



THE CALIFORNIA ENDOWMENT  
*A Partner for Healthier Communities*

**Principles and Recommended  
Standards for Cultural  
Competence Education of  
Health Care Professionals**

Prepared for The California Endowment  
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Dear Colleague:

The California Endowment is pleased to share our publication *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals*. Recognizing the changing national demographics and the unacceptable disparities in access to quality health care across population groups, The California Endowment is committed to building the fields of Multicultural Health and Cultural Competence, in part through the creation of publications such as this.

The Endowment's Cultural Competence Program Area aims to advance this emerging field until culturally responsive and linguistically accessible health care is considered a basic right for consumers and an integral part of quality health systems in California. With the broad dissemination of these Principles and Standards, The California Endowment adds to its growing number of educational resources and publications designed to develop and to strengthen the ability of health care professionals and organizations to serve diverse and underserved populations.

In April of 2001, The California Endowment provided funding for Jean Gilbert and Julia Puebla-Fortier to solicit input from across the nation to develop consensus standards for cultural competence education of health care professionals. The 18-month process included the work of an expert panel, a working symposium and a listserv comment process involving numerous interested persons, experts and stakeholders. I want to recognize Jean Gilbert, Julia Puebla-Fortier and the expert panel for their work in this endeavor. I also want to commend Jai Lee Wong, Senior Program Officer, and Sakinah Carter, Program Associate, for their leadership, and Joseph Betancourt, M.D., Senior Advisor for The Endowment, and Alice Chen, M.D., Health Policy Scholar in Residence at The Endowment, for their guidance on this project.

*Principles and Recommended Standards* includes guidance on content, training methods and modalities, evaluation and qualifications of teachers and trainers. These Principles and Standards are designed to accompany the Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) adopted by the Office of Minority Health last year. We hope this publication will assist health professionals in their efforts to provide culturally appropriate education, with the ultimate goal of contributing to the overall improvement in the quality of health care for all consumers.

As this publication embodies an aggregate of information and opinions gathered from many different sources, it does not necessarily represent the opinions of The California Endowment. We hope you find this resource of benefit, and we thank you, as always, for being an important partner for healthier communities.

Sincerely,



Robert K. Ross, M.D.  
President and Chief Executive Officer  
The California Endowment



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## The Need for Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals

While attention to cultural issues as they arise in the health care of diverse populations has been a part of the training of *some* professionals in *some* schools for *some* of the time, this field has not been regularly offered or institutionalized in many courses of study for health care professionals. However, the United States has experienced, over the last two decades, the largest wave of immigration in its history. As a result, many cultural groups with diverse concepts of illness and health care are coming into our clinics and hospitals, making it increasingly important that health care professionals acquire new knowledge and competencies to meet their needs.

Additionally, there is clear evidence of large disparities in health access and status across race/ethnic groups within the U.S. population—a serious situation that calls for focused attention to the health care needs of these groups and the factors that are affecting their levels of care. The result of these circumstances is a call for educating health care professionals in the attitudes, knowledge and skills necessary for providing quality care to a diverse population—a nexus of practice patterns and attributes that has come to be known as cultural competence. The need for this type of education is seen to be important in the basic, formal education of health care professionals and in continuing education for professionals already in practice.

Numerous professional associations, including the American Medical Association, the Association of American Medical Colleges, the American Association of Medical Students, the American Academy of Nursing and the National Association of Social Workers have endorsed cultural competence education as important in the training of professionals in their disciplines. Specific practice specialties, such as the American Academies of Family Practice and Pediatrics and the American Colleges of Emergency Medicine and Obstetrics and Gynecology, have policy statements recommending study in culture and health care.

While excellent courses of study in cultural competence education have been developed in some medical schools, residency programs, nursing schools and in the programs of study for health educators, social workers and dentists, this kind of training is by no means universal nor is it standardized as to content, duration or integration into overall curricular programs. Offerings range from a one-time brown-bag lecture to a full-scale integration of cultural competence knowledge and skills infused into several years of training. For the continuing education of practicing professionals, cultural competence education is even more haphazard and varying in quality. Up until now, there have been no criteria by which to plan or assess courses of study in cultural competence. This set of *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals*, created by a diverse group of health care professionals and educators, is designed to fill that need. The project, conceived and funded by The California Endowment, was conducted by the consulting firm Cultures in the Clinic and directed by M. Jean Gilbert, Ph.D.

## The Process Used to Develop the Principles and Recommended Standards

There were several stages in the development of this publication. The first was an environmental scan of all the published and unpublished curricula and training materials used over the last three decades in medical and nursing training, social work, health education and public health (*see* appendices for a selected listing of these materials and The California Endowment's publication, *Resources in Cultural Competence for Health Care Professionals* for a more extensive bibliography). Policy statements and standards from numerous professional associations were obtained and reviewed. A contact list of several hundred educators and trainers working in the field was developed. Letters were sent to these persons inviting them to forward curricula, tools and methods they had developed. They were also asked if they would be interested in participating in an on-going dialogue that would result in the creation of standards for cultural competence education. Many responded with materials and expressions of interest.

An initial Expert Panel met in the Fall of 2001 to set the framework and direction for the work. Following this, materials were drafted and more resources gathered. In the Spring of 2002, a Working Symposium of 40 physicians, nurses, medical anthropologists, health educators, behavioral health professionals and association representatives from all parts of the United States met for two days. This multicultural group of individuals were persons who had in-depth experience and well-developed expertise in the field of cultural competence education in health care. The symposium provided opportunities to discuss critical issues, review resources and demonstrate best practices in the field of cultural competence education. Five multidisciplinary working groups were formed to meet all of one day to create criteria around the areas of content, skills, training methods, evaluation and qualifications of cultural competence education. Each workgroup summarized and discussed their work product with the full group.

Following the symposium, these summaries were posted on a Listserv for review and more discussion. Based on the materials produced by the workgroups and subsequent commentary, a first draft of *Principles and Recommended Standards* was drawn up and posted on the Listserv for review and input. Then a newly revised draft of the document was posted, and the Listserv was opened to an expanded group of persons drawn from the original contact list that had expressed interest in participating in the process. The Listserv method for circulating the document and posting responses made it possible for the many who participated to see what others had to say about the *Principles and Recommended Standards* and to comment on their observations and points of discussion. Thus, this final document is the result of research and input from numerous trainers and educators working in the field, many constituencies within the health care professions and various stakeholder groups.

## Who Are the Principles and Recommended Standards For?

The *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals* are designed to provide guidance to:

**Health Care Professionals**, to assist them in becoming aware of the depth and relevancy of cultural competence issues in the provision of quality, patient-centered care and to help them in evaluating their own needs for education and training in these aspects of health care delivery.

**Educators** in academic settings where health care professionals receive their basic training, to help them design curricula and activities that will provide comprehensive background in the skills and knowledge of cultural competence. These would include medical schools, residency programs, nursing schools, schools of social work, public health and any other basic education of professionals that provide direct services to patients.

**Trainers and Consultants** who design in-service training, continuing education workshops, symposia and conferences for the purpose of educating practicing health care professionals in culturally competent care. The *Principles and Recommended Standards* will aid them in assessing the levels and kinds of training that are required for quality training in the field.

**Administrators and Managers** who are charged with allocating resources for curricula or training students or practicing professionals, to help them understand the rationale for and components of quality education in the field of cultural competence in health care.

**Licensing and Accreditation Organizations** who oversee the credentialing of health care professionals or accrediting of the organizations in which they practice, to ensure that cultural competence education is appropriately and fully included as part of basic professional education and continuing education requirements.

**Policymakers**, to guide them in drafting requirements which include cultural competence education for health care professionals in contracts for publicly supported health care services and in creating regulations covering the quality of care provided under those services.

**Advocates**, to promote cultural competency as a specific standard of care expected of the health care professionals and organizations that serve their communities.

The *Principles and Recommended Standards* are written at a level of generality that makes them applicable to the education of all types of health care professionals, that is, persons who are charged with direct patient care and the delivery of health care services. However, the *Standards*, in particular, are specific enough to provide guidance in the design of cultural competency education with respect to content, pedagogical methods and the qualifications of teachers and trainers. Furthermore, while the *Standards* provide guidance as to the general content and organization of educational programs, they do not suggest specific disciplinary content (e.g., what types of epidemiological data, gender role issues and case studies, that might be used to appropriately flesh out a treatment of cultural competence in obstetrics and gynecology). Experts in specific health care disciplines, using the guidance supplied by *Principles and Recommended Standards*, are best able to integrate relevant subject matter into the framework suggested.



Appendices were constructed to provide resources supportive of *Principles and Recommended Standards* so that interested persons could acquaint themselves with the scope of the field and the tools and models available. A glossary of cultural competence terms is also appended.

It is critical for all audiences and users of these *Principles and Recommended Standards* to understand that it takes time to implement them in educational curricula and practice. They should be viewed as guidance for long-term, carefully planned and constructed programs to integrate cultural competence education into basic and on-going education for health care professionals.

The *Principles and Recommended Standards* are not intended for use by consumers/patients. Working with advocates and consumers, The California Endowment hopes to develop and disseminate tailored, multilingual guides about culturally competent care to patients and health care consumers.

## Guiding Principles and Recommended Standards for Cultural Competence Education and Training of Health Care Professionals

### Considerations:

In reviewing the recommendations of the Expert Panel and the work of the five Working Symposium teams that addressed standards for cultural competence education, there emerged a number of principles. These seemed to implicitly guide the development of the specific standards regarding cultural competence, including what should be taught, when it should be taught, how it should be taught and who should teach it. These underlying principles are cross-cutting and apply to various health professionals, in multiple training formats. These guiding precepts are reflected in the more specific Standards in the areas of Attitudes, Knowledge, Skills, Methods, Evaluation and Qualifications of Educators and Trainers.

### Guiding Principles

(This list is **not** ranked in any particular order.)

