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Linguistic and Cultural Competency

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Linguistic and Cultural Competency

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The U.S. population is becoming more diverse and cultural and linguistic barriers may adversely affect the quality of health care for some individuals. Cultural and linguistic competencies are now a high priority for national health policy. Research commissioned by the American Society of Radiologic Technologists indicates that diversity among patients is a leading health care trend that will have an impact on radiologic technologists in the immediate future.

This ASRT Directed Reading Classic was originally published in Radiologic Technology, *July/August 2005, Vol. 76/No. 6.*

After completing this article, readers will be able to:

- *Summarize national health policy regarding cultural and linguistic competencies.*
- *Explain the benefits of understanding other cultures and languages.*
- *Describe how to deal with potentially challenging situations a registered technologist may encounter when caring for a patient from a different culture.*
- *List the Culturally and Linguistically Appropriate Services standards that are mandatory for all agencies receiving money from federal sources.*

As the U.S. population becomes increasingly diverse, linguistic and cultural competencies take on a more important role in society. It is especially important to improve linguistic and cultural competencies in health care. Clear and unimpeded communication between the patient and the health care provider is essential to delivering good care and achieving positive outcomes.

Cultural competence is defined as a set of congruent behaviors, attitudes and policies coming together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.[1] Linguistic competence is defined as providing readily available, culturally appropriate oral and written language services to limited English proficiency (LEP) patients through bilingual and bicultural staff, trained medical interpreters and qualified translators.[1]

Cultural competence policies and practices are not without their share of controversies. Several vocal groups have taken a position that because the United States is an English-speaking country, "English-only" policies ought to be adopted, and people who immigrate to the United States should learn about and adapt to this country. Those advocating an English-only position make some very powerful arguments, including the "melting pot" view of the United States and the idea that others have assimilated into American society. However, those who use this argument fail to account for the fact that although assimilation occurs, it does not happen instantly. English-only advocates also have operated on the erroneous assumption that English is the official language of the United States. The United States has never adopted an official language at the national level.[2] The truly compassionate position is to aid those who are ailing, regardless of the language they speak. Communicating and relating to the individual are the most effective means of helping the patient medically and improving outcomes.

Learning about other cultures and then demonstrating cultural competency is difficult. Although people may desire to be sensitive, there is a fine line between being culturally aware and ethnic stereotyping. Certainly mistakes are bound to be made in the process. However, health care workers should strive to improve substandard treatment and trust levels.

As the largest and oldest professional society for medical imaging and radiation therapy professionals, the American Society of Radiologic Technologists (ASRT) plays a leading role in raising the awareness of the importance of linguistic and cultural competencies, increasing sensitivity to patient needs, educating practitioners about these competencies, and recruiting and retaining minorities in the profession.

Linguistic Competency

Linguistic competency is an important aspect for any organization seeking to be culturally competent. Language is an important part of culture; linguistic competency is critical. Perhaps the most apparent measure of the increased cultural diversity in the United States is in the growth of the LEP population. According to the 2000 U.S. Census, approximately 18% of households spoke a language other than English at home, up from 14% in 1990 and 11% in 1980. Eight percent of households in the 2000 Census also reported an ability to speak English as "less than very well." In California, New Mexico, Texas, Arizona, New York, Hawaii and New Jersey, more than 25% of households reported that they were LEP households.[3]

The increase in the number of LEP patients presents significant challenges in the health care field. An incident originally reported in *Medical Economics* in 1984, still frequently cited, describes a patient who was brought to an emergency room accompanied by his Hispanic mother and girlfriend. The mother and girlfriend told the physicians and medical staff that he was *intoxicado*, which means nauseous in Spanish. The hospital staff, who did not speak Spanish, assumed, based on being told the patient was *intoxicado*, that the man was drunk or on drugs. This is known as a "false cognate" (ie, when there is a similar English word with an entirely different meaning). Two days later the patient experienced respiratory arrest and was found to have multiple hematomas and brainstem compression. He ended up a quadriplegic and sued the hospital, the paramedics and the physicians involved in his case. He was awarded a settlement that could eventually reach more than $70 million.[4]

Frequently, institutions rely on bilingual individuals untrained in health care or on bilingual family members to facilitate communication between health provider and patient. In the past, researchers identified a number of problems associated with the use of interpreters who lacked health care experience. For example, inexperienced interpreters have omitted questions about drug allergies; instructions on the dose, frequency and duration of antibiotics; and directions for fluid rehydration. Interpreters have instructed patients not to answer personal questions posed by the health care provider. In 2003 the Department of Health and Human Services estimated that interpreter errors accounted for multiple mistakes and that two-thirds of interpreter mistakes had negative consequences for patients.[5] Language barriers may even keep LEP patients from making appointments for preventive care.

