

ClaimsRx

clinical & risk management perspectives

August 2008

Moving Toward Cultural Competence

CME Information

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Learning Objectives

In the context of culturally and linguistically diverse providers and patients, the participant will increase patient safety and reduce liability exposure by:

- Advancing the goal of mutual understanding and full patient participation in medical care and treatment (e.g., informed consent) through cultural competence.
- Providing appropriate interpretation and translation services for patients with limited English proficiency (LEP).
- Reducing communication breakdowns among health-care team members, using appropriate training on roles, responsibilities, expectations and chain of command.

Target Audience

All healthcare providers.

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Introduction

Over 30 percent of individuals now living in the United States are not Caucasians of Anglo-European heritage. That percentage is expected to rise to 50 percent by 2050.¹ As the number of patients from diverse ethnic and cultural heritages steadily increases in the United States, the issue of cross-cultural miscommunication in the healthcare setting becomes increasingly important. Research indicates that cultural differences between

patients and their healthcare providers influence communication and clinical decisionmaking.² Misunderstandings based on cultural differences can affect core aspects of providing healthcare, including informed consent, pain relief and medication prescription.³ Consequently, achieving an appropriate level of cultural competency has become a necessity for service providers in today's healthcare environment.

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Although the general focus of cultural competency law and literature is on the relationship between the provider and patient, similar issues can arise among members of a healthcare team who have culturally diverse backgrounds. This *Claims Rx* provides strategies for understanding and responding appropriately to cultural and linguistic differences healthcare providers encounter among their patients and coworkers.

What is Cultural Competence?

At present, there is no universal definition for cultural competence. For purposes of this article, the term refers to a healthcare provider's ability to respect and respond to the specific needs and preferences of ethnically, culturally, racially and/or linguistically diverse patients and coworkers.

Cultural competence goes far beyond providing interpretation or translation services. Here are examples of culturally-associated patient beliefs that might challenge Western-educated providers:

- Wellness and illness are caused by spirit possession of the body
- Healthcare decision-making must be accomplished by family agreement, a shaman or a clan leader
- Personal modesty prohibits being treated by a member of the opposite sex
- Talking about illness or death might make it happen
- Loss of a body part prohibits the person from passing into the afterlife
- Looking into the eyes of a stranger is a sign of disrespect
- An animal sacrifice will promote wellness

Optimal treatment of patients holding such beliefs may require finding ways to allow their beliefs and practices to be part of their healthcare.

Generally, one cannot attain a level of cultural competence without a conscious effort to do so. Even with education and training, it is practically impossible for a provider to become competent in every culture he or she might encounter in a medical practice. Fortunately, a variety of healthcare-related cultural competency resources are available:

- The L-E-A-R-N Model of Cross Cultural Encounter Guidelines for Health Practitioners, available on the DiversityRx website at: www.diversityrx.org/HTML/

MOCPT2.htm (accessed 6/14/2008). L-E-A-R-N stands for Listen, Explain, Acknowledge, Recommend and Negotiate.

- A Physician's Practical Guide to Culturally Competent Care, a free, online continuing medical education (CME) course available on the website of the U.S. Department of Health & Human Services Office of Minority Health: <https://cccm.thinkculturalhealth.org> (accessed 6/14/2008).
- Quality Care for Diverse Populations, a web-based training program developed by the American Academy of Family Physicians (AAFP) to assist physicians and other health care professionals in becoming more culturally proficient. It is available on the AAFP website at: www.aafp.org/online/en/home/cme/selfstudy/qualitycarevideo.html (accessed on 6/14/2008).
- Culture Clues™ tip sheets designed to increase clinician awareness of cultural concepts and preferences of patients from diverse cultures, including Korean, Chinese, Latino and Somali. They are available on the University of Washington Medical Center website at: <http://depts.washington.edu/pfes> (accessed on 6/14/2008).