1. The **goals** of cultural competence training should be: 1) increased self-awareness and receptivity to diverse patient populations on the part of health care professionals; 2) clinical excellence and strong therapeutic alliances with patients; and 3) reduction of health care disparities through improved quality and cost-effective care for all populations.
2. In all trainings, there should be a broad and inclusive definition of cultural and population diversity including consideration of race, ethnicity, class, age, gender, sexual orientation, disability, language, religion and other indices of difference.
3. Training efforts should be developmental, in terms of the institution and the individual. Institutions may start out simply in their inclusion of cultural competency training as a specific area of study but are expected to build in more complex, integrated and in-depth attention to cultural issues in later stages of professional education. Trainees should be expected to become progressively more sophisticated in understanding the complexities of diversity and culture as they relate to patient populations and health care. Both instructional programs and student learning should be regularly evaluated in order to provide feedback to the on-going development of educational programs.
4. Cultural competence training is best organized around enhancing providers' attitudes, knowledge and skills, and attention to the interaction of these three factors is important at every level of the training. It is important to recognize the extensive preexisting knowledge and skill base of health care professionals, and to seek to promote cultural competence within this context.

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5. While factual information is important, educators should focus on process-oriented tools and concepts that will serve the practitioner well in communicating and developing therapeutic alliances with **all** types of patients.
  6. Cultural competence training is best integrated into numerous courses, symposia and experiential, clinical, evaluation and practicum activities as they occur throughout an educational curriculum. Attention may need to be directed to faculty, staff and administrative development in cultural competence in order to effect this integration.
  7. Following on the above, cultural competence education should be institutionalized within a school or health care organization so that when curriculum or training is planned or changed, appropriate cultural competence issues can be included.
  8. Cultural competence education is best achieved within an interdisciplinary framework and context, drawing upon the numerous fields that contribute to skill and knowledge in the field.
  9. Education and training should be respectful of the needs, the practice contexts and the levels of receptivity of the learners.
  10. Education in cultural competence should be congruent with, and, where possible, framed in the context of existing policy and educational guidelines of professional accreditation and practice organizations, such as the Accreditation Council on Graduate Medical Education, the Liaison Committee on Medical Education, the American Academy of Nursing, the National Association of Social Workers, the Society for Public Health Education and the Academies and Colleges of Family Practice, Pediatrics, Emergency Medicine and Obstetrics and Gynecology.
  11. Wherever possible, diverse patients, community representatives, consumers and advocates should participate as resources in the design, implementation and evaluation of cultural competence curricula.
  12. Finally, cultural competence education should take place in a safe, non-judgmental, supportive environment. While the *Principles and Recommended Standards* are focused on the education and training of health care professionals, the schools and organizations in which they study and work must be settings that are conducive to functioning in a culturally competent way and visibly support the goals of culturally competent care.

## Recommended Standards for the Content of Cultural Competence Education

### Considerations:

While the content and subject matter of cultural competence training/education are extremely varied, they generally fall into three general categories: Attitudes, Knowledge and Skills. Each of these areas is supportive of the other two. Like a three-legged stool, the structure would fail if one “leg” were missing. Most importantly, the knowledge and skills related to cultural competence in health care would be seriously reduced in effectiveness if a committed consciousness and receptive attitude did not underlie their use. From a practical standpoint, these three content areas are applicable in the education of all professional health care disciplines and are useful at any stage of the developmental learning process. The basic tenets of Professionalism, Patient-Centeredness and Ethics of Practice should be a consideration for all movements in medicine.

### **Attitudes:**

- Similar to all aspects of health care professionals’ continuing education, cultural competence education should be a continuous learning process as well. Cultural competence education for health care professionals should foster a lifelong commitment to learning and self-evaluation through an ability to recognize and question their own assumptions, biases, stereotypes and responses.
- Health care professionals should be encouraged to adopt attitudes of open-mindedness and respect for all patients including those who differ from them socially or culturally.
- Health care practitioners should be taught techniques that promote patient- and family-centered care, along with the understanding that effective therapeutic alliances may be construed differently across patients and cultures.
- As they learn about health care disparities and inequities and the factors that lead to unequal treatment, health care professionals should be encouraged to undertake a commitment to equal quality care for all and fairness in the health care setting.
- To actively serve this commitment, educators can teach students ways to identify systemic or organizational barriers to access and use of services by their patients and encourage them to be proactive within their practice environments to eliminate these barriers.

### **Knowledge:**

- Self-awareness and self-knowledge are the first types of knowledge cross-cultural training would seek to establish. This involves bringing to the learner's awareness internalized beliefs, values, norms, stereotypes and biases. They should be made aware of how ethnocentrism, that is, the belief that one's own culture is superior to others, operates in all cultures and encouraged to be attentive to the possibility of ethnocentrism in their own thinking. They should be made aware of how ethnocentrism may influence their own interaction with patients.
- Essential to their understanding of both themselves and their patients is an understanding of the concept of culture. The theory of culture makes clear the connections between worldview, beliefs, norms and behaviors related to health, illness and care-seeking in different populations. In this regard, practitioners can be taught to explore how their own cultures, including the cultures of biomedicine, inform their perceptions and behaviors. All people operate within multiple cultures.
- Information about local and national demographics would be part of a health professional's cultural competence education. This should include attention to specific populations, immigration and changing demographics, such as alterations in age or occupational distributions. Students/trainees should be encouraged to draw implications from this information for their current and future professional practices. Organizations should have a process in place to reassess relevant demographics on a consistent basis.
- Practitioners need to know the legal, regulatory and accreditation issues which address cultural and linguistic issues in health care. These would include such things as the position of the federal Department of Health and Human Services (DHHS) on civil rights and language access, federal and state cultural competence contract requirements for publicly funded health care and state legislation around the provision of language services and culturally sensitive health care. The DHHS Recommended Standards for Culturally and Linguistically Appropriate Health Care Services should be reviewed.
- Health care professionals need to be made aware of any cultural and linguistic policy statements or standards espoused by their own or other professional associations, such as the Society for Teachers of Family Medicine, the American Academies of Family Physicians, Pediatrics or the American Academy of Nursing. They should be given an understanding of how cultural competence fits into the goals of their professional education.
- Health care professionals should know the kinds and degrees of disparities in health status, health care access and use of preventive strategies across racial, ethnic, gender and other discrete population groups in the United States. This information should be placed in a context that allows the learner to understand how class, racial and ethnic discrimination, social variables and structural variables, including the structure of health care, contribute to these disparities.

- Health care professionals should be given a framework for exploring the family structure and dynamics, health beliefs, behaviors and health practices demonstrated in different cultures and population groups, especially those in the local areas of service.
- Practitioners should understand the concept of medical pluralism—the concurrent use of both traditional and biomedical systems of care. Familiarity with the kinds of healers and healing traditions within their communities of practice or those frequently associated with their specialty field should be discussed. Interaction with traditional healers, if possible, is recommended. Improved understanding of traditional practices does not mean endorsing them, but it can lead to improved provider-patient or provider-family interaction.
- In developing understandings about epidemiology and group health practices, the tendency to make inferences from probabilistic, group-level generalizations to individual cases, which, carelessly done, can lead to stereotyping, should be addressed. Its clinical risks and benefits should be carefully explored. Sources of within-group variation, including class and acculturation need to be clarified. A “recipe” approach to cultural and clinical descriptions of groups should be rigorously avoided.
- Emergent data, such as those being developed in genome research and ethnopharmacology, which apply to specific racial and ethnic groups, should be carefully evaluated as to their potential use in enhancing the quality of care for these groups. The positive and negative implications of these types of data for the care of diverse populations should be discussed and well understood.
- Practitioners should learn about the epidemiology of disease among specific populations, both nationally and within their local areas, and be able to use this knowledge in patient assessment, health promotion and other aspects of care. This includes an awareness of the limitations of epidemiological information for diverse populations. For example, there is not much data on epidemiological differences for ethnic sub-populations. Existing broad ethnic group data may not be able to be applied generally across sub-populations.
- Knowledge of the dangers of attempting to care for a patient whose language they do not understand well and of the problems associated with the use of family members, friends or unskilled interpreters should be part of a health professional’s cultural competence training.
- Without using a recipe approach, health care practitioners should become knowledgeable about cross-cultural variations in verbal and non-verbal communication and etiquette and be taught techniques for recovering, if they discover that they have inadvertently breached a cultural norm.
- Trainers and teachers should inform trainees of available resources, such as bibliographies, web sites, case studies and community contacts and resources, so that practitioners can continue to expand their knowledge and education around cultural issues while engaging in professional practice.

### **Skills:**

- Skills that enable health care professionals to assess their own responses, biases and cultural preconceptions on an ongoing basis are critical baseline skills to be learned.
- Providers need to be given communication tools and strategies for eliciting patients' social, family and medical histories, as well as patients' health beliefs, practices and explanatory models. Communication skills for fostering positive therapeutic alliances with diverse patients should be taught. These would include ways for assessing patients' expectations around levels of interactive formality with providers, valuing and incorporating the patients' beliefs and understanding into diagnosis, treatment options and preventive health care where possible and negotiating conflicting patient/provider perspectives when necessary.
- Health care practitioners should be taught ways of accessing and interacting with diverse local communities for the purpose of understanding their traditional or group specific health care practices and needs. Collaboration with local communities, for example, is useful in tailoring effective outreach, prevention and educational programs and materials.
- Health care professionals should be able to assess patients' language skills as they relate to their ability to communicate fully with the practitioner and staff and to their understanding of written instructions, prescriptions and educational materials. While language and literacy issues may be particularly important in working with limited English speakers, they should be considered in relating to all patients.
- Practitioners should be taught methods of *realistically* assessing their own proficiency in languages other than English and should acquire the skills for effective use of interpreters, including working with an untrained interpreter, a trained interpreter and telephone interpreting.
- Skills in accessing translated written materials through their organizations and commercial resources; as well as computer programs and web-based resources should be taught.
- Cultural competence education should foster skills for retrieving data concerning cultural issues in health care, population data and epidemiological information on the web.

### Considerations:

Cultural competence is a relatively new field and is being taught in a variety of settings and venues, from formal professional school curricula to stand-alone workshops and conferences. Though the content areas are complex and many of the subjects to be covered are sensitive, the subject must compete with others in crowded curricula of professional schools or in time-limited workshops or training modules. Students/trainees are varied in their receptivity, sophistication and educational background. Thus, careful selection of training approaches is critical.

