks, such as, common in Mexico, making a pilgrimage to a holy shrine on their knees or making promises to abandon their former immoral behavior, hoping that this will reverse the punishment.

The exception of the suffering of self or loved one as a "test" of one's faith or character is embedded deeply in many cultures…remember the book of Job in the Old Testament? Remember his boils as just part of his tests of faith? Many Buddhists also believe that the calm acceptance of suffering in this life will elevate the soul to greater heights in the next.

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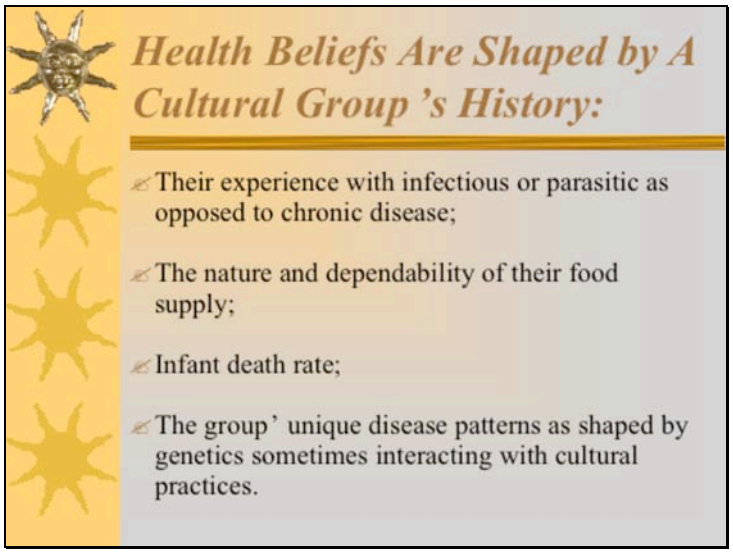

Many cultural groups from which recent immigrant populations are drawn, such as Latinos and Southeast Asians have not made what has been called the "Epidemiological Transition," that is the reduced prevalence of infectious and parasitic disease and the increased prevalence of chronic lifestyle disease such as diabetes 2, CHD, and COPD.

Most critically, their thinking around prevention activities may tend more toward short-term modalities: injections, immunization, pills and herbs, and magico-religious therapies. It oftentimes doesn't include long-term behavior or lifestyle change as preventive or therapeutic strategies.

In cultures in which famine has played a recurring historical role, definitions of good health tend to revolve around body size, particularly among babies and women: plump is definitely good. Food choice and culinary practices support this belief. Overcoming that belief is often difficult among immigrant cultures that are experiencing a more sedentary lifestyle and different food availability upon migration to the U.S.

When the group has historically experienced a high infant death rate, the loss of very young child is sad but common experience. Studies have also shown that in very poor

cultures, babies that have difficulty thriving are often paid less attention than those who seem to have more resilience.

We are learning that genetics does play a significant role in the disease profile of a cultural group. The storage diseases such as Tay Sachs have had such an effect on Ashkenazi Jews that they have energized around elimination of the gene through genetic education programs.

Cultural practices, possibly interacting with genetics, often produce prevalence patterns that affect family dynamics within a cultural group and family dynamics are important in a patient's overall prognosis and response to treatment. A case in point is the 25% lifetime prevalence rate of alcoholism among Mexican American men which often results in precarious and unstable family circumstances, particularly for adolescents. The very high prevalence and early onset of clinical depression among Mexican American women is another epidemiological pattern that could affect care in pediatric patients.

Most ethnic groups have unique epidemiological profiles which have the potential to affect a groups beliefs and practices around health issues

Club feet are more common in some African groups…so much so that these groups believe that such an occurrence is not a difficulty but a sign of special spiritual abilities have been bestowed on the club-footed child.