Although many of these resources refer to characteristics, perspectives and beliefs that may be shared by members of a particular culture, NORCAL does not intend to promote the perpetuation of stereotypes of individuals based on cultural backgrounds. Patients should be considered first as individuals, not as representatives of their culture or race.

Persons with Limited English Proficiency (LEP)

Approximately 300 different languages are spoken in the United States. According to the United States Census Bureau, in 2000 nearly one in five people, or 47 million U.S. residents, had limited English proficiency (LEP), basically meaning they spoke a language other than English as their primary language at home. That was an increase of 15 million people since 1990.⁵ This growing language diversity requires that healthcare providers implement methods to ensure that their patients can understand what is being said. As the following case indicates, failure to provide a qualified interpreter to a patient who does not understand

English can have a tragic outcome and can result in a costly lawsuit.

Case Study #1

Allegation: *Failure to provide appropriate interpretation during the informed consent process resulted in a patient having her leg amputated without her consent.*

The patient, a 62-year-old woman, had immigrated to the United States from Laos in the 1980s. She spoke Hmong, but was unable to read or write the language. She neither spoke nor read English. She had a history of diabetes, hypertension and kidney problems.

She presented to the hospital emergency department for foot pain due to a sore that was not healing. After admission, she was provided with various forms to sign by a hospital employee who spoke only English. Because the patient could not read the forms and could not understand the employee, she refused to sign.

(Tens of thousands of Hmong-speaking individuals lived in the vicinity of the hospital and many of them relied on its services. The hospital was beginning to develop patient-education materials in Hmong but had no consent forms or other materials available yet. Although there was a detailed policy on providing interpreters to patients with LEP, the hospital had no qualified Hmong interpreters available on staff. Instead, the hospital frequently used a Hmong-speaking employee or a relative of the patient to interpret for Hmong patients.)

The next morning, the patient was diagnosed with a life-threatening infection necessitating debridement and the possible amputation of her foot or lower leg. Shortly before her operation, she was approached by the surgeon and a female Hmong-speaking staff member whom the patient had observed emptying garbage cans earlier. She was presented with a consent form. Through the staff member, the surgeon told the patient her foot wound needed debridement and that he might have to amputate both her foot and leg, depending on how advanced the infection was. The patient, however, thought that the doctor was seeking permission simply to clean her foot. She initially refused to sign the consent form, but after repeated assurances from the staff member that it was only for permission to clean the foot, she signed the form.

The patient was placed under general anesthesia. The surgeon, who thought the patient had consented to a

possible amputation, determined that her lower leg needed to be amputated and did so. The patient woke up and discovered the amputation. She began crying uncontrollably. An interpreter was then called in from the hospital's interpretation service. Through the interpreter, the patient was able to express her anger and grief over having her leg amputated without her permission. The surgeon, seeing the patient's reaction to the amputation, realized that something had gone wrong during the translated pre-operative consent discussion. Subsequently, the surgeon fitted the patient with a prosthesis.

Following the amputation, the hospital continued to treat the patient without an official interpreter, except for isolated incidents. On numerous occasions, the hospital required that the patient's son or daughter act as an interpreter.

The patient and her husband filed a lawsuit against the hospital and doctor based on the following claims:

1. Battery: The patient's leg was amputated without her consent.
2. Violation of state and federal civil rights laws: The providers discriminated against the patient by failing to provide adequate interpretation services.
3. Negligence: The hospital negligently failed to supervise, train, hire and retain managers, staff, agents and contractors to ensure that interpretation and translation services were readily available at the hospital.
4. Negligent and intentional infliction of emotional distress.
5. Violations of state and federal privacy regulations: While they were translating, family members had gained access to proprietary medical information.

After multiple depositions, a government investigation, mediation and various court hearings, many of the claims against the hospital and surgeon were dismissed. However, faced with defending numerous violations of its own policies on providing translation for patients with LEP, the hospital settled for an undisclosed amount. The physician, whose only defense was that he had believed that the patient knew what she was consenting to, also ultimately settled.