- Recognizing that health care professionals are a large and diverse set of audiences and that achieving cultural competence is an incremental process, cultural competence education and training methods should be suited to the level, needs and learning styles of the students and trainees.
- Cultural competence training should be developmental in nature—a step-by-step process, increasing in complexity as the students/trainees acquire the ability to apply the understandings and skills in a variety of situations and settings. No brief or one-time training can meet these criteria appropriately.
- Cultural competence education is best achieved through a diverse set of training strategies; e.g., lectures, in-depth, interactive exercises and discussions, case study analysis, genograms, journal keeping, selected readings and web-based learning and data gathering, videos, CD-ROMs, DVDs and simulations.
- While many training methods as suggested may be used, the most important learning opportunities should come through experiential learning, ranging from role plays with feedback to working with diverse patients and getting hands-on experience in community settings where care is delivered to diverse patient populations.
- Ideally, cultural competence education should not be confined to one course or workshop but should be integrated into many curricular offerings and educational activities such as case discussions, grand rounds, symposia, clinical rotations, preceptorships and continuing education courses and conferences.
- Cultural competence training may best be accomplished by an interdisciplinary, multicultural team and should bring together information from different backgrounds and perspectives as it relates to patient care and health care settings. The use of community members and indigenous healers as informants, lecturers and training team members has been extremely effective in many instances and should be considered as an appropriate part of education and training.
- Faculty and trainers should articulate the attitudes engendered by cultural competency and model cultural competency skills, knowledge and attitudes so that students/trainees can learn by example.

## Standards for Evaluating Cultural Competence Learning

### Considerations:

If cultural competence is considered to be a body of knowledge and a set of skills critical to the ability of health care professionals to effectively provide quality health care to a diverse patient population, then assessment of the degree to which students and trainees actually acquire and apply the information, as with any other set of competencies, is important. Given that there are a variety of training and educational venues and modalities, assessment strategies need to be flexible and adaptable to the training circumstance.

- Evaluation of students' mastery of cultural competence attitudes, knowledge and skills should rely on a variety of techniques both qualitative and quantitative, including written examination, self-assessment and, where possible, evaluation of the application of attitudes, knowledge and skills in actual practice. Similar and consistent high-level expectations should be obtained, whether in a didactic course or in a practice setting.
- Students and trainees may demonstrate application of knowledge, processes and skills through role play, case study analysis or observed interactions with diverse patients followed by self-, peer, patient, staff, professor or trainer feedback and evaluation. Work with standardized patients and Objective Structured Clinical Examinations (OSCEs) offer similar opportunities.
- Students should be given the opportunity to self-assess their application of cultural competence knowledge and skills at various points along their educational trajectory. A developmental assessment inventory or tool may be useful in this regard. For example, The California Endowment funded a project for Stanford University's Geriatrics Department wherein providers were given tools for self-assessment.
- The effectiveness and usefulness of the cultural competence curriculum or training itself should be evaluated by students/trainees, teachers and trainers, faculty, administrators and patients, in order to refine and improve its effectiveness in developing the desired attitudes, knowledge and skills in health care professionals.
- Clearly, the ultimate test of knowledge and application of cultural competence attitudes, content and skills is in increased patient satisfaction with clinical encounters and improved health status. Efforts to test competencies in these ways are certainly desirable but may not be possible within an education and training context. Should tests of these kinds of outcome be desired, they should be designed with the same scientific rigor that any intervention is subject to, including well-designed methods to recruit, track and monitor the attitudinal, behavioral and health outcomes of patients while controlling for intervening variables.

## Standards Relating to the Qualifications of Cultural Competence Teachers and Trainers

### Considerations:

In recent years, and especially since the publication of the CLAS standards, teaching cultural competence to health care professionals has become more common in academic settings, conferences and symposia, continuing education and in-service training. However, little attention has been paid to the kinds of expertise and qualifications necessary to do this kind of training well. It is important for the trainer/educator to have credibility with the focus audience of health care professionals. Whereas in academic programs professional degrees are usually required, this is often not the case in other training arenas. The ability to provide effective cultural competence training in health care is not essentially degree dependent. It is, however, attitude, knowledge and skill dependent, and it differs essentially from work force diversity training because its focus is on the relationship between the health care professional and patient, as well as the effective organization of patient care.

- A cultural competence educator/trainer should clearly demonstrate a commitment to the attitudes and values underlying cultural competence education in health care and an ability to model their application in life-long learning and practice.
- The educator should have a thorough understanding of the concept of culture and be able to demonstrate how it is reflected in the interconnected beliefs, values and behaviors of various groups, including those involved in the culture of biomedicine. He or she should be able to analyze complex cultural situations in health care and be able to move beyond simple stereotypical assessments.
- The educator must have knowledge and skills in pertinent medical/health care content areas and be familiar with health care settings and service delivery.
- The educator should be well versed in educational methods and demonstrate strong teaching skills, be able to use a wide variety of teaching methods and evaluative techniques and be able to flexibly adapt them to the training situation and level of the trainees.
- Because the subject areas of cultural competence education sometimes involve controversial and/or emotional issues, the educator should be skilled in facilitation and management of diverse opinions.
- The educator/trainer should recognize the limits of his/her knowledge and be ready to enrich the training with contributions from community members, traditional healers and educators from various disciplines. Some of the best cultural competence information can come from bicultural individuals with a thorough knowledge of their cultures and their experiences with the health care system.

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- The educator should be able to work respectfully and well with an interdisciplinary team.
  - If teaching cultural competence in an academic setting, the educator ideally should have a professional degree, clinical knowledge and experience commensurate with the rest of the academic faculty. He/she should have a thorough knowledge of the overall curriculum design and other course offerings.
  - The educator/trainer should be well versed in the resources available for education and training in cultural competence and for enhanced learning by students.
  - There is significant and growing literature on cultural competence in health care, including a body of theory, standards, policy, legislative and accreditation requirements. The educator/trainer should be familiar with this literature.

### Words related to culture and cultural competence

**Acculturation:** The process of taking on some of the traits, values, norms and behaviors of another culture.

**Concept of culture:** The understanding that culture plays a controlling role in shaping how people perceive reality, acquire a sense of self, think, feel, behave and understand the behaviors of others. Includes an understanding that there is variation in the degree and extent of a shared culture across individuals within a cultural group.

**Cross-cultural:** Action or understanding that involves a comparison of or interaction across more than one culture.

**Cultural competence:** A set of integrated attitudes, knowledge and skills that enable a health care professional or organization to care effectively for patients from diverse cultures, groups and communities.

**Cultural effectiveness:** The ability to achieve desired results for patients through mutually satisfactory relationships between providers and patients.

**Cultural humility:** A concept proposed by M. Tervalon and J. Murray-Garcia, two physicians, which they defined as “a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.”

**Cultural relevance:** The congruence of a concept, value or behavior with a particular cultural orientation.

**Cultural responsiveness:** Ability to knowledgeably and congruently meet the needs of people belonging to a specific culture or cultures.

**Cultural sensitivity:** An awareness of the nuances of one’s own and other cultures.

**Culture:** An integrated pattern of learned core values, beliefs, norms, behaviors and customs that are shared and transmitted by a specific group of people. Some aspects of culture, such as food, clothing, modes of production and behaviors, are visible. Major aspects of culture, such as values, gender role definitions, health beliefs and worldview, are not visible.

**Ethnocentrism:** The assumption that the beliefs, values, norms and behaviors of one’s own culture are the correct ones, and that those of other cultures are inferior or misguided.

**Multicultural:** Characterized by two or more cultures.

## Other words and phrases

**Developmental:** A step-by-step process—each step building upon the one before, progressing through stages or levels on a continuum over time.

**Ethnicity:** Identity defined by membership in a specific group with a shared cultural and social heritage.

**Evidence-based:** A concept, theory, understanding or practice that is based upon scientifically established fact.

**Generalization:** A statement or description of a type, rule or quality based on deductive evidence from many cases; e.g., a prevalence or incidence rate of a disease in a specific population. Appropriate generalizations are based on scientific evidence.

**Health care professionals:** Individuals educated to provide specialized care.

**Identity:** Individuals have multiple aspects to their persons, and these aspects may be referred to as identities. The salience of identity changes in different contexts. For example, in one setting, a person's identity as a woman is more salient than her identity as an American.

**Medical pluralism:** The resort to treatment and healing from more than one medical system; e.g., the use of traditional and biomedical systems simultaneously or alternatively.

**Race:** A socially defined population that is based on distinguishable physical characteristics.

**Recipe approach:** A method of teaching about cultures that simply lists the core beliefs, values, norms, practices and behaviors of groups without consideration of factors effecting within group variation or cultural context.

**Stereotyping:** The idea that all people from a given group are the same, that there is no within group variation.

**Universal:** Traits, needs and behaviors that are shared across all cultural and racial groups, such as families, need for healing and health-seeking behaviors. The expression of universals is shaped by culture, such as concepts of illness etiology or perception of appropriate healing methods.

**Within group differences:** Cultural or biological differences across individuals within a specific ethnic or racial group. Differs from across group differences, which identify cultural or biological differences across cultural or racial groups.

1. Accreditation Council for Graduate Medical Education Outcome Project: *General Competencies*. [Outcomes@acgme.org](mailto:Outcomes@acgme.org)

Patient Care is made up of the following: (1) A commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse population; and (2) Sensitivity and responsiveness to patients' culture, age, gender and disabilities.

2. 2001 American Academy of Family Physicians (AAFP). *Cultural Proficiency Guidelines*. The guidelines were approved by the AAFP Board of Directors in March 2001. For more information, contact AAFP at 11400 Tomahawk Creek Parkway, Leawood, KS 6621 or call 913-906-6000. Web site: [www.aafp.org](http://www.aafp.org).

### Cultural Proficiency Guidelines

The AAFP believes in working to address the health and educational needs of our many diverse populations. A list of issues to consider in preparing informational or continuing medical education material and programs has been developed to ensure cultural proficiency and to address specific health related issues as they relate to special populations of patients and providers. The list, while perhaps not complete, is meant as a dynamic template to assist those developing Academy material and programming for patients and physicians.

*Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Care*. Like, R, Steiner, P, & Rubel, A. *Family Medicine*, Vol. 28 (4).

3. 2001 American College of Emergency Physicians. *Cultural Competence and Emergency Care*. Approved by the ACEP Board of Directors, October. For more information, contact ACEP at 1125 Executive Circle, Irving, TX 75038-2522 or call 800-798-1822.

### Abstract:

- The American College of Emergency Physicians believes that: Quality health care depends on the cultural competence as well as the scientific competence of physicians;
- Cultural competence is an essential element of the training of health care professionals and to the provision of safe, quality care in the emergency department environment; and
- Resources should be made available to emergency departments and emergency physicians to assure they are able to respond to the needs of all patients regardless of the respective cultural backgrounds.

4. 1998 The American College of Obstetricians and Gynecologists (ACOG) Committee on Health Care for Underserved Women. *Committee Opinion*, No. 201, March. Copyright Clearance Center Danvers, MA 01923. Call 978-750-8400. For more information, contact ACOG at 409 12<sup>th</sup> Street, SW, PO Box 96920, Washington, D.C. 20090-6920.

*Abstract:*

Cultural Competency in Health Care

The racial and ethnic composition of the population of the United States has changed significantly during the past decade. Between 1981 and 1991 there was a 90% increase in the Asian population; a 50% increase in people of Hispanic origin; a 43% increase in Native Americans, Eskimos, and Aleuts; and a 15% increase in the African-American population. The white non-Hispanic population, however, increased by only 4%. As of August 1, 1997, Asians and Pacific Islanders comprised 3.8% of the total U.S. population, Hispanics (of any race) comprised 11%, African Americans comprised 12.7%, and Native Americans, Eskimos and Aleuts comprised 0.9%. In some areas of the United States, the combined number of African Americans, Hispanics, and Asians now exceeds that of whites.

Culture and Health Care

During every health care encounter, the culture of the patient, the culture of the provider, and the culture of medicine converge and impact upon the patterns of health care utilization, compliance with recommended medical interventions, and health outcomes. Often, however, health care providers may not appreciate the effect of culture on their own lives, their professional conduct or the lives of their patients. When an individual's culture is at odds with that of the prevailing medical establishment, the patient's culture will generally prevail, often straining provider-patient relationships. Providers can minimize such situations by increasing their understanding and awareness of the culture(s) they serve. Increased sensitivity, in turn, can facilitate positive interactions with the health care delivery system and optimal health outcomes for the patients served, resulting in increased patient and provider satisfaction.

5. American Nurses Association. *Position Statements: Cultural Diversity in Nursing Practice*.  
<http://www.nursingworld.org/readroom/position/ethics/etcldiv.htm>

Knowledge of cultural diversity is vital at all levels of nursing practice. Ethnocentric approaches to nursing practice are ineffective in meeting health and nursing needs of diverse cultural groups of clients. Knowledge about cultures and their impact on interactions with health care is essential for nurses, whether they are practicing in a clinical setting, education, research or administration. Cultural diversity addresses racial and ethnic differences, however, these concepts or features of the human experience are not synonymous. The changing demographics of the nation as reflected in the

1990 census will increase the cultural diversity of the U.S. population by the year 2000, and what have heretofore been called minority groups will, on the whole constitute a national majority (Census, 1990).

Knowledge and skills related to cultural diversity can strengthen and broaden health care delivery systems. Other cultures can provide examples of a range of alternatives in services, delivery systems, conceptualization of illness, and treatment modalities. Cultural groups often utilize traditional health care providers, identified by and respected within the group. Concepts of illness, wellness, and treatment modalities evolve from a cultural perspective or worldview. Concepts of illness, health, and wellness are part of the total cultural belief system.

6. 1990 American Psychological Association (APA). *Guidelines for Culturally Diverse Populations: APA Guidelines Approved by the APA Council of Representatives* in August. For more information, write to 750 First Street, NE, Washington, DC 20002. Tel. 202-336-5500. [www.apa.org/pi/guide.html](http://www.apa.org/pi/guide.html)

This public interest directorate consists of guidelines, illustrative statements and references. The Guidelines represent general principles that are intended to be aspirational in nature and are designed to provide suggestions to psychologists in working with ethnic, linguistic and culturally diverse populations. There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services. This increased motivation for improving quality of psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs and cultural expectations have been introduced into educational, political, business and health care systems by the physical presence of these groups. The issues of language and culture impact on the provision of appropriate psychological services.

7. 1998 Association of American Medical Colleges(AAMC). *Teaching and Learning of Cultural Competence in Medical School. Contemporary Issues in Medical Education*, Feb; Vol. 1 (5). Division of Medical Education, AAMC, Washington, DC.
8. 2000 CLAS Culturally and Linguistically Appropriate Services in Managed Care Organizations. *Member Services Questionnaire (MCP). Provider Relations Questionnaire (PCP)*. <http://www.omhrc.gov/clas/>

This project makes recommendations for national standards for culturally and linguistically appropriate services in health care. Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. Each standard is

accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards and offers recommendations for implementation and oversight to providers, policymakers and advocates. Most of the questions in the interviews ask about the operating unit or units that are responsible for delivering health services in variable.

9. 1999 Committee on Pediatric Work force and the American Medical Association Advisory Committee on Minority Physicians. *Culturally Effective Pediatric Care: Education and Training Issues*. American Academy of Pediatrics, Jan; Vol. 103 (1):167-170.

This policy statement defines culturally effective health care and describes its importance for pediatrics. The statement also defines cultural effectiveness, cultural sensitivity, and cultural competence and describes the importance of these concepts for training in medical school, residency and continuing medical education. The statement is based on the premise that culturally effective care is important and that the knowledge and skills necessary for providing culturally effective health care can be taught and acquired through: 1) educational courses and other formats developed with the expressed purpose of addressing cultural competence and/or cultural sensitivity; and 2) educational components on cultural competence and/or cultural sensitivity that are incorporated into medical school, residency and continuing education curricula.

10. 1997. New York State Cultural and Linguistic Competency Standards. New York State Office of Mental Health. For information, contact Design Center, 44 Holland Avenue, Albany, NY 12229. Tel. 518-473-2684.

The methods and strategies employed are discussed and the team members introduced. The scope of the project is presented along with a review of the five domains or standards for cultural competency in mental health services.

11. Liaison Committee on Medical Education. *Standard on Cultural Diversity*. Full text of LCME Accreditation Standards (from Functions & Structure of a Medical School, Part 2). [www.lcme.org](http://www.lcme.org)

“Faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient.”

12. National Association of Social Workers (NASW).  
<http://www.naswdc.org/diversity/default.asp#top>

NASW is committed to social justice for all. Discrimination and prejudice directed against any group are damaging to the social, emotional, and economic well-being of the affected group and of society as a whole. NASW has a strong affirmative action program that applies to national and chapter leadership and staff. It supports three national committees on equity issues: the National Committee on Women's Issues, National Committee on Racial and Ethnic Diversity and the National Committee on Gay, Lesbian and Bisexual Issues. The information contained in their web site reflects some of NASW's material and work on diversity and equity issues.

13. Society for Public Health Education (SOPHE). *Code of Ethics for the Health Education Profession*. <http://www.sphe.org/> (click on "About SOPHE" and then click "Ethics.")

*Abstract:*

The Health Education profession is dedicated to excellence in the practice of promoting individual, family, organizational and community health. Guided by common ideals, health educators are responsible for upholding the integrity and ethics of the profession as they face the daily challenges of making decisions. By acknowledging the value of diversity in society and embracing a cross-cultural approach, Health Educators support the worth, dignity, potential and uniqueness of all people. The Code of Ethics provides a framework of shared values within which Health Education is practiced. The Code of Ethics is grounded in fundamental ethical principles that underlie all health care services: respect for autonomy, promotion of social justice, active promotion of good and avoidance of harm. The responsibility of each health educator is to aspire to the highest possible standards of conduct and to encourage the ethical behavior of all those with whom they work. Regardless of job title, professional affiliation, work setting or population served, Health Educators abide by these guidelines when making professional decisions.

14. WICHE Western Interstate Commission for Higher Education. *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups*. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; U.S. Department of Health and Human Services.

"The standards are designed to provide readers with the tools and knowledge to help guide the provision of culturally competent mental health services within today's managed care environment. This document melds the best thinking of expert panels of consumers, mental health service providers and academic clinicians from across the four core



racial/ethnic populations: Hispanics, American Indians/Alaska Natives, African Americans and Asian/Pacific Islanders. Developed for states, consumers, mental health service providers, educators and organizations providing managed behavioral health care, the volume provides state-of-the-science cultural competence principles and standards–building blocks to create, implement and maintain culturally competent mental health service networks for our diverse population.” The site provides educators, policymakers, and legislators with data and issues-oriented analysis by subject matter.

### Appendix 3: Models for Culturally Competent Health Care

This list is presented alphabetically and is intended to be a helpful resource. While every attempt has been made to make this list as complete as possible at the time of publication, it is not exhaustive.

1. American Medical Student Association Home Page – Diversity in Medicine. <http://www.amsa.org/div/>

*Abstract:*

The American Medical Student Association (AMSA) is the oldest and largest independent association of physicians-in-training in the United States. The association focuses its energies on the problems of the medically underserved, inequities in our health-care system and related issues in medical education. There is a PowerPoint presentation that outlines current health disparities with a closer look at the causes and student-driven solutions. An exercise called *Diversity Shuffle* and modules, *Cross-cultural Issues in Primary Care and Cultural Competency in Medicine Project in a Box*, are provided to educate, provoke interest, and encourage discussion about differences and similarities within our communities. This site also has an online survey, which addresses the required cultural diversity curricula at your school.

2. 1983 Berlin, Eloise Ann; Fowkes, William C. Jr. *A Teaching Framework for Cross-cultural Health Care*. Western Journal of Medicine, Vol. 139 (6):934-938.

