By Oliver Goldsmith, MD

Culturally Competent Health Care

Many of us remember a time when patients visited the doctor with a single expectation: that we could cure their problem. That time is fading into the past as today's members and patients increasingly expect that we be sensitive to the nuances of their cultural heritage. By 2020, 35% of the American population will consist of ethnic minorities—an amount considerably higher than today's 28%.[1] Our increasing diversity means that the medical profession must adjust its methods for providing health care to accommodate different cultural attitudes.[2,3] Indeed, Permanente Medicine has already begun to develop programs that address this pressing need.

Culturally competent care requires a commitment from doctors and other caregivers to understand and be responsive to the different attitudes, values, verbal cues, and body language that people look for in a doctor's office by virtue of their heritage. The concept of tailoring health care isn't a new one; we already have medical specialties based on age and gender. Cultural sensitivity is one more dimension of that kind of refinement.

Cultural competence does not require that patients be treated by using the same methods used in their country of origin. However, cultural competency does create a compelling case for understanding the different ways patients act in a clinical setting and for communicating with patients to ensure the best possible clinical outcome.

Our increasing diversity also compels us to look within our organization to identify the opportunities available to a wide spectrum of individuals. We must ask ourselves whether our doctors and other employees reflect the communities they serve. If they do, their ability to deliver culturally competent care is enhanced; if they do not, then a chance to improve the care experience for a large portion of Health Plan members is being lost, and the organization is missing an opportunity.

American medical practitioners have worked hard to equalize care delivery across the country so that patients at any hospital in the nation can be assured of receiving high-quality health care. We are now recognizing that cultural perceptions of "quality" differ and that we therefore must rethink certain practices.

Most people intuitively understand that different cultural groups have different value systems and traditions. Health care providers should begin to familiarize themselves with these differences to improve treatment outcomes and patient satisfaction. For example, research has shown that Latino patients have a tendency to be forthcoming about the symptoms they experience and are very receptive to conventional treatments, whereas Chinese patients tend to be circumspect about their symptoms and may withhold information from the doctor if they are nervous or uncomfortable. (These patients also often prefer homeopathic remedies.) Being aware of this kind of information does not necessarily alter the way in which doctors perform their job, but the information does offer doctors a tool for evaluating whether a doctor-patient interaction in a particular situation might explain any inconsistency between the information the patient has volunteered and the findings of the examination.

Cultural competency also offers health care organizations a valuable opportunity to devote limited health care resources to the best possible use. As we look for innovative ways to guarantee that Health Plan members receive full value for their health care premiums, cultural competence will be an important way to give members a superior experience without added expense or capital investment. Cultural competency will thus produce a twofold benefit: outcomes will improve, and this improvement may encourage some members to seek more preventive care and thus reduce their reliance on costly emergency care.

Clinical research continues, but early results indicate that high-quality outcomes are directly affected by cultural competence. At a minimum, we recognize that basic diagnostic errors are possible if a language barrier exists between doctor and patient. On a more intuitive level, however, we acknowledge that the doctor-patient interaction cannot be as maximally successful if the patient feels uncomfortable because of the doctor's gender, age, tone of voice, physical gestures, or other behaviors that are meaningless in American culture but that have cultural significance for some groups.

Medical services are designed around shared cultural experiences that affect the interaction between patient and caregiver. The interaction will be more difficult if patient and caregiver come from different cultures. I have proposed that Permanente Medicine include a physician self-test to enable individual doctors to assess themselves and determine whether they need more training.

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Incorrect diagnoses or treatment instructions that arise because of cultural barriers can turn misunderstandings into serious mistakes. Patients who have an unpleasant experience as a result of cultural insensitivity (even if the treatment is successful) will not look forward to returning to their doctor and will not speak well of Permanente physicians.

Diversity is also adding a new dimension to overall patient satisfaction rankings. In addition to price, convenience, and accessibility, minority groups will increasingly assess whether an organization is addressing, or attempting to address, their unique needs. Our responsibility is to make every effort to meet these needs as part of our mission to provide high-quality care to our Health Plan members.

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Cultural competence will become increasingly important to purchasers as a way to help differentiate between highly competitive health plans. Organizations with a reputation for cultural expertise will naturally attract people who value that type of service for themselves or their family. Companies who employ culturally diverse workforces will value cultural competency because of its effectiveness in enabling employees to return to work more quickly after an illness.

Some commentators have suggested that cultural competency is merely a clever euphemism for segregated health care, in which patients of different races are induced to voluntarily separate themselves. This suggestion is very disturbing and could not be further from the truth. Patients coming to an environment specifically designed to put them at ease and offer care that is attuned to their needs have a better experience and better health. Instead of presenting a way to limit care, cultural competence provides a way to deliver maximum care.