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Discussion

During the patient's deposition, she admitted that she would have consented to the option of amputation if someone had told her that it might prove to be the only way to save her life. Although the hospital contracted for interpretation services at the time of the incident, the hospital had relied on a staff member to interpret who happened to speak Hmong to some degree. Whether this person was competent to interpret was never established; her identity was not disclosed in the patient's medical chart, her consent form or in the hospital's interpreter log.

During the litigation process, it became clear that the healthcare providers who treated this patient had violated several of the hospital's policies on providing competent interpreters to patients with LEP:

- The providers did not have the patient sign a consent form in the patient's primary language.
- After the consent form had been translated orally, the staff member who had translated did not sign the required confirmation on the form that the document had been translated entirely and accurately in the patient's primary language and that the patient had understood what had been translated.
- The providers subsequently requested that family members be used as interpreters, although in each case there was no emergency and the patient had not requested that family members be used in this way.

Had the hospital staff followed the hospital's policies and had the surgeon made a greater effort to confirm the accuracy of the translation during the informed consent process, this claim might never have been filed.

As this case illustrates, when a patient's limited English prohibits the flow of information between patient and provider, the use of an interpreter and foreign language medical forms (e.g., informed consent forms) can enhance the quality of care and decrease liability risks. Additionally, because U.S. and state regulatory agencies consider lack of language access a form of discrimination, a provider's failure to provide appropriate interpretation services can result in statutory and regulatory violations that can ultimately lead to fines and prohibition from participation in various federally funded programs (e.g., Medicare and Medi-Cal).

The U.S. Department of Health & Human Services provides detailed compliance information regarding LEP discrimination on the DHS website at: www.hhs.gov/ocr/lep/ (accessed 6/8/2008). Further guidance on federal and California state laws and regulations mandating interpretation and translation services can be found in California Medical Association On-Call document 0813 (Language Interpreters), available through the CMA website at www.cmanet.org (accessed on 6/14/2008).

Working with Foreign Interpreters

Various strategies can be used to optimize interpreted patient-physician communications in both office and hospital settings:

- Plan to spend more time with the patient than normal (interpreter-assisted communication takes more time)
- Brief the interpreter on the goal of the examination
- If appropriate, ask the interpreter for cultural input
- Assure the patient that the interpreter is bound by confidentiality rules
- Speak directly to and look at the patient, not the interpreter (e.g., "Mr. Smith, do you...?" instead of "Ask Mr. Smith if he...")
- Ask one question at a time
- Pause between sentences, questions or concepts to allow adequate time for interpretation
- Avoid medical jargon, slang or idiomatic expressions (for example, the physician might ask, "Do you have pain in your side?" rather than, "Do you have pain in your kidneys?")
- Use pictures and diagrams
- Ask the patient to repeat back what has been recommended
- When the patient appears to be struggling to understand, ask for permission to speak directly to the interpreter to determine whether something is interfering with communication.^{6,7,8}

As with all patient encounters, one in which an interpreter is used should be appropriately documented in the patient's medical record. In addition to the clinical information, include the patient's language and the interpreter's name and/or the telephone interpretation

company used. If the patient requests a family member or friend to interpret, document the request. Additionally, as appropriate comply with hospital/clinic/practice policies and procedures for providing interpreter services to patients.

Finding, Creating and Implementing Communications Solutions

There are a variety of resources available to healthcare providers seeking to address language diversity issues in their practices. In 2005, the California Academy of Family Physicians (CAFP) published "Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members." The toolkit is organized around three main steps to help providers organize and implement solutions for dealing with language barriers:

- Identify the languages current patients speak and the languages that future patients are likely to speak
- Locate interpretation services and resources and determine which ones are right for a particular practice
- Implement services appropriate to a particular practice.

The toolkit can be accessed on the CAFP website at: www.familydocs.org/assets/Multicultural_Health/Addressing%20Language%20AccessToolkit.pdf (accessed 6/14/2008).