*Abstract:*

Significant demographic changes in patient populations have contributed to an increasing awareness of the impact of cultural diversity on the provision of health care. For this reason methods are being developed to improve the cultural sensitivity of persons responsible for giving health care to patients whose health beliefs may be at variance with biomedical models. Building on methods of elicitation suggested in the literature, [the authors] have developed a set of guidelines within a framework called the LEARN model. Health care providers, who have been exposed to this educational framework and have incorporated this model into the normal structure of the therapeutic encounter, have been able to improve communication, heighten awareness of cultural issues in medical care, and obtain better patient acceptance of treatment plans. The emphasis of this teaching model is not on the dissemination of particular cultural information, though this too is helpful. The primary focus is rather on a suggested process for improved communication, which we see as the fundamental need in cross-cultural patient-physician interactions.

3. 1999 Betancourt, Joseph R.; Carrillo, J. Emilio; Green, Alexander R. *Hypertension in Multicultural and Minority Populations: Linking Communication to Compliance*. Current Hypertension Reports, Vol. 1:4828.

*Abstract:*

Cardiovascular disease disproportionately affects minority populations, in part because of multiple socio-cultural factors that directly affect compliance with anti-hypertensive medication regimens. Compliance is a complex health behavior determined by a variety of socioeconomic, individual, familial, and cultural factors. In general, provider-patient communication has been shown to be linked to patient satisfaction, compliance, and health outcomes. In multicultural and minority populations, the issue of communication may play an even larger role because of linguistic and contextual barriers that preclude effective provider-patient communication. These factors may further limit compliance. The ESFT Model for Communication and Compliance is an individual, patient-based communication tool that allows for screening for barriers to compliance and illustrates strategies for interventions that might improve outcomes for all hypertensive patients.

4. 1991 Bobo, Loretta; Womeodu, Robin J.; Knox, Alfred L. Jr. *Society of General Internal Medicine Symposium: Principles of Intercultural Medicine in an Internal Medicine Program*. American Journal of Medical Science, Vol. 302 (4):244-248.

*Abstract:*

Internal Medicine and medicine-pediatric residents completed a questionnaire that measured variables including sociodemographics, family dynamics, cross-cultural exposure, and exposure to intercultural medicine principles. Questions were answered regarding perceptions of their patients and level of comfort discussing specific cultural variables. Gender, training status, and geographic background did not influence responses, but the responses of European-Americans (71%) vs. ethnic minorities and foreign medical graduates (29%) were significantly different. European-Americans were more likely to be men, less likely to have an urban background, and their self-described socioeconomic status was upper-middle to upper class. European-Americans vs. all others differed in their perceptions of patients' financial support, and reasons for doctor-patient miscommunications. The European-Americans had significantly less exposure to friends and classmates, and instructors of ethnic origins different than their own prior to residency training. [Their] data supports the inclusion of intercultural medicine principles in the general medicine curriculum.

5. 2000 Brach, Cindy; Fraser, Irene. *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*. Medical Care Research and Review, Vol. 57 (1):181-217.

*Abstract:*

This article develops a conceptual model of cultural competency's potential to reduce racial and ethnic health disparities, using the cultural competency and disparities literature to lay the foundation for the model and inform assessments of its validity. The authors identify nine major cultural competency techniques: interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, immersion into another culture, and administrative and organizational accommodations. The conceptual model shows how these techniques could theoretically improve the ability of health systems and their clinicians to deliver appropriate services to diverse populations, thereby improving outcomes and reducing disparities. The authors conclude that while there is substantial research evidence to suggest that cultural competency should in fact work, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly.

6. 1991 Burkett, Gary L. *Culture, Illness, and the Biopsychosocial Model*. Family Medicine, May/June; Vol. 23 (4):287-91.

*Abstract:*

Family medicine has appropriated the biopsychosocial model as a conceptualization of the systemic interrelationships among the biological, the psychological, and the social in health and illness. For all its strengths, it is questionable whether this model adequately depicts the centrality of culture to the human experience of illness. Culture (as meaning system) is not an optional factor that only sometimes influences health and illness; it is prerequisite for all meaningful human experience, including that of being ill. A more adequate model of the relationship between culture and illness would demonstrate the preeminence of culture in the experience of illness among all people, not just members of "exotic" cultures; would view healers as well as patients as dwellers in culture; would incorporate the role of culture as meaning system in linking body, mind, and world; and would promote the significance of the cultural context as a resource for research and therapy.

7. 1998 Campinha-Bacote, Josepha. The Process of Cultural Competence in the Delivery of Health care Services: A Culturally Competent Model of Care (3<sup>rd</sup> Edition). To place an order, contact: Transcultural C.A.R.E. Associates, 11108 Huntwicke Place, Cincinnati, OH 45241. Tel. /Fax 513-469-1664.

*Abstract:*

The proposed conceptual model can provide health care providers with an effective framework for delivering culturally competent care. The model's constructs of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire have the potential to yield culturally responsive interventions that are available, accessible, affordable, acceptable and appropriate. The goal of engaging in the process of cultural competence is to create a "cultural habit."

8. 1996 Campinha-Bacote, Josepha. *The Challenge of Cultural Diversity for Nurse Educators*. The Journal of Continuing Education in Nursing, Mar/Apr; Vol. 27 (2):59-64.

*Abstract:*

Nurses are awaking to the critical need to become more knowledgeable and culturally competent to work with individuals from diverse cultures (Leininger, 1994). However, teaching cultural awareness in nursing education can present a major professional challenge for nurse educators. This article discusses cultural competence and presents a conceptual model of culturally competent health care. Based on this model, the article also discusses the implementation of a four-session cultural diversity program in a rural hospital setting.

9. 1997 Carballeira, N. *The LIVE and LEARN Model for Cultural Competent Family Services*. Continuum, Jan./Feb., pp. 7-12.
10. 1999 Carrillo, J. Emilio; Green, Alexander R.; Betancourt, Joseph R. *Cross-cultural Primary Care: A Patient-Based Approach*. Annals of Internal Medicine, Vol. 130 (10):829-834.

In today's multicultural society, assuring quality health care for all persons requires that physicians understand how each patient's sociocultural background affects his or her health beliefs and behaviors. Cross-cultural curricula have been developed to address these issues but are not widely used in medical education. Many curricula take a categorical and potentially stereotypic approach to 'cultural competence' that wed patients of certain cultures to a set of specific, unifying characteristics. In addition, curricula frequently overlook the importance of social factors on the cross-cultural encounter. This paper discusses a patient-based cross-cultural curriculum for residents and medical students that teaches a framework for analysis of the individual patient's social context and cultural health beliefs and behaviors. The curriculum consists of five thematic units

taught in four 2-hour sessions. The goal is to help physicians avoid cultural generalizations while improving their ability to understand, communicate with, and care for patients from diverse backgrounds.

11. 1996 Clinton, Jacqueline F. *Cultural Diversity and Health Care in America: Knowledge Fundamental to Cultural Competence in Baccalaureate Nursing Students*. Journal of Cultural Diversity, Vol.3 (1):4-8.

*Abstract:*

In order for undergraduate nursing students to integrate cultural diversity concepts into clinical practice, they require prerequisite theoretical knowledge of the relationships between cultural phenomena and health. This article is an overview of a beginning level theory course designed to enhance students' cultural awareness and sensitivity to United States ethnic groups. These attributes are viewed as two of the antecedents of culturally competent nursing practice.

12. 1997 Culhane-Pera, Kathleen A.; Reif, Chris; Egli, Eric; Baker, Nancy J.; Kassekert, Rosanne. *A Curriculum for Multicultural Education in Family Medicine*. Educational Research and Methods, Vol. 29 (10):719-723.

*Abstract:*

**Background and Objectives:** To deliver effective medical care to patients from all cultural backgrounds, family physicians need to be culturally sensitive and culturally competent. Our department implemented and evaluated a 3-year curriculum to increase residents' knowledge, skills, and attitudes in multicultural medicine. Our three curricular goals were to increase self-awareness about cultural influences on physicians, increase awareness about cultural influences on patients, and improve multicultural communication in clinical settings. Curricular objectives were arranged into five levels of cultural competence. Content was presented in didactic sessions, clinical settings, and community medicine projects. **Methods and Results:** Residents did self-assessments at the beginning of the second year and at the end of the third year of the curriculum about their achievement and their level of cultural competence. Faculty's evaluations of residents' levels of cultural competence correlated significantly with the residents' final self-evaluations. Residents and faculty rated the overall curriculum as 4.26 on a 5-point scale (with 5 as the highest rating). **Conclusions:** Family practice residents' cultural knowledge, cross-cultural communication skills, and level of cultural competence increased significantly after participating in a multicultural curriculum.

13. 2000 Donini-Lenhoff, Fred G.; Hedrick, Hannah L. *Increasing Awareness and Implementation of Cultural Competence Principles in Health Professions Education*. Journal of Allied Health, Vol. 29 (4):241-245.

*Abstract:*

Even as the importance of improved communication between health professionals and patients grows, the factors making it more difficult continue unabated—everything from expanding medical technology and increased sub-specialization to America’s ever-increasing cultural diversity. This article looks at some of the ways health care professionals, administrators, accreditors, and educators across the continuum of medical and health-related professions are seeking to increase the cultural competence skills of current and future practitioners. Many of these efforts, however, are still too recent and limited to produce measurable results. Data on the implementation of educational standards and curricula need to be collected, analyzed, and disseminated to begin to identify the degree to which standards and educational materials are being developed and implemented and what, if any, impact they are having on the delivery of culturally effective care.

14. 2000 Flores, Glen. *Culture and the Patient-Physician Relationship: Achieving Cultural Competency in Health Care*. Journal of Pediatrics, Vol. 136 (1):14-23.

*Abstract:*

It is hardly news to physicians on the front lines of patient care that the cultural diversity of our patients is broadening daily. Those of us who want to provide sensitive, competent care to families from cultures other than our own are in urgent need of practical advice. In many health care settings today, this need is addressed by “diversity consultants” who put their “clients” through mind-numbing exercises. It is unusual to come out of such exercises with a practical strategy to use in the office or clinic. In this context, readers will find the article by Flores a much needed breath of fresh air. Although the author bases his recommendations that any health care provider can immediately incorporate into his or her practice. The specific recommendations are targeted at those caring for Latinos, but the model of cultural competency he presents is widely applicable.