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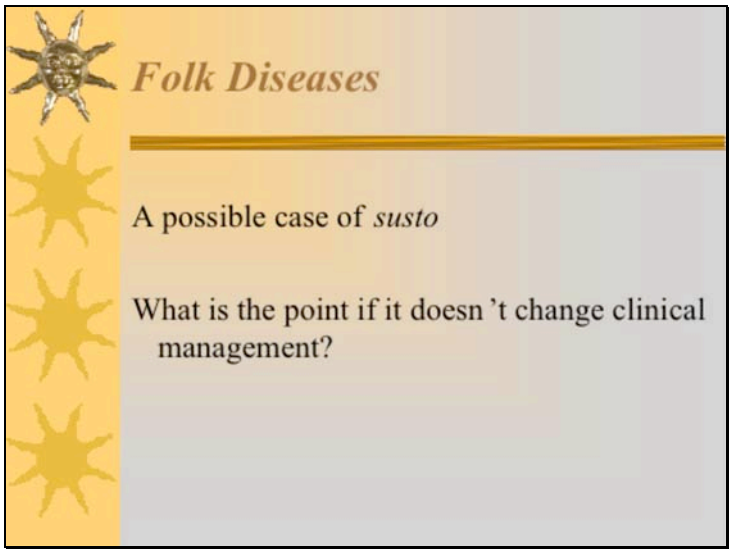

One of the topics you can read a lot about in the literature is folk diseases. Simply put, these are a constellation of symptoms that are labeled as a disease within the culture, but generally not recognized as such outside the culture. I've rarely heard physicians or nurses report having seen such cases, but after what we saw here on rounds, I suspect that they may be much more common that I had thought.

The case I'm referring to involved a young boy presenting with cyclic vomiting. [He also had numerous other problems related to premature birth and failure to thrive.] The mother reported that the episodes had occurred in conjunction with specific events. The first was when he saw his dog run over in the street and he watched his father carry the dog's bloody body into the house. The second was when a friend of the family was shot while he was standing next to him. Just before his most recent admission his father informed the family that he (dad) was moving back to Mexico. On the day of admission, his teacher yelled at him for something that he did wrong. His mother was called to pick him up from school for vomiting. Jean and I both immediately shared a single thought: *Susto*. This is an Hispanic folk disease in which a shock -- such as the ones the boy experienced -- causes the soul to leave the body. No one mentioned *susto* -- not the mother, nor the attending, nor the interpreter. Jean and I wanted to, but as observers, didn't feel it was

our place to do so. But we left wondering, what if the attending had said something like, "That sounds like it could be *susto*." Perhaps the mother didn't see it that way. But what if she did? Would it have changed the clinical management of the boy's condition? Probably not. His symptoms were treated successfully. But what might it have done for the relationship between the patient and the physician?

We tend to think that everyone respects the knowledge of doctors, but that's not always the case. What if you had just moved to a foreign country and were diagnosed with soul loss by the traditional healer who was held in high esteem by all the villagers. Would you be impressed with his diagnostic skill, or would you think he's not very smart and doesn't really understand what's going on? Might some of your patients feel the same way?

No one is expecting you to work within the health model of your patients, but by showing some respect and understanding for it, you will greatly increase their trust in you.

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We've prepared a handout on several common Hispanic folk diseases, which you can look over at your leisure. One other one I'd like to mention, however, is mal de ojo, or evil eye. This is a disease recognized in a variety of cultures, from the Mediterranean to the Middle East to Latin America, as well as some parts of the Philippines and Ethiopia. It is believed to be caused by envy, and given when complimenting a child. It is based on what anthropologists call a theory of limited good. That's the idea that there's a limited amount of good stuff -- health, beauty, intelligence -- in the world, and if your child has some, there's less for my child.

One of my medical students was doing a rotation on the pediatrics unit at an LA hospital, and was learning how to perform a newborn exam. The attending started to explain what is important to look for on the physical exam, and proceeded to ask her questions. As they were talking, the patient's mom came over to the crib. In an attempt to welcome her into their conversation, the med student said "hello," and proceeded to complement her on her beautiful child. As soon as she finished the sentence, the mom said "thank you," but her demeanor changed; she stopped smiling, and looked nervous. The med student soon realized that this family was Mexican, and her complement, intended as a tool to

gain the mother's trust, resulted in causing her distress. Remembering what she had learned about Mexican culture and "*mal de ojo*," she touched the baby's hand, and looked back at the mother. The change was dramatic - the mother smiled back at her, and nodded her head. She didn't say anything, but her smile and nod clearly communicated her gratitude removing the curse.

