

# Interpreters of Maladies: Will "Cultural Competency" Reduce Care Disparities?

by Cary Groner

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Byline: Cary Groner

In Jhumpa Lahiri's Pulitzer Prize-winning story "Interpreter of Maladies," a couple visiting India meet their driver, Mr Kapasi, who reveals that he also works in a doctor's office translating for patients who speak Gujarati rather than Hindi. The full implications of this second profession unfold in the course of the tale, as readers are shown the extent to which communication barriers exist in all cultures, often with devastating consequences.

S. Manzoor Abidi, MD, a New Jersey neurologist, can relate to Lahiri's work. He grew up in India and went to medical school there, then emigrated to the United States in 1965 when he was 25. He studied internal medicine, then psychiatry, then neurology. Abidi is now proud to call himself a "damn Yankee." His son is an orthopedic surgeon who teaches at Stanford University, and his daughter is an executive at the Gap.

Abidi is clear about "cultural competency" in his practice. He considers it vital to understand his patients, regardless of where they come from, and has zero tolerance for disparities in treatment related to ethnicity. To him, this is simply good medicine.

"Many patients from India are vegetarians, so when we see illnesses such as peripheral neuropathy, we may think diabetes or Guillain-Barre when we should think deficiency neuropathy instead," Abidi said. "Similarly, if you have a stroke patient in the Indian, Chinese, or Japanese population, small-vessel disease inside the head is more likely responsible than narrowing of the carotid artery. Wherever you grew up, you have your own risk factors."

## Disparities in Care

Recent studies have illuminated the degree to which cultural and language barriers may lead to poorer care for minorities. A 2002 report from the Institute of Medicine (IOM) documented evidence of consistent and significant disparities in quality of care according to race, even when insurance status, income, age, and illness severity were comparable.<sup>1</sup>

Another study by the Agency for Healthcare Research and Quality reached similar conclusions.<sup>2</sup> Examples of disparities include the following:

- Minorities and poorer patients are less likely to receive cancer screening and tend to have more advanced-stage cancer at diagnosis. For example, late-stage breast or colorectal cancer is more likely to be diagnosed in minorities than in whites.

- Poorer patients receive recommended diabetic services less frequently and are more likely to end up hospitalized for diabetes and its complications.

- Hispanics are less likely to receive optimal care when hospitalized for myocardial infarction.

- African Americans and poorer patients have higher rates of avoidable hospital admissions, partially as a result of not receiving as much routine care as their white counterparts, which may be attributed to lack of health care coverage among many of these patients.

In a 2004 position paper, the American College of Physicians (ACP) offered further examples. Although the mortality rate for heart disease is 50% higher among African Americans than among whites, the rates for angioplasty or bypass surgery among African Americans are 50% lower than those among whites.<sup>3</sup> Although state-of-the-art clot-buster drugs are given to 59% of white men for treatment of myocardial infarction, only 44% of African American women receive them for this condition.<sup>4</sup>

The IOM report, titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, outlined a variety of possible sources for these problems. Some relate to health care systems and include cultural or linguistic barriers; system fragmentation (eg, that minorities may be disproportionately enrolled in lower-cost health plans with more limited services); and treatment location (minorities are less likely to get their care in a doctor's office).

## Taking Action

In its position paper, the ACP proposed a variety of solutions, including affordable health coverage for all Americans, mobilization of health organizations to redress problems, and physician training to improve physician-patient communication and provide culturally competent care. In addition, the ACP encouraged increased diversity in the health care workforce partly because, for example, minority physicians tend to see more minority patients than do other physicians and such concordance is associated with significantly higher patient

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satisfaction.

Last January, the AMA, the National Medical Association, and the National Hispanic Medical Association joined with leaders from physicians' organizations and other groups to launch the Commission to End Health Care Disparities.

The goal is to educate physicians and other health professionals about care disparities and develop interventions to address them.<sup>4</sup>

Large insurers and managed care organizations, including Aetna and Kaiser Permanente, have begun initiatives-Kaiser has established its own Institute for Culturally Competent Care, for example-and state legislatures have jumped into the fray. In January 2005, New Jersey mandated cultural competency training for licensure, and in October, California gave weight to an earlier law by mandating that beginning in July 2006, all continuing medical education (CME) courses include curricula that address cultural and linguistic competency. Medical schools and residency programs are increasingly making cultural competency part of routine training, and the American Medical Student Association (AMSA) has devoted extensive resources to promoting the idea. For a list of resources, visit [www.amsa.org/ programs/gpit/cultural2.cfm](http://www.amsa.org/programs/gpit/cultural2.cfm).