In recognition of the increasing percentage of the population classified as racial or ethnic minorities, Congress mandated the creation of the Office of Minority Health (OMH), part of the Department of Health and Human Services, in 1994 through the passage and signing of Public Law 101-527. The office was tasked with developing the capability of health care professionals to address linguistic and cultural barriers to health care delivery and increasing access to health care for LEP individuals. Additionally, the mandate directed OMH to support research, demonstrations and evaluations to test new and innovative models aimed at increasing knowledge, and provide a clearer understanding of risk factors and successful prevention strategies for minority populations.[6] Congress further encouraged OMH to take additional steps to improve the ability of health care workers to deliver services in the native languages of LEP populations as part of the implementation of the Disadvantaged Minority Health Improvement Act of 1990.[6]

To further address language barriers in the delivery of services to LEP individuals, Executive Order 13166 was issued in 2000. The order mandated that each federal agency examine services provided and develop and implement a system by which LEP individuals could meaningfully access those services consistent with the fundamental mission of the agency. The order also required each federal agency to ensure that recipients of federal financial assistance provide meaningful access to their LEP applicants and beneficiaries.[7] Compliance requirements were broad. All federal, state and local government agencies and any public or private entity that received federal money were required to implement this executive order.[8] Given that most health care facilities accept patients with Medicare and many facilities also treat Medicaid patients, this order affected practically every health care provider and facility.

Besides English, the most frequently spoken languages in the United States are Spanish, Chinese, French, German, Tagalog (official language of the Philippines), Italian and Vietnamese.[5] These are by no means the only

languages spoken in this country. Health care facilities are required to accommodate individuals with LEP when a significant population speaking a certain language resides in the service area of the facility.[7] Executive Order 13166 brings agencies in compliance with Title VI of the Civil Rights Act of 1964.

Cultural Sensitivity

Sometimes it is not enough to be linguistically competent or even have a bilingual family member present to assist with patient communication. Often a failure to appreciate cultural norms in a given ethnic group can cause problems. For example, a Hispanic woman had to sign an informed consent document for a hysterectomy. The patient did not speak English, and the hospital staff relied on her bilingual son to serve as the interpreter. When the son explained the procedure to the mother, he appeared to translate accurately and indicate the proper body parts. His mother signed the consent form willingly. The next day, however, when she learned that her uterus had been removed and she could not bear children, she was very angry and threatened to sue the hospital. In this case, the son was embarrassed to discuss reproductive organs with his mother – it may have been inappropriate for a Hispanic man in this family to do so. The son instead had explained to his mother that a tumor would be removed from her abdomen and pointed to the general area where surgery would be performed.[9]

This incident is an example in which simple translation is not enough, and some knowledge of the culture would be helpful. Even speaking the same language is not always sufficient. Cultural rules often dictate matters that may be discussed among people. In this situation, a bilingual female interpreter or a Spanish-speaking member of the medical staff might have provided a better translation and there might have been a different outcome. The hospital may have lost a malpractice lawsuit because a procedure was performed without informed consent. In a similar incident, a 9-year-old Vietnamese girl had to translate a doctor's personal questions to her elderly grandmother because there was inadequate staff to assist in communicating with the patient.[10]

Certain cultural traditions can lead to critical misunderstandings with dire consequences. These misconceptions contribute to a distrust of the health care system, potentially resulting in people avoiding medical care. The following cases involve the Asian tradition of rubbing a coin on the body to heal ailments; they resulted in gross misunderstandings and less than optimal outcomes:

- A nurse thought an elderly Chinese man was trying to hurt himself when she witnessed him rubbing his body with a quarter. When she took the coin away from the patient, the upset man grabbed it back and continued to rub his arms and legs, leaving dark red scratches.
- A Vietnamese girl in her first year at an American elementary school was not feeling well, so her mother rubbed the back of her neck with a coin. When the school staff discovered the welts on the girl's neck, they assumed a case of child abuse and reported the family to the authorities.

There are several variations of the coin rubbing custom, including heating the coin, all of which involve vigorously rubbing the body. This practice produces red welts that can distract medical staff from the real problem or be mistaken for some form of abuse. It is important for health care providers to recognize and become familiar with this practice.

The reaction of many Westerners to the tradition of coin rubbing presents an interesting lesson in ethnocentrism. Ethnocentrism is the perception that one's own way is superior when viewing the world or the tendency to view the world through the perspective of one's own culture. Just as a Westerner might consider the practice of coin rubbing to be abusive or self-abusive, an Asian might view the Western practice of orthodontics (wrapping thin pieces of metal around children's teeth and tightening the wires until their teeth have moved into the desired position) as an abusive practice, especially because the application of braces on the teeth is mostly for aesthetic purposes rather than healing.[9] Such issues present major dilemmas for health care workers. In most states, health care workers have a duty to report suspected abuse, especially when children are involved. When health care workers are not aware of traditional practices in other cultures, they may make improper allegations.

A patient's mental well-being plays an important role in ultimate recovery. Failure to be culturally sensitive can negatively affect the mental welfare of a patient. A case in point is when a nurse entered the room of her Iranian patient and found the woman huddled on the floor, mumbling. At first the nurse thought the patient had fallen out of bed, but when she tried to help her up, the patient was visibly upset. She spoke no English and the nurse had no idea what the problem was. The patient had been praying in the traditional Muslim manner. Because she was scheduled for surgery the next day,