So, if you're complimenting a Mexican child and the family does not speak English and do not appear to be acculturated, it wouldn't hurt to touch the child. If you notice them wearing something like the item pictured, attached to their clothing, or a red ribbon or string around their wrist, this is their way of protecting their child against the evil eye of strangers.

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Most people, probably including you, will try home remedies before seeing a physician. Many cultures have discovered numerous herbal remedies which people may grow in their own gardens or obtain from a neighborhood or professional healer. These plants may be used as first aid, to treat wounds and burns, aches and pains, upper respiratory infections, earaches, and chronic conditions. Some of these remedies are safe and efficacious, and may successfully treat the problem. Others may be safe but ineffective, and there are some, including greta and azarcón, which can cause lead poisoning. In your packet you'll find a chart of some of the more common Latino herbal remedies with some notations as to their safety and efficacy. It's important that you know what your patients are taking, since its possible that some products may interfere with medications you're prescribing. For example, there are some Chinese herbal products that contain the prescription diabetes drugs, glyburide and phenformin. If you prescribe medications to treat their diabetes as well, they may be taking an overdose.

What you can say to your patients (or parents) is something along the lines of:

Many of my patients will try home remedies before coming in to see me. Oftentimes they are effective and can save them a trip to the doctor. However, it's important that I know what you've been using, because this may affect what I prescribe for you.

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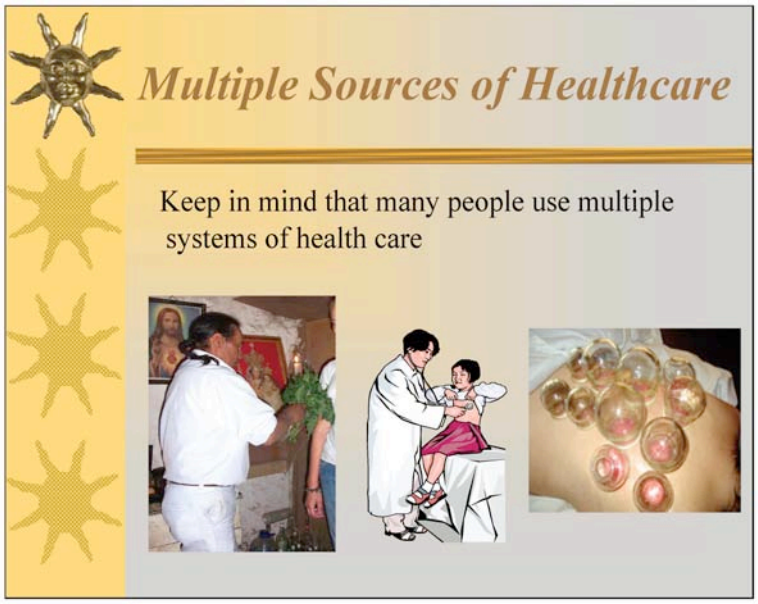

As many people hold multiple paradigms of health & illness, many also use multiple health care systems. It's called "medical pluralism." They may see a *curandero*, acupuncturist or other type of traditional healer, as well as seeing a biomedical physician. There is a lot of cross-pollination, and it's not uncommon to find Mexican patients using traditional Chinese medicine. But again, it's important to find out what else they've tried.

You need to convey three things:

- That you expect patients will try alternative treatments
- That it's okay for them to do so
- That it's important that they share that information with you

But what if you don't believe in any of these alternative treatments? Realistically, you will probably not change your patient's attitude, especially if it's something they've grown up with. If you convey your negativity, all you will likely do is alienate your patient. What you want to do instead is make sure they don't do anything harmful, and allow them to continue anything that may be helpful or at least neutral. Many treatments,

even if they have no proven pharmacological value, may have psychological value, and allowing your patient to continue to use them will help you gain their trust.

Let them know that your primary concern is their health and well being, and that you will not look down on them or criticize them for anything else they do, as long as they tell you about it.

You should be aware that in Mexico, it's common for pharmacists to prescribe drugs and thus many patients are used to buying drugs from storefront botanicas. Unfortunately, there are a lot of unscrupulous fake doctors and pharmacists out there, selling drugs to patients that may not be up to FDA standards. Dosages may vary considerably, and there may be a problem with counterfeit drugs. However, they are often cheaper than buying reputable pharmaceuticals, which contributes to their appeal. It's therefore extremely important that you make your patients feel comfortable enough to share the information with you.