### Evolving Ideas

In the medical community, this burst of activity is being received with a mixture of elation and irritation. Part of the problem is that there are a number of different ideas about what, exactly, cultural competency is. The AMSA defines it as "a set of academic and personal skills that allow us to increase our understanding and appreciation of cultural differences between groups." The objective, in any case, is to improve communication and trust between physicians and patients, increase clinicians' knowledge of epidemiology and treatment efficacy as they relate to different ethnic and cultural groups, and expand their understanding of patients' cultural behaviors and environment.<sup>5</sup>

Ideas about cultural competency are evolving rapidly. As Joseph Betancourt, MD, MPH, a leader in the field, wrote in the *New England Journal of Medicine* in 2004,<sup>6</sup> "Culture is a pattern of learned beliefs, values, and behavior . . . it includes language, styles of communication, practices, customs, and views on roles and relationships. We all belong to more than one culture . . . social, professional, or religious; the concept goes beyond race, ethnic background, and country of origin."

Betancourt's colleague and frequent collaborator,

Alexander Green, MD, MPH, is a senior scientist at the Institute for Health Policy at Massachusetts General Hospital in Boston. "Cultural competency has broadened in its perspective," Green said. "The idea that you could learn everything you need to know to take care of all the cultures you might encounter has started to go by the wayside as new groups emigrate to this country and the situation becomes more complex. It's helpful to know certain things, but if I walk into the office and see a patient whose culture I'm totally unfamiliar with, I should still be able to provide good care."

The field has grown from a knowledge-based, culture-specific construct, that is, and has become more skill-based, Green explained. It now refers not only to physicians' interpersonal skills but also to a range of features involving systems and organizations. "When you talk about a hospital or managed care organization, does it have systems in place that make it culturally competent?" Green asked. "Those could include good interpreter services, ways of being more available to different patient groups, and diversity within the organization in terms of leadership and staff."

Green and Betancourt also have advanced the idea that social factors should play a more prominent role in cross-cultural medical education.<sup>7</sup> "Cultural competence is often taught as separate from social factors, but you really have to integrate the two," Green said. "If you're a medical student training in an impoverished place, with people from many different cultural backgrounds, there may be a lot of social barriers to care. It's not clear which are culturally based and which are based on limited resources and lower socioeconomic conditions. If a patient isn't taking medication, is it a cultural bias or is it just that they can't afford it? Social factors can be more relevant in some scenarios."

Cultural competency has begun to merge naturally with patient-centered care. "Health professionals should take patients' perspectives, needs, and concerns into account as individuals," Green said. "It just tends to be more pronounced, and more important, the more different the perspective is from that of the health professional. If a patient from Cambodia comes to see a white doctor, the doctor may not be as aware of the types of issues that are important to that individual. The idea of patient-centered care is that you find out what is important, you build a relationship, and you try to provide care tailored to their needs."

### Ethics

In individual cases, physicians say that while cultural

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competency stands to improve care, it also elucidates the difficulty of navigating certain situations. Consider the case of Lia Lee, a 3-month-old Hmong child with epilepsy.<sup>8</sup> Her American doctors prescribed a complicated drug regimen to control her seizures, but her parents didn't give her the medication as indicated because of the therapy's complexity and side effects. Because they believed the problem was caused by her "losing her soul," they took her to a shaman, sacrificed animals, and took other steps traditional in their culture. Because of this, Lia's doctors thought she was endangered and had her placed in foster care.

Proponents of cultural competency believe that better communication between the doctors and the family could have prevented such drastic action. Still, doctors enter tricky territory when they must balance respect for different cultures against their own beliefs in the most effective therapeutic approaches.

"In situations where the law is clear, as sometimes comes up with Christian Scientist parents, there's not much room for debate," said Green. "If a young child is endangered by the parents' denial of treatment, the state has the right to step in. People over 18 can refuse treatment as long as they are psychologically capable of making that decision."

Green added that if physicians haven't established a trusting relationship with their patients, they are less likely to find out about alternative approaches that may be complicating their own treatment efforts. "If you don't know what your patient is doing, you can't do anything about it," he explained. "And if you're perceived as closed-minded, patients won't tell you. So you have to have that open relationship so that once you find out about something like that, it's a negotiation process. You might say, 'We've found a danger with these remedies, and I'd suggest you try this medication instead. Or if you prefer an herbal remedy, maybe we can find one that isn't dangerous.'"

Green has had good communication with herbalists about some of his patients and, in fact, has found that problems usually arise only if the allopathic doctor doesn't accept that there's any other way to do things (see also, "Integrative Medicine Gains a Mainstream Foothold," *Applied Neurology*, October 2005, page 16).