15. George Washington University – Module 2: Cultural Competence. <http://learn.gwumc.edu/iscope/Cultcomp.htm>

This web page details a specific outline for the George Washington University School of Medicine students. It provides learning objectives, definitions, case histories, and examples of potential differences in values, references and links. It presents general information about cultures, minority populations, and recently immigrated minorities, compares and contrasts non-verbal communication, such as distance, eye contact, and body language, to verbal communication, and offers self-reflection and team exercises.

16. 1987 Gonzalez-Lee, Teresa; Simon, Harold J. Simon. *Teaching Spanish and Cross-cultural Sensitivity to Medical Students*. Western Journal of Medicine, Vol. 146 (4):502-504.

*Abstract:*

The authors note that the Department of Community and Family Medicine at the University of California, San Diego (UCSD) and the UCSD Medical Center recognized that communication process is a vital factor in patient care. Also, they recognized the need to overcome language and other cultural barriers to enable health care professionals to understand the concepts of health and illness in other cultures and to teach the tenets of science-based medicine to patients from diverse cultural backgrounds. As a result, health care providers and the teaching faculty designed two specialized Spanish and cross-cultural programs—one for the second-year medical students of the UCSD School of Medicine and the other for family medicine residents at UCSD-Medical Center in San Diego. The demographics and location of San Diego contributed to the rationale for the establishment of these programs. The authors describe the novel approaches and frameworks of the two different programs and their success with the programs thus far. The two programs share the objectives of developing a high-level of cross-cultural understanding and sensitivity among students by means of a language acquisition process and through carefully supervised contacts with Latino patients in clinical settings.

17. 2002 Green, Alexander R.; Betancourt, Joseph R.; Carrillo, J. Emilio. *Integrating Social Factors into Cross-Cultural Medical Education*. Academic Medicine, Vol. 77 (3):193-197.

*Abstract:*

The field of cross-cultural medical education has blossomed in an environment of increasing diversity and increasing awareness of the effect of race and ethnicity on health outcomes. However, there is still no standardized approach to teaching doctors in training how best to care for diverse patient populations. As standards are developed, it is crucial to realize that medical educators cannot teach about culture in a vacuum. Caring for patients of diverse cultural backgrounds is inextricably linked to caring for patients of diverse social backgrounds. In this article, the authors discuss the importance of social issues in caring for patients of all cultures and propose a practical, patient-based approach to social analysis covering four major domains — (1) social stress and support networks, (2) change in environment, (3) life control and (4) literacy. By emphasizing and expanding the role of social history in cross-cultural medical education, faculty can better train medical students, residents, and other health care providers to care for socioculturally diverse patient populations.

18. Hablamos Juntos Resource Center: Models, Approaches, and Tools. <http://www.hablamosjuntos.org/resourcecenter/default.asp>

The purpose of the Resource Center is to provide users with general resources to language access, information about the rationale for a program like Hablamos Juntos, information about what is being done in the field of language barriers, and information about what they are learning from their grantees and colleagues. The *Models, Approaches, and Tools* document, prepared by the National Council on Interpreting in Health Care, reviews four types of models that are being used to improve language access: Bilingual Provider Models, the Bilingual Patient Model, Ad Hoc Interpreter Models, and Dedicated Interpreter Models. Within each of these types, the advantages and disadvantages of different models are discussed.

19. 1998 Janes, Sharyn; Hobson, Kay. *An Innovative Approach to Affirming Cultural Diversity Among Baccalaureate Nursing Students and Faculty*. Journal of Cultural Diversity, Vol. 5 (4):132-137.

*Abstract:*

“Cultural Diversity” has become the buzzword of the nineties. The United States has become the most culturally diverse nation in the world. Since there is no arena where cultural diversity is more critical than health care, it is imperative that nursing students and faculty become comfortable with the issues surrounding the delivery of culturally competent care. The University of Southern Mississippi has developed an innovative program with a dual purpose: (a) to provide an environment of mutual understanding and respect for people of different cultures; and (b) to provide a comfortable environment where minority students can be valued and nurtured.

20. 1999 Kai, Joe; Spencer, John; Wilkes, Michael; Gill, Paramjit. *Learning to Value Ethnic Diversity - What, Why and How?* Medical Education, Vol. 33 (8):616-623.

*Abstract:*

Learning to value ethnic diversity is the appreciation of how variations in culture and background may affect health care. It involves acknowledging and responding to an individual’s culture in its broadest sense. This requires learning the skills to negotiate effective communication, a heightened awareness of one’s own attitudes, and sensitivity, to issues of stereotyping, prejudice and racism. This paper aims to contribute to debate about some of the key issues that learning to value ethnic diversity creates. Although some medical training is beginning to prepare doctors to work in an ethnically diverse society, there is a long way to go. Promoting “value ethnic diversity” in curricula raises challenges and the need to manage change, but there are increasing opportunities within the changing context of medical education. Appropriate training can inform

attitudes and yield refinement of learners' core skills that are generic and transferable to most health encounters. Care must be taken to avoid a narrow focus upon cultural differences alone. Learning should also promote examination of learners' own attitudes and their appreciation of structural influences upon health and health care, such as racism and socio-economic disadvantage. Appropriate training and support for teachers are required, and learning must be explicitly linked to assessment and professional accreditation. Greater debate about theoretical approaches, and much further experience of developing, implementing and evaluating effective training in this area are needed. Medical educators may need to overcome discomfort in developing such approaches and learn from experience.

21. 1978 Kleinman, Arthur; Eisenberg, Leon; Good, Byron. *Culture, Illness, and Care - Clinical Lessons from Anthropologic and Cross-Cultural Research*. *Annals of Internal Medicine*, Vol. 88 (2):251-8.

*Abstract:*

Major health care problems, such as patient dissatisfaction, inequity of access to care and spiraling costs, no longer seem amenable to traditional biomedical solutions. Concepts derived from anthropologic and cross-cultural research may provide an alternative framework for identifying issues that require resolution. A limited set of such concepts is described and illustrated, including a fundamental distinction between disease and illness, and the notion of the cultural construction of clinical reality. These social science concepts can be developed into clinical strategies with direct application in practice and teaching. One such strategy is outlined as an example of a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application. The implementation of this approach in medical teaching and practice requires more support, both curricular and financial.

22. 1983 Kristal, Laura; Rennock, Patrick W.; Foote, Sandra McLaren; Trygstad, Carl W. *Cross-Cultural Family Medicine Residency Training*. *The Journal of Family Practice*, Vol. 17 (4):683-687.

*Abstract:*

Over the past four years the University of California, San Diego (UCSD), Family Medicine Residency Program has developed a cross-cultural training program. The goal of the program is to prepare residents to function as effective health care providers in medically underserved areas with ethnically diverse patient populations. The required training activities include (1) a Spanish language course, (2) a clinical rotation in a community health clinic serving a Hispanic, medically underserved population, (3) a preceptorship in home-based health education and counseling for Spanish-speaking families, and (4) a set of cross-cultural sensitivity training activities that are part of the Residency Behavioral Science Program. The UCSD Cross-Cultural Family Medicine Training Program is described here as a prototype for consideration by other family medicine residency programs.

23. 1996 Like, Robert C.; Steiner, R. Prasaad; Rubel, Arthur J. *Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care*. Family Medicine, Vol. 28 (4):291-297.

*Abstract:*

To aid in dissemination of curriculum guidelines created by Society of Teachers of Family Medicine (STFM) groups and task forces. Family Medicine will begin publishing such guidelines when deemed to be important to the Society's members. The information that follows are recommendations for helping residency programs train family physicians to provide culturally sensitive and competent health care. These guidelines were developed by the STFM task force and groups listed below and have been endorsed by the Society's Board of Directors and the American Academy of Family Physicians. Family Medicine encourages other STFM groups and task forces to submit similar documents that can serve as curricular models for residency training and medical education. Groups or task forces that submit information to the journal should follow the Instructions for Authors published each year in the January issue of Family Medicine and available on the Internet on STFM's home page (<http://stfm.org>).

24. 1999 Louden, Rhian Frances; Anderson, Pauline Monica; Gill, Paramjit Singh; Greenfield, Sheila Margaret. *Educating Medical Students for Work in Culturally Diverse Societies*. JAMA, Vol. 282 (9):875-880.

*Abstract:*

Recent attention has focused on whether government health service institutions, particularly in the United Kingdom, reflect cultural sensitivity and competence and whether medical students receive proper guidance in this area. [The researchers' objective with this study was to] systematically identify educational programs for medical students on cultural diversity, in particular, racial and ethnic diversity. Studies included in the analysis were articles published in English before August 1998 that described specific programs for medical students on racial and ethnic diversity. Of 1456 studies identified by the literature search, 17 met the criteria. The following data were extracted: publication year, program setting, student year, whether a program was required or optional, the teaching staff and involvement of minority racial and ethnic communities, program length, content and teaching methods, student assessment, and nature of program evaluation. Of the 17 selected programs, 13 were conducted in North America. Eleven programs were exclusively for students in years one or two. Fewer than half the programs were part of core teaching. Only one required program reported that the students were assessed on the session in cultural diversity. [This] study suggests that there is limited information available on an increasingly important subject in medical education. Further research is needed to identify effective components of educational programs on cultural diversity and valid methods of student assessment and program evaluation.

25. 1999 National Center for Cultural Competence, Georgetown University Child Development Center; 3307 M Street, NW Suite 401, Washington, DC 20007-3935. Tel. 800-788-2066. [cultural@georgetown.edu](mailto:cultural@georgetown.edu)

*Abstract:*

The Policy Brief provides a rationale for cultural competence in regards to demographics, eliminating disparities and improving the quality of services and health outcomes. It also discusses meeting legislative and accreditation mandates, gaining a competitive edge in the market place, and decreasing liability and malpractice claims. A Checklist to Facilitate the Development of Culturally and Linguistically Competent Primary Health Care Policies and Structures is provided. Cultural competence at the organizational and individual level is a developmental process. It gives steps in a continuum from cultural destructiveness to cultural proficiency.