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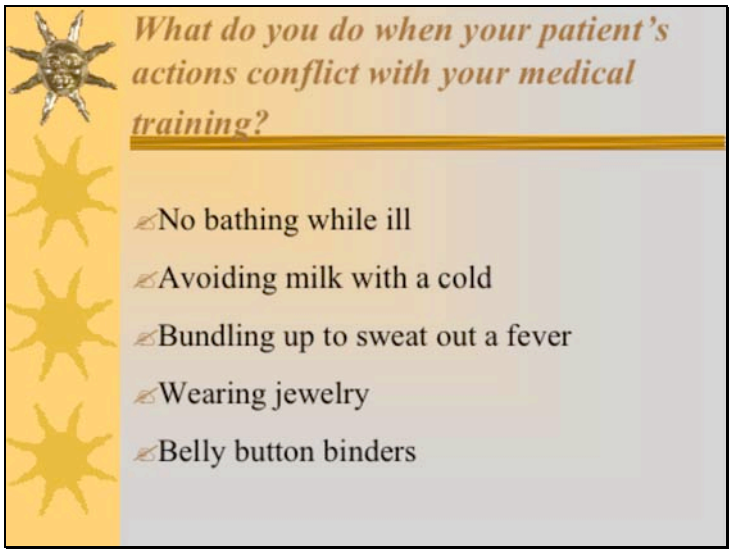

You may find that your patients do things that conflict with your medical training. For example, when a child is sick, they may believe that you don't give him a bath. Or if a child has a cold, they may not give him milk, believing that the milk will create more mucous. Or when a child has a fever, they may bundle him up with lots of clothes and blankets. Often times it will be a grandparent who is giving a young parent this advice.

What do you say? Basically, you need to do a risk/benefit analysis. If it's not going to hurt the child, don't worry about it. Avoiding milk for a few days if the child is well-nourished is not going to cause a problem. But telling them that their beliefs are wrong, may cause a loss of trust, or alienate the grandmother, who can be a key resource for you. If the medical risk is truly significant, then ask about their concerns, and make sure they understand (using an interpreter if necessary) why you want them to do something that goes against their beliefs.

There are some other traditional Hispanic practices which often cause concern among pediatricians. For example, belly button binders, which are commonly used to prevent an unsightly "outie." Your concerns should be with the cleanliness of the coin and the

tightness of the binder. Rather than telling them not to use a binder, teach them to make sure the coin is clean and the binder is not too tight.

Then there's the issue of jewelry. It's common for Hispanic babies to wear pierced earrings. (I remember my Sephardic grandmother saying that it was good to pierce baby's ears because it let out the evil spirits.) If you notice earrings on the young girls in the family, talk to the mother about making sure the ear is pierced under clean conditions. Babies will often wear necklaces as well. Standard teaching is that babies should not wear necklaces. But is there any evidence of a 3 month old strangling from a necklace? Have you ever seen one who has? The chains are usually very fine. But if you're too uncomfortable with it, you can recommend that they remove the necklace before the baby goes to sleep. The same is true for charms to protect against the evil eye.

A lot of pediatricians will tell parents point blank not to do any of these things … but the risk of problems is very low, while the risks attending loss of trust in the physician is high. So pick your battles carefully. And keep in mind that most of these practices are very widespread and have been followed for many generations. If they regularly led to injury or illness, it's very unlikely that they would be continued.