Interpreter Resources

The following is a selection of some of the many interpretation services resources available to healthcare providers (NORCAL does not specifically endorse or guarantee the quality of the services offered by the entities listed below):

Translation Organizations

- American Translators Association (www.atanet.org)
 - Provides online directories of translation and interpretation services provided by both individuals and organizations
- National Council on Interpreting in Health Care (www.ncihc.org)
 - Provides links to healthcare interpreter associations in various states

Telephone Translation Services

- Language Line Services (800-752-6096 or www.language.com)
- Pacific Interpreters (800-311-1232 or www.pacificinterpreters.com)
- Lionbridge Interpretation (www.lionbridge.com/lionbridge/en-US/services/interpretation/medical.htm)

Additionally, hospitals and health plans may have interpreter resources that are available to physicians.

Foreign Language Healthcare Materials

There is a wealth of foreign language material available on the Internet. The U.S. Committee for Refugees and Immigrants (USCRI) has recently posted health brochures on a number of different healthcare topics in 19 different languages, including Arabic, Farsi (Persian), French, Hmong, Karen, Spanish and Vietnamese. The topics covered in the brochures include: HIV/AIDS prevention and stigma, STDs, cold and flu, tuberculosis, PAP test and mammograms. All of the brochures are available for download free of charge on the USCRI website at: www.refugees.org/article.aspx?id=1851&subm=178&area=Participate (accessed 6/8/2008).

Risk Management Recommendations

- Identify the languages current patients speak and that future patients are likely to speak.
- Develop policies and procedures for identifying patients with LEP and providing them with appropriate translation services.
- Utilize trained interpreters whenever possible.
 - The National Coalition on Health Care Interpreter Certification is in the process of developing a national certification program. Updates on the process can be obtained on their website at: www.ncihc.org (accessed 6/18/2008).
 - Develop policies and procedures for assessing the competency of translators.
 - Avoid using family members for interpretation services unless the patient requests it.
 - Children may not fully understand what the healthcare provider is saying and fail to provide an accurate interpretation. They may also be too

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embarrassed by discussion of the parent's medical condition to translate accurately.

- Some languages do not have words for English-language concepts pertaining to medical procedures. A child or inexperienced interpreter may not be able to accurately convey the intended meaning.
- Provide a translator when a patient is unable to understand the risks, benefits and alternatives of any given procedure.
 - Develop informed consent forms in the languages of prevalent patient populations.
 - Document informed refusal discussions.
- Be aware of and comply with state and federal laws that mandate translation for patients with LEP.
- Provide patients with LEP with health materials written in their own language
 - Take advantage of medical information available on the Internet in foreign languages

Appropriate provider-patient communication leads to greater patient satisfaction, adherence to medical instructions and better outcomes.⁹ Conversely, poor outcomes and professional liability is often linked to inadequate communication. Providers are therefore encouraged to take advantage of the various resources available to improve communication with patients with LEP.

Cultural Diversity in the Healthcare Team

Although cultural-competence law and commentary frequently focus on provider-patient relationships, it is also important that staff members and physicians recognize the ways that cultural differences among themselves can compromise patient safety. Cultural diversity within the healthcare team can result in a variety of difficulties, including miscommunication, gender role conflicts and physician-nurse role conflicts.¹⁰

Case Study #2

Allegation: *The patient's neurologic damage was caused by a Dilaudid® (bhydromorphone hydrochloride) overdose.*

A 25-year-old man presented to the hospital for migraine pain. The admitting orders were for Dilaudid® 2-4 mg per hour, with a 2 mg bolus and a 15-minute lockout. The physician had originally written the order for morphine but later decided on

Dilaudid. Unfortunately, she forgot to change the dosage on the order. The admitting nurse, who was new to her position and a graduate of a foreign nursing program, knew that the dosage was too high. However, in her home country nurses are trained to be submissive; questioning a physician's orders is not an accepted practice. The patient was given the Dilaudid as ordered, resulting in permanent, severe brain damage. He and his family brought a medical negligence action against his providers and the hospital, claiming the medication error caused his injuries. Due to negative reviews, the case was settled.