### Communication

Communication is at the heart of good care, of course, and it takes many forms. Recent research found that patients with limited English proficiency (LEP) experienced more barriers to care and increased risk of adverse reactions to medication compared with those who are fluent in

English.<sup>9</sup> Another study found that inpatient hospital stays for people with LEP were roughly 6% longer than those for patients proficient in English, although LEP did not affect in-hospital mortality.<sup>10</sup>

However, as noted, in the arena of cultural competency and ethics, decisions can become less clear-cut. Situations in which family members want to withhold troubling information from others occur in many cultures. In one case, a 49-year-old Chinese woman living in the United States was diagnosed with metastatic lung cancer. Her 22-year-old son felt responsible for her care and did not want her to learn of the diagnosis. When the cancer spread to her brain, her doctors suggested a do-not-resuscitate order, which the son refused; he accused the physicians of racism and threatened litigation.<sup>11</sup> In a similar case—that of an elderly Italian woman with metastatic colon cancer—her son requested that her physician not tell her the truth because he thought it would destroy her hope.<sup>6</sup>

Green said that although individuals may waive their right to receive information, in such situations he tries to talk to the family about the issues. "Sometimes they simply don't understand there is actually a good treatment for the condition and that this may not be a fatal diagnosis," he said. "So you can solve the problem before you go back to the patient."

If this approach fails, Green asks the patient what role he or she would like the family to take in the decision-making process. "The family might be presuming that the patient wants them to withhold information when, in fact, the patient doesn't want that. That's when you run into the ethical problem, because you have to listen to the patient, and then there needs to be a discussion with the family. That is oftentimes tense."

### Dealing with Cultural Stigmas

Craig Hou, MD, an assistant clinical professor of neurology at the University of California at San Francisco, grew up in a Chinese American family in Los Angeles. He now focuses on racial and ethnic issues in dementia and sometimes encounters the stigma associated with mental illness in Asian cultures. This makes him careful about terminology.

"In Chinese, a common term for dementia translates literally as 'old person's stupid disease,' and I still hear family members use that term," he said. "Instead, I'll use a phonetic translation of Alzheimer's disease, or tell them that their family member has memory loss without using the term 'dementia,' so I can avoid the stigma."

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Hou also tries to educate patients and their families about the fact that cognitive symptoms are not signs of mental illness. "There's a strong tradition of family pride, and if they know that the problem is organic-biological-it's easier for them to accept it and buy into the treatment plan," he said.

In the same vein, Hou has discovered that it's best to be careful how he questions patients. "I can just ask my Caucasian patients, 'Do you feel depressed or sad?'" he explained. "In some of the Chinese population you have to get at it indirectly. I might ask, 'How is your appetite? Your sleep? Your energy level?'"

In terms of alternative modalities, such as Chinese medicine or herbology, the first thing Hou does is assess what patients are using; then he evaluates the safety of those agents. When he suspects that the medicines are unsafe because of their side effects or because of contamination, he asks his patients to stop using them. In other cases, even though he may doubt the effectiveness of traditional approaches, he lets patients use them if he anticipates no harm or no negative interactions with the medications he prescribes.

### Backlash and Compromise

Hou attributes his expertise to a combination of training and personal background. Abidi feels the same way. "You learn cultural competence in the lap of your grandmother, not in a classroom," Abidi said. He credits his grandmother in India with imbuing him with egalitarian values as a child.

But Abidi also recognizes that not everyone has the benefit of such an influence and that cultural competency may be a valid subject for some CME training. As an advisor to the state of New Jersey, he helped steer the legislation away from stipulating a mandatory classroom requirement in favor of CME credit for the coursework. In its recent legislation, California took a similar tack.

Some physicians bristle at the notion that they have to learn cultural competency. In his Web log, Robert Centor, MD, an internist at the Veterans Affairs Hospital in Birmingham, AL, noted that although cultural competency is a good idea in theory, "we must worry about what [these] courses would mean in practice."

Speaking from his office, Centor said, "I deal with Southern culture, so I know rural African American culture, rural white culture, urban African American culture; I learned those, and when I don't know, I ask somebody. A course isn't going to help you do that; you learn it as you go by talking to other doctors and nurses. All residency programs

are like that, because doctors want to understand their patients."

Green, who with his colleague Betancourt put together a CME-accredited cultural competency e-learning program ([www.qualityinteractions.org](http://www.qualityinteractions.org)), acknowledges that physicians may rebel against a perceived force-feeding of cultural competency. He doubts that will happen because the training tends to be engaging. "Everyone who has taken our program has found it really useful and interesting," he said.

Similar courses are proliferating. The US Department of Health and Human Services, through its Office of Minority Health, has contracted with Science Applications International Corp. of Falls Church, VA, to produce a cultural competency course, according to Project Director Ann Kenny ([www.thinkculturalhealth.org](http://www.thinkculturalhealth.org)).

Extensive information and learning tools are also available at Diversity Rx ([www.diversityrx.org](http://www.diversityrx.org)) and from other sources.

As the United States grows increasingly heterogeneous, everyone stands to benefit, whether from the broad perspective of a wider variety of cultures from which to draw strengths and ideas, or from the simple pleasure of having a better selection of ethnic restaurants. Physicians want to match that breadth with quality health care, and cultural competency-in whatever forms it takes-will provide them the tools to do so.

Cary Groner is a freelance writer in northern California.

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