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Improved satisfaction from cultural competence extends to minority employees as well. Given a shortage of health care workers in particular—and a shortage of qualified employees in general—employers must do everything reasonable to recruit and retain the best staff from an increasingly competitive and diverse labor pool. Making a commitment to culturally competent care is one part of an effective strategy to communicate an organization's respect for the diversity of its workforce and thus attract the most qualified staff.

Workforce Diversity within KP

Kaiser Permanente's substantial progress in creating a diverse workforce over the past 20-30 years is often cited as an example of how successful such efforts can be at large organizations that show strong leadership and support for diversity:

- 42% of our nonphysician workforce are ethnic minorities;
- Women constitute 43% of our executive workforce

In general, diversity among the Permanente physician population equals or exceeds national levels:

- Of the ten Permanente Medical Groups, one is led by an Asian-American woman, and one by an African-American man.
- We have twice as many Asian physicians as the national average;
- 32% of our physicians are female—a percentage which exceeds the national average by 10%;
- We continue to add Latino and African-American physician partners as fast as we can despite the unfortunate fact that medical school enrollment is low for these two populations. (Since Proposition 209 passed in California, enrollment of Latino and African-American students in medical schools has dropped by almost half.)

In addition, we have opened three clinical care modules that focus almost exclusively on providing culturally competent care. The first module, located at our San Francisco Medical Center, focuses on serving the Chinese-American community; another module, located at our West Los Angeles Medical Offices, focuses on serving the African-American community; and another module, located in East Los Angeles, focuses on serving the Latino community. Successful practices from these pilot locations will be used as the foundation for future modules located at additional sites.

To design these centers to meet the needs of specific populations, every detail has been reviewed to ensure that the module conforms to the expectations of its surrounding community. Signage is posted in several languages, physicians and other staff members are bilingual where necessary, and everyone participates in sensitivity training so they understand cultural considerations in the doctor-patient relationship. They also receive special training to diagnose and treat illnesses that may be uniquely associated with the community.

An equally important element of culturally competent care is expertise in diagnosing and treating illnesses known to have a higher incidence in a given population. Different minority groups may have vary-

ing susceptibility to certain ailments or may have higher susceptibility to these ailments as a result of any change to a new environment in the United States. Health care practitioners who understand these differences can more quickly diagnose these conditions and can give patients better care. For example,

- The Latino population has a 100%-200% greater prevalence of diabetes than non-Hispanic white persons and therefore is at greater risk for renal failure, congestive heart failure, and blindness. Latinos also have the highest median cholesterol level (222.9 mg/dL; 5.76 mmol/L) than any other ethnic group in America;
- Not only do African-Americans have a higher prevalence of sickle cell anemia; in the United States, African-American men have a 300% higher mortality rate from prostate cancer than white men;
- Chinese-Americans have a high incidence of somatic illness related to stress; the physical symptoms are often brought on by emotional strain the patient is uncomfortable discussing.

As part of its internal education program, Kaiser Permanente has developed handbooks that show how to better understand individual populations and the role that culture plays in treatment outcome. Permanente physicians prepared the guides, which specifically discuss Latino, African-American, and Asian-American/Pacific Islander populations. An upcoming series of booklets will discuss Eastern Europeans, women, and sexual orientation in the context of promoting effective doctor-patient interactions.

In addition, Kaiser Permanente has for the past 21 years hosted a national diversity conference, at which leaders in medicine, education, and diversity training speak to those in medicine and government about the importance of diversity in health care.

We grant physicians continuing education credits for taking diversity training, and we encourage them to take advantage of the opportunity. Beginning in 1999, elements of the diversity training courses will be integrated into all ongoing training programs for physicians, nurses, technicians, and administrative staff.

Kaiser Permanente has also established the Culturally Competent Care Institute to coordinate our efforts nationally and to bring research, fundraising, and oversight of the centers of excellence under one entity. As a result of our ongoing efforts, Kaiser Permanente has emerged as a national leader among large health plans in developing sound cultural competency programs.

National Diversity Council

Our commitment to employee diversity began more than 30 years ago through the policy of affirmative action, which Kaiser Permanente aggressively supported. In 1988, recognizing that we needed a more formal approach to setting and reaching our goals, we established the KP National Diversity Council to spur change and to provide top-level leadership. The Council is a national policy-making group that develops initiatives and goals for the organization in cultural competency, workforce diversity, and member growth in diverse communities.

As Chairman of the National Diversity Council for the next two years, I intend to use the opportunity to raise the level of importance physicians place on cultural competency.

I addressed the California Medical Association at its annual conference in November, 1999 to present the issue of culturally competent care as a primary concern of all medical practitioners for the foreseeable future.

A degree of urgency is involved in adopting this type of expertise, and I hope that our profession can move quickly to embrace its principles. We face inordinate pressures to provide affordable service; therefore, when opportunities are presented that can help us improve members' care experience solely through increased training and attentiveness, we should be willing to commit ourselves to these important changes. ❖

References
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