26. 1994 Nora, Lois Margaret; Daugherty, Steven R.; Mattis-Peterson, Amy; Stevenson Linda; Goodman, Larry J. *Improving Cross-cultural Skills of Medical Students Through Medical School-Community Partnerships*. Western Journal of Medicine, Vol. 161 (2):144-147.

*Abstract:*

Postulating that a program integrating language skills with other aspects of cultural knowledge could assist in developing medical students' ability to work in cross-cultural situations and that partnership with targeted communities was key to developing an effective program, a medical school and two organizations with strong community ties joined forces to develop a Spanish Language and Hispanic Cultural Competence Project. Medical student participants in the program improved their language skills and knowledge of cultural issues, and a partnership with community organizations provided context and resources to supplement more traditional modes of medical education.

27. 2000 Nunez, AE. *Transforming Cultural Competence into Cross-Cultural Efficacy in Women's Health Education*. Academic Medicine, Vol. 75 (11): 1071-80. Correspondence can be sent to Dr. Nunez at [nuneza@drexel.edu](mailto:nuneza@drexel.edu).

*Abstract:*

To prepare students to be effective practitioners in an increasingly diverse United States, medical educators must design cross-cultural curricula, including curricula in women's health. One goal of such education is cultural competence, defined as a set of skills that allow individuals to increase their understanding of cultural differences and similarities within, among, and between groups. In the context of addressing health care needs, including those of women, the author states that it is valid to define cultural groups as those whose members receive different and usually

inadequate health care compared with that received by members of the majority culture. The author proposes, however, that cross-cultural efficacy is preferable to cultural competency as a goal of cross-cultural education because it implies that the caregiver is effective in interactions that involve individuals of different cultures and that neither the caregiver's nor the patient's culture offers the preferred view. She then explains why cross-cultural education needs to expand the objectives of women's health education to go beyond the traditional ones, and emphasizes that learners should be trained in the real-world situations they will face when aiding a variety of women patients. There are several challenges involved in both cross-cultural education and women's health education (e.g., resistance to learning; fear of dealing openly with issues of discrimination; lack of teaching tools, knowledge, and time). There is also a need to assess the student's acquisition of cross-cultural efficacy at each milestone in medical education and women's health education. Components of such assessment (e.g., use of various evaluation strategies) and educational objectives and methods are outlined. The author closes with an overview of what must happen to effectively integrate cross-cultural efficacy teaching into the curriculum to produce physicians who can care effectively for all their patients, including their female patients.

28. Perspectives of Differences: *A Diversity and Cross-Cultural Medicine Teaching Module for the Internet*. <http://dгим.ucsf.edu/pods/html/main.html>

"Perspectives of Differences" is a curriculum that teaches the principles of diversity and cross-cultural medicine. The need for instruction on issues of diversity and cross-cultural training across all health professional programs is nationally recognized. "Perspectives of Differences" is designed for trainees at all levels of health professional training. The program includes four Perspectives of Differences (PODs) for the individual trainee to learn the knowledge, skills and attitudes needed to become culturally competent providers."

29. 1998 Robins, Lynne S.; Fantone, Joseph C.; Hermann, Julica; Alexander, Gwen L.; Zweifler, Andrew J. *Improving Cultural Awareness and Sensitivity Training in Medical School*. *Academic Medicine*, Vol. 73 (10 Suppl.):S31-S34.

*Abstract:*

Authors describe a series of sessions for first year medical students at the University of Michigan. Sessions included videotapes, small groups discussions and other diversity exercises. Introspection, self-awareness and some knowledge about the connection between culture and patient care were the program goals. This set of activities was specifically designed to mitigate medical students' resistance previously documented by program planners following the presentation of other multicultural material. In an intriguing evaluation strategy, Likert ratings of sessions were stratified by whether participants were minority men, minority women, majority men or majority

women. Consistently, across 8 points of evaluation, the lowest rating was given by majority men. Focus groups data documented that majority men “felt under attack” in this year of the program. In subsequent years, incorporating participants’ suggestions for more clinically-oriented examples and additions of facilitators with clinical experience, ratings increased significantly. Majority men were apparently much more engaged in the program than in the previous year. This is an important and to-date rare example of the implementation and evaluation of specific instructional techniques in multicultural medical education.

30. 1997 Scott, Carol Jack. *Enhancing Patient Outcomes Through an Understanding of Intercultural Medicine: Guidelines for the Practitioner*. Maryland Medical Journal, Vol. 46 (4):175-80. Emergency Department, University of Maryland Medical Center.

*Abstract:*

As cultural and ethnic diversity increase within American society, physicians face new challenges in recognizing patients’ culturally defined expectations about medical care and the cultural/ethnic dictates that influence physician-patient interactions. Patients present to practitioners with many mores related to concepts of disease and illness, intergenerational communication, decision-making authority, and gender roles. In addition, many cultural groups follow folk medicine traditions, and an increasing number of Americans seek treatment by practitioners of alternative therapies before seeking traditional western medical attention. To facilitate patient assessments, enhance compliance with health care instructions, and thus achieve the best possible medical outcomes and levels of satisfaction, practitioners must acknowledge and respect the cultural differences patients bring to medical care environments.

31. 1996 Shapiro, Johanna; Lenahan, Patricia. *Family Medicine in a Culturally Diverse World: A Solution-oriented Approach to Common Cross-cultural Problems in Medical Encounters*. Family Medicine, Vol. 28 (4):249-255.

*Abstract:*

Using cultural sensitivity in the training of family practice residents generally results in positive consequences for patient care. However, certain potential problems associated with cross-cultural educational efforts deserve examination, including patient stereotyping, assumptive bias and the confounding of ethnicity with class and socioeconomic status. Even awareness of these pitfalls may not guarantee physician avoidance of other barriers to effective patient care, such as communication difficulties, diagnostic inaccuracies and unintentional patient exploitation. Despite these complications, future family physicians must continue to participate in educational activities that increase sensitivity toward and understanding of patients of different ethnicities. This article discusses certain features characteristic of the ways in which cultural variables operate in the doctor-patient encounter and identifies specific ways in which residents can successfully elicit and use cultural knowledge to enhance patient care.

32. 1998 Tervalon, Melanie; Murray-Garcia, Jann. *Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education*. Journal of Health Care for the Poor and Underserved, Vol. 9 (2):117-125.

*Abstract:*

Researchers and program developers in medical education presently face the challenge of implementing and evaluating curricula that teaches medical students and house staff how to effectively and respectfully deliver health care to the increasingly diverse populations of the United States. Inherent in this challenge is clearly defining educational and training outcomes consistent with this imperative. The traditional notion of competence in clinical training as a detached mastery of a theoretically finite body of knowledge may not be appropriate for this area of physician education. Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.

33. 1998 Welch, Melissa. *Required Curricula in Diversity and Cross-cultural Medicine: The Time is Now*. Journal of the American Medical Women's Association, Vol. 53 (Suppl.):121-123.

*Abstract:*

Culture affects the health of patients in many ways. The increasing diversity of the US population and of medical students, residents, and faculty underscores the need for training in diversity and cross-cultural medicine. Curricula addressing culturally diverse populations are well defined in nursing and psychiatry, but have only recently been introduced in medical school and residency programs. This discussion reviews the justification for introducing specific, required curricula in diversity and cross-cultural medicine for all residency programs. Principles underlying diversity curricula, effective teaching approaches, and challenges to consider when implementing such curricula are discussed. Teaching and evaluation strategies from the published literature are highlighted. Based on the literature review, examples of ways to integrate diversity and cross-cultural curricula into academic-based residency programs are described.

34. 1998 Zweifler, John; Gonzalez, Anna Marie. Teaching Residents to Care for Culturally Diverse Populations. Academic Medicine, Vol. 73 (10):1056-1061.

*Abstract:*

To care for diverse populations, authors propose that three areas outside the traditional medical curriculum must be presented to students: cultural competency, public health and community oriented primary care. "The goal



is to have physicians go beyond addressing the needs of individual patients to partnering with community and on the community level to improve the health of many individuals.” These are overlapping disciplines, according to the authors, each with its own set of challenges in teaching residents about them. For instance, authors see an effective public health intervention effort as limited by financial constraints, saying, “Imagine if primary care residents could refer to a community health worker as easily as they could order an x-ray or refer to a cardiologist!” Authors are very frank about the expectation for residents’ competencies, insisting:...”an overall sensitivity to the influence of the patient’s culture and the willingness to try to understand the patient’s perspective, no matter how different, and no matter how little the physician knows of the patient’s culture, is both realistic and necessary for good care.”

## Appendix 4: Videos and CD-ROMs

This list is presented alphabetically and is intended to be a helpful resource. While every attempt has been made to make this list as complete as possible at the time of publication, it is not exhaustive.

1. *“The Bilingual Medical Interview.”* Boston City Hospital.

Length of video in minutes: 31:15

Prepared by The Faculty and Staff of the Primary Care Training Programs in Internal Medicine and Pediatrics at Boston City Hospital. The Boston University School of Medicine and Office of Interpreter Services, Department of Health and Hospitals, Boston, MA and The Boston Area Health Education Center. Written and directed by Eric J. Hardt, M.D. Video Post Production: CF Video/Watertown © 1987.

The intended audience for this video is health care providers.

Content and Structure:

- Primarily designed to improve the skills of the viewer in the bilingual medical interview.
- The video discusses the problem areas in cross-cultural communication:
  - i. Cross-cultural medicine - epidemiology, health belief systems, family, religious, class, ethnic group relations, social, economic and political relatives
  - ii. Translation - medical jargon, idioms, nonverbal and unspoken messages, paraphrasing, editing, summation, complex/confusing/lengthy comments
  - iii. Triadic interviewing - control, interpersonal issues, team function (goals, roles and procedures)
- They suggest role-playing in areas of your own ethnic interest.

Skills taught:

- Assess the patient’s background and take it into consideration when providing care.
- Provides Arthur Kleinman’s “Tool to Elicit Health Beliefs,” which is made up of nine questions to ask that will help clarify patients’ problems.