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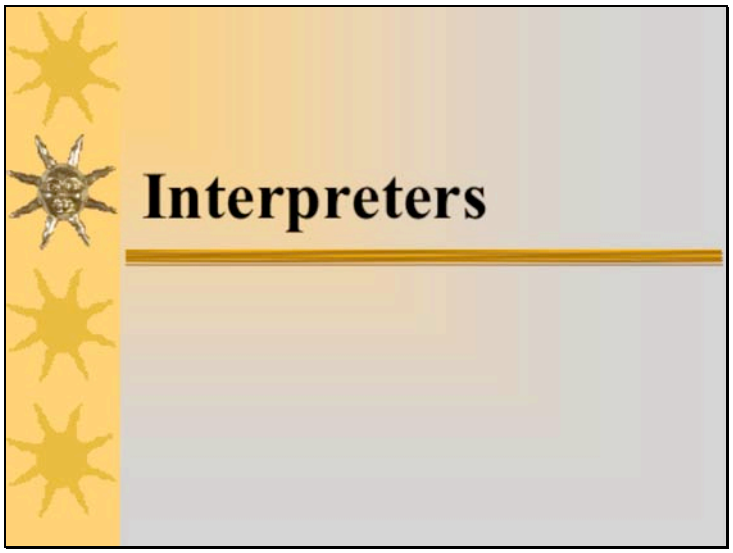

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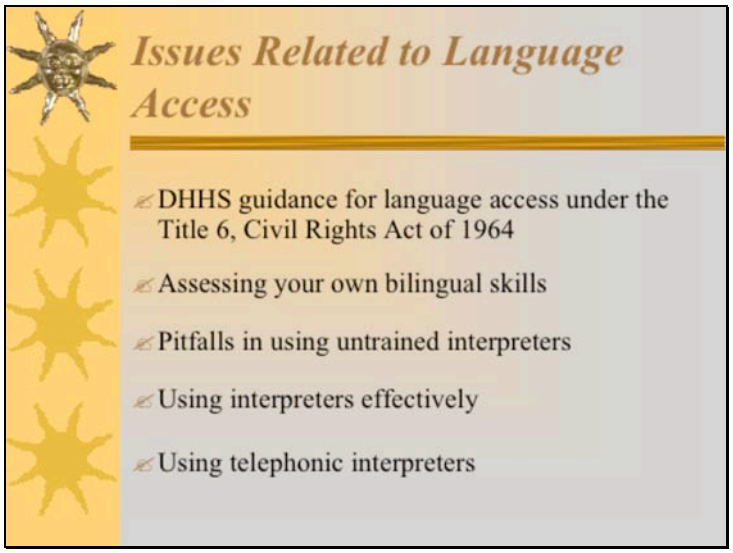
Issues Related to Language Access
DHHS guidance for language access under the Title 6, Civil Rights Act of 1964
Assessing your own bilingual skills
Pitfalls in using untrained interpreters
Using interpreters effectively
Using telephonic interpreters

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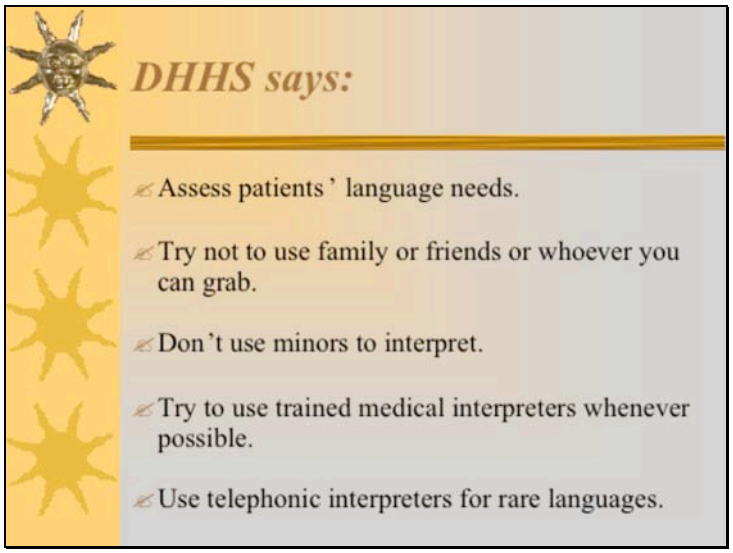

Each hospital, health plan, or clinic receiving federal funds is bound by the language guidance given by DHHS Office of Civil Rights.

Various means of assessment are used: most common is a mandatory field on patient demographic data base.

There is currently a California Senate Bill under consideration (Yee) that forbids the use of minors for interpreting elaborating on the federal guidance.

County/USC currently has trained over 100 staff persons who do interpreting and plans to train more.

It's impossible to have staff interpreters fro every language; telephonic interpreting fills the need for uncommonly encountered languages.