Discussion

At the time of this incident, it had not occurred to hospital administrators to provide the nurse with training in patient advocacy. In addition to physician authority issues, foreign-trained nurses may have opinions about teamwork, multi-tasking, the asking of questions, acceptance of assistance from coworkers, and other attitudes that conflict with the culture of the American hospital system. Language barriers among members of the healthcare team can also result in difficulties that negatively impact patient care.¹⁰ For example, a registered nurse, whose first language is not English, may have trouble discerning which drug or treatment an English-speaking physician has verbally ordered. Alternatively, a nurse may have trouble understanding a physician whose first language is not English, especially when verbal orders are involved or a stressful situation such as a code is under way.

Risk Management Recommendations

- Provide training in the culture of the American hospital system to healthcare providers who have been educated in culturally diverse environments.
 - Include training on the facility's chain-of-command policies and procedures, including when they should be utilized.
- Avoid communication methods that can lead to misunderstandings (e.g., verbal medication orders).
 - Provide written orders whenever possible.
 - When verbal orders must be provided, ensure accuracy of understanding by speaking slowly, using as few medical terms as possible, and having the recipient of the verbal orders read them back.

- When there is a question as to what a member of the healthcare team has said, ask for clarification.
- Provide opportunities for members of the healthcare team to become familiar with the diverse cultures of their coworkers.
- Foster the view that cultural diversity is an asset to the healthcare team, not a liability.^{10,11}

Conclusion

Growing cultural diversity within the patient population and the ranks of healthcare professionals can present challenges which, if not addressed appropriately, can significantly diminish quality of care and increase potential liability exposure. Developing the degree of cultural competency appropriate to a given practice is a goal that every provider can achieve.

¹ Rust G, Kondwani K, Martinez R, Dansie R, Wong W, et al. A CRASH-course in cultural competence. *Ethn Dis.* 2006 Spring; 16(2 Suppl 3):S3-29-36.

² Park E, et al. Internal Medicine Residents' Perceptions of Cross-Cultural Training Barriers, Needs, and Educational Recommendations. *Gen Intern Med.* 2006 May; 21(5): 476–480.

³ Cegala D, Post D. On Addressing Racial and Ethnic Health Disparities. *American Behavioral Scientist.* 2006; 49:853.

⁴ Examples drawn from "A Physician's Practical Guide to Culturally Competent Care", U.S. Department of Health and Human Services Office of Minority Health website. Available at: <https://cccm.thinkculturalhealth.org/> (accessed 6/14/2008).

⁵ U.S. Census Bureau Press Release, October 8, 2003. Available at: www.census.gov/Press-Release/www/releases/archives/census_2000/001406.html (accessed 1/17/2007).

⁶ Clinical Pearl: Working with Interpreters. *Ethnomed* website. Available at: http://ethnomed.org/pearls/pearl_jan06.htm (accessed 7/24/2007).

⁷ Communication/Working with Interpreters: Communications Overview Sheet. Harvard Medical School website. Available at: www.hms.harvard.edu/coewh/cultural/pdf/comminterp-overviewsheet.pdf (accessed 7/24/2007).

⁸ Herndon E, Joyce L. Getting the Most from Language Interpreters. *Family Practice Management.* 2004; 11:6. Available on the American Academy of Family Physicians website at: www.aafp.org/fpm/20040600/37gett.html (accessed 7/24/2007).

⁹ JT. Berger. Culture and Ethnicity in Clinical Care. *Arch Intern Med.* 1998; 158:2085-2090.

¹⁰ Fostering Linguistically and Culturally Competent Care. HRC Risk Analysis. ECRI. January 2004.

¹¹ Grossman D, Taylor R. Working with People: Cultural Diversity on the Unit. *AJN.* 1995 Feb; 95(2):64-67.

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Moving Toward Cultural Competence

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