If an interpreter is not used, this must be recorded in the patient's chart. If an interpreter is used, record the interpreter's name.

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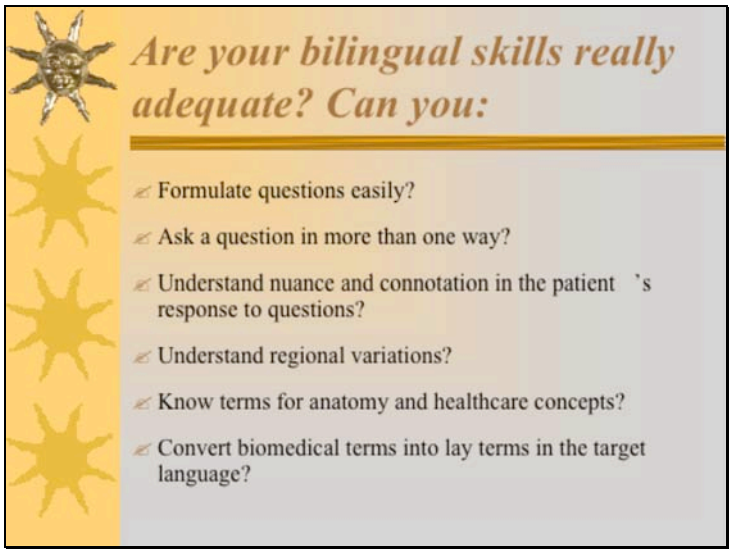

It's easy to be over-optimistic about your skills in another language, particularly when it takes time to find an interpreter. Dr. Eric Hart of Boston City Hospital, who has studied this issue, warns against this strategy.

Be sure, for example, that you can differentiate between past, present, and future verb forms. If these aren't used correctly, it can be confusing to patients in understanding, say, a treatment plan. Best practice: while learning the language, have an interpreter back-up present.

Don't hesitate to ask a patient to slow down if you are only picking up pieces of what s/he is saying.

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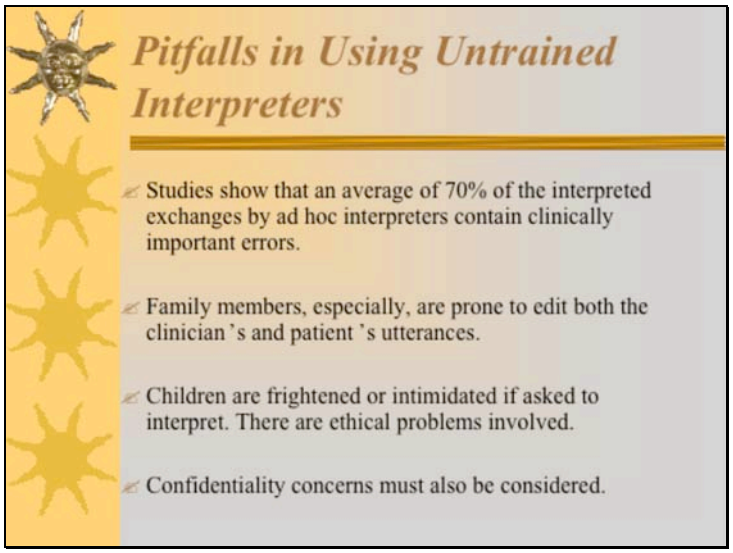

Many of the numerous errors were unintentional: omissions, inaccurate word substitutions, mistranslations of anatomical parts, etc.

Intentional editing is more common than you might think: the family or friend interpreter may want to shield the patient or may even have a personal agenda and so edits what the clinician is saying. On the other hand, they may not tell the clinician all of what the patient is saying out of embarrassment or because they don't want the doctor to know all of what the patient is disclosing.

Children who interpret for parents often experience uncomfortable role reversals. If the topic is delicate or serious, they may be too embarrassed or too nervous to interpret well.

Recent confidentiality regulations call into question the appropriateness of using casual interpreter substitutes.

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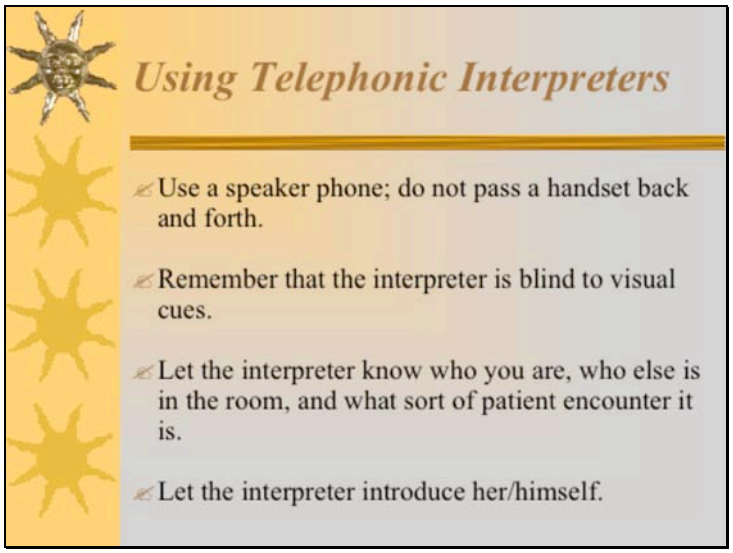

Properly used, a speaker phone works very well in an interpreting situation. Many facilities have a well-maintained speaker phone on a cart that is used only for telephonic interpreting.

At County USC hospital, various other technologies are in use at different locations: duel headsets and hands free telephones. Pet Delgado, the Hospital Administrator, is looking into bringing in VMI: Video Medical Interpreting.

One sentence can orient a telephone interpreter: “Hello interpreter, this is Dr. Jameson. I have Mrs. Gupta and her daughter here for Mrs. Gupta’s first visit following her gall bladder surgery.”

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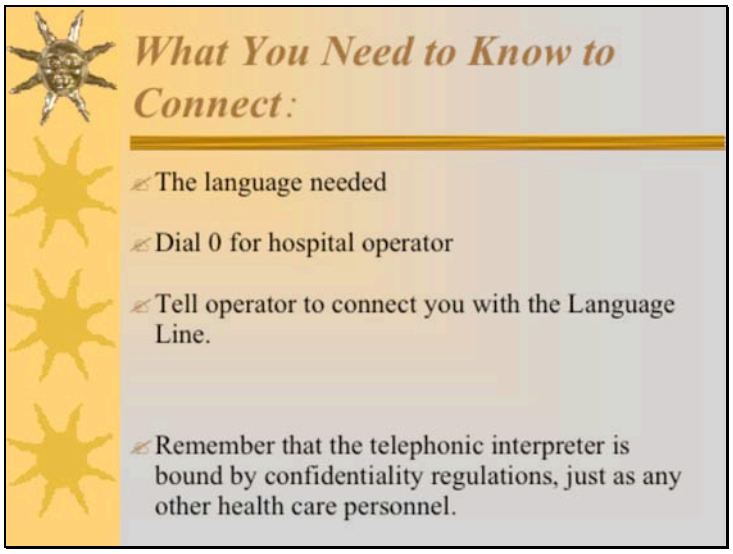

The process of obtaining a telephone interpreter usually takes about 40 seconds.

Over time, use of telephone interpreters becomes much easier and seems less impersonal.

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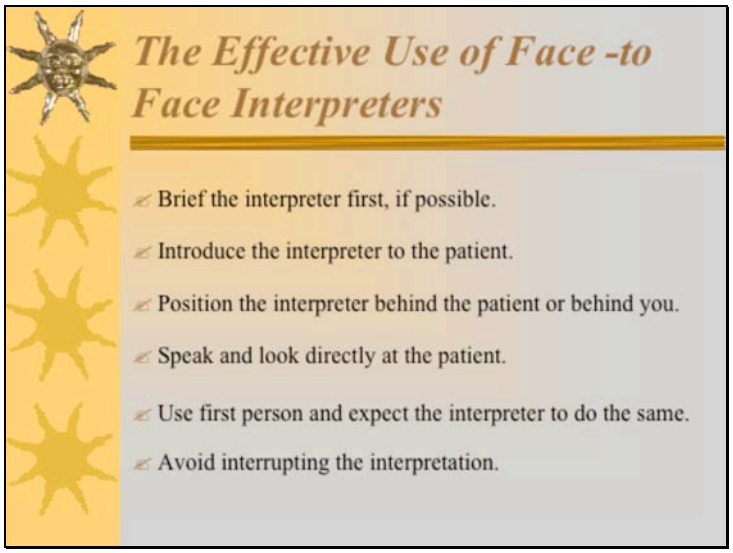

It's good, if possible, to meet the interpreter outside the room where the patient is. Briefly tell the interpreter what is going on, for example, history-taking, treatment planning, consenting, etc.

Usually it's important to get the patient to agree to the use of the interpreter: "This is Gloria Morales, out interpreter, she'll help us talk to each other, if this is ok with you.

It's not good to have the interpreter positioned in such a way as you will be attempted to address your remarks to her/him. This makes the patient feel left out.

Why first person? It keeps you in control of the conversation and focuses the encounter on your interaction with the patient. It may seem awkward for you and for the interpreter at first, but it results in greater accuracy in the interpretation, for example, fewer additions and omissions.

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It may seem as if we've given you a lot of information today. That's because we have. But it all boils down to a few simple points. Assuming that your primary goal is to help your patients get well, and that in order for them to do that, they may need to adhere to your recommendations for follow-up treatment, there are a few things you need to remember.

A key point is the importance of building rapport. If your patients trust you and like you, they will be much more likely to do what you tell them.

You want to try to get at the patient's understanding of disease as well as the kind of barriers they may face regarding your treatment. The best way to ascertain this is to ask the right questions. In your packet, we've provided two sets of questions: Kleinman's 8 Questions, and a condensed version which uses the mnemonic The 4 C's of Culture.

You need to understand something about family dynamics, including the authority figures both within the home in terms of child care, and outside the home when it comes to such issues as signing consent. How will you find out such information? Simply by asking.

Use interpreters when you are not fluent in your patient's language, and use them appropriately. In your packet there is a set of Tips on Using Interpreters.

Finally, know something about the cultural beliefs of your patient. To that end, we've provided a list of resources, including books, articles, films, and websites. We've also included information on a number of cultural competency courses you can take for CMEs.

In addition, we're providing you with a special gift for being part of this pilot program to bring cultural competence into the LA County Health Care System. That's the pocket handbook, Cultural Sensitivity. It's designed to fit into your pocket, and give you quick access to the common cultural patterns found among nine broad ethnic groups. Consult it before you go on rounds. But remember, your patient is an individual and may not fit the cultural patterns described. Use it to get a sense of some of the possibilities you might consider when treating your patient.

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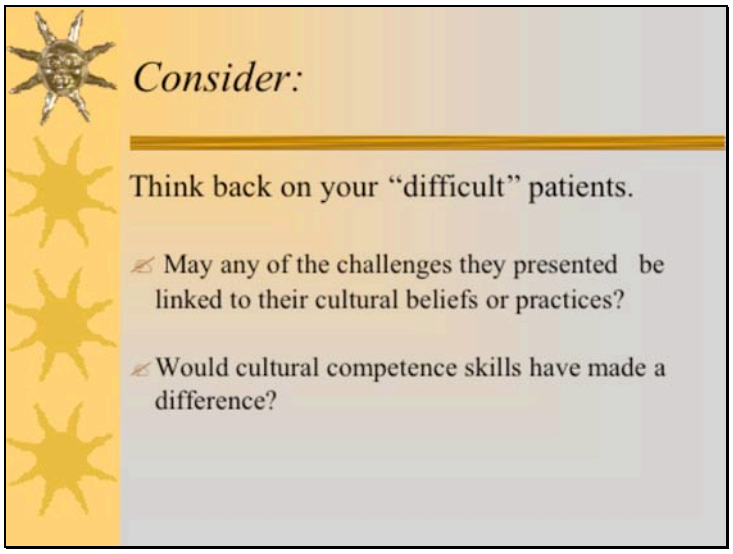

We hope you've all enjoyed and learned from today's presentation. But more importantly, we hope you will integrate what you learned into your clinical practice.

Think back on your "difficult" patients.
May any of the challenges they presented be linked to their cultural beliefs or practices?
Would cultural competence skills have made a difference?

We think the answer is YES.