Vignettes/Case Studies richly illustrate many aspects of clinician/patient interpreter interaction and the do’s and don’ts involved.

2. *“Communicating Effectively Through An Interpreter: Barriers to Communication.”* CCHCP – The Cross Cultural Health Care Program.

Length of video in minutes: 28:14

Contact: PacMed Clinics, 1200 12th Avenue S, Seattle, WA 98144. Call 206-621-4161 or 206-326-4161 or visit their web site at [www.xculture.org](http://www.xculture.org).

This is an instructional video. The intended audience for this video is health care providers.

Content and Structure:

- Unscreened, untrained and unqualified interpreters make many mistakes which can lead to longer appointments, more diagnostic tests, multiple visits, inappropriate treatments, and, in some cases, the office for civil rights has sighted some health care institutions for not providing appropriate language services.
- Interpreters transmit the word they hear in one language into another language
- Translators transmit a written message from one language into another
- Using an interpreter may take practice, but health care providers can still offer the same amount of sensitivity and efficiency they give their English-speaking patients.

Vignettes/Case Studies:

- A few health care providers discuss the difference between well-trained interpreters and untrained interpreters.
- A physician and a Spanish-speaking patient tried to communicate through an untrained interpreter, namely, a receptionist.
- A professionally trained interpreter interprets for a physician and a Cambodian patient. The interpreter had a pre-session with both the doctor and patient, introducing him and the two to one another.
- The pre-session provided some ground rules for effective communication and also established a professional relationship between doctor and patient.
- The health care provider in the first interview tried to improve the communication between herself and the patient, through the interpreter. The physician began with a pre-session, wherein she introduced herself to the patient, then to the interpreter. This way, her expectations of the interpreter were clear because she knew the interpreter was a bilingual receptionist.

3. *“Cultural Assessment.”* American Journal of Nursing Company.

Length of video in minutes: 28:37

Cultural Assessment CNE #7633; Hospital Satellite Network, 1986.

The intended audience for this video is nursing professionals.

Content and Structure:

- Describes how unique the U.S. is because of all the different people and cultures; provides statistics on different diseases that affect various cultures and ethnicities.

- They identify seven variables of health in different cultures: ethnic/racial identity, value orientation, language communication process, family system, healing beliefs and practices, religious beliefs and practices, and nutritional behavior and cultural influences.
- It defines cross-cultural communication and gives examples of what certain things mean to different cultures.
- A demonstration of an effective nursing assessment follow-up is given.

Skills taught:

- Assess the patient's background and take it into consideration when providing care.
- Ignoring cultural beliefs/values or showing a lack of respect for them can prove detrimental to effective patient care.

Respecting beliefs enhances recovery

- Accommodate patient and incorporate their cultural values and beliefs into their nursing plan of care.
- Treat patients equally, but take their differences into consideration for optimum care

4. *"The Culture of Emotions: A Cultural Competence and Diversity Training Program."* Francis Lu, M.D., Executive Scientific Advisor; Juan Mezzich, M.D., Ph.D., Scientific Advisor; Harriet Koskoff, Producer/Co-Coordinator. Contact Ms. Koskoff at 415-864-0927.

*The Cultures of Emotions* is a 60-minute video program designed to teach cultural competence and diversity skills in medical, psychiatric and related academia, to professionals in the behavioral health and primary health care sectors and at continuing education seminars across that nation. *The Cultures of Emotions (COE)* will feature didactic interviews with distinguished researchers and clinicians from the ethnic and culturally diverse populations, which present for treatment across the spectrum of public and private health care systems. In an engaging, relaxed manner, they introduce the Outline for Cultural Formulation (OCF): the most advanced, comprehensive and inclusive diagnostic system ever developed for the assessment and treatment of psychiatric distress phenomena across cultural boundaries and diagnostic categories. The OCF provides a conceptual bridge between Euro-Western diagnostic concepts, categories and etiological explanations of normative and non-normative experience and traditional world views of health, disease and pathology in diverse cultural societies worldwide.

5. “*Doctoring II.*” Farsi Interpreter Tape.

UCR/UCLA Biomedical Sciences © 1995 UCLA School of Medicine.  
This video is intended for health care providers and interpreters.

Vignettes/Case Studies:

- *The Cousins.* A patient comes into a clinic and is seen by a male physician. Since the patient speaks only Farsi, she brought her cousin to interpret. The cousin is an interference and a distraction many times because she insists the doctor hurry with the exam, she speculates what her cousin’s answers will be and she ignores the doctor’s questions to the patient and the patient’s comments to the doctor.

6. “*Female Circumcision/Female Genital Mutilation: Clinical Management of Circumcised Women.*” The American College of Obstetricians and Gynecologists, 1999. You can order this video from the ACOG Bookstore at: [http://sales.acog.com/acb23/showdetl.cfm?&DID=6&Product\\_ID=540&CAT\\_ID=17](http://sales.acog.com/acb23/showdetl.cfm?&DID=6&Product_ID=540&CAT_ID=17).

Cost of video: \$125 (\$95 for ACOG members)  
Length of video in minutes: 60:0

This video is intended for undergraduate medical education and ob-gyn residency programs students.

As physicians increasingly encounter patients from diverse backgrounds, they are likely to come upon women who have undergone some form of female circumcision/female genital mutilation (FC/FGM). To help obstetrician-gynecologists and other health care providers deliver optimum care to affected women, the ACOG Task Force on Female Circumcision/Female Genital Mutilation has developed a slide-lecture kit. This educational module is intended for use as a formal 60-minute presentation in undergraduate medical education and ob-gyn residency programs. It includes 56 slides, of which nearly 50% are photographic or illustrative images, accompanying speaker’s notes, learning objectives and a resource listing. Learning more about FC/FGM and its concomitant consequences can help physicians play a vital role in preventing this harmful and unnecessary practice.

7. Kaiser Permanente CARE Actors award-winning (Finalist Award, New York Festival) cultural issues videos. Contact: Gus Gaona (323-259-4776) at Kaiser Permanente MultiMedia Communication, 825 Colorado Boulevard, Suite 301, Los Angeles, California 90041.

The brief but dramatic vignettes are accompanied by support materials for facilitators and participants. These materials can be sent electronically and are included in the nominal price of \$15.00. The

vignettes, scripted with the help of physicians, nurses and medical anthropologists, raise numerous issues around differing health beliefs and practices, values in conflict, stereotyping, overt and covert prejudices and language barriers as they occur in health care settings. The format of the tape allows for pauses for facilitated discussion of each vignette, and the support materials provide questions and discussion point for each vignette. This format lends itself equally well to a series of short modules (30 minutes) or incorporation into a longer workshop.

Length of video in minutes: 70:0

Series A: Cultural Issues in the Clinical Setting contains 10 vignettes

- Diabetic Compliance: Latino. Deals with how not to and how to handle an encounter interpreted by an inexperienced interpreter. Includes numerous family issues.
- Sickie-Cell Case in the E.R.: An African American adolescent is in crisis and needs pain medication; the E.R. staff is not so sure.
- Pediatric Asthma: A Middle Eastern doctor and an aggressive mother tangle over the care of a young girl, and values clash made more problematic by diverse communication styles.
- A Somatic Complaint: Long buried painful memories manifest in diffuse symptoms that are not well understood by this physician.
- A Gay Adolescent: An adolescent football player comes out to his family doctor. The doctor deals with the situation both knowledgeably and sensitively.

Series B: Birthing Issues (on the same tape)

Goes through a day in the life of a young OB/Gyn physician coping with a diverse group of patients. Good advice from another, more experienced physician is at first spurned, then sought as the doctor is confronted by many special needs and circumstances.

- Lesbian Parents: The physician is caught off-guard when she learns that the two women before her are both the prospective parents and have some special concerns.
- The Hmong Way: The physician is upset when a young woman's mother wishes to incorporate unusual birthing practices in the care of her pregnant daughter.
- A Middle Eastern Dilemma: A conversation between the more experienced physician and one of her Middle Eastern patients reveals conflicts and familial concerns around acculturation in an immigrant family.
- A Big Baby is Coming: A non-English speaking woman from Mexico is delivering a very large baby with macrosomia. She is diabetic and has lost several babies at birth. Her husband is very uncomfortable in the labor room. A nurse reveals her tendency to stereotype through prejudicial remarks.

- A Circumcised Somali Mother in Labor: A tired and concerned physician discovers that the woman presenting for childbirth, having had no prenatal care, must have her vaginal opening enlarged in the presence of thick scar tissue or have a C section.

8. *“Lost in the Interpretation.”*

Length of video in minutes: 14:40

This is a co-production of Kaiser Permanente’s Member Language Services and the Advisory Team; sponsored by Northern California Diversity Steering Committee and Regional Medical Group Administration, 1997.

This video is intended for health care professionals.

Content and Structure:

- California’s work force is changing; therefore, KP members are changing.
- KP needs to provide quality health care and access to all members.
- KP has developed brochures in different languages, has a language line and has increased the number of qualified, bilingual employees.

Skills taught:

- The ability to care for members in a language other than English increases efficiency; it shows patients that KP is trying to accommodate them and make them feel comfortable.
- The wrong interpretation can lead to bad patient care.

Vignettes/Case Studies:

- An English speaking woman cannot find her way around a medical center, and the staff members to whom she turns for help speak only non-English languages.
- An English-speaking female with a fever cannot communicate with a Cantonese physician.
- An English-speaking female picks up her prescription and needs to know how to take her medicine according to the doctor’s orders.
- A Spanish-speaking pharmacist can’t help, and neither does the Cantonese man from the computer department who speaks very little English.
- A doctor can’t even see an English speaking man because the Spanish-speaking receptionist couldn’t communicate with him effectively.

9. *“Mental Health Interpreting: a Mentored Curriculum.”* Pollard, Robert. Accompanied with workbook.

Length of video in minutes: 32:02

University of Rochester, School of Medical and Dentistry. Produced in association with the Monroe County Office of Mental Health and the Department of Psychiatry at the University of Rochester Medical Center © 1997-2000 University of Rochester. Contact: Robert Pollard, Ph.D. 716-275-3544 or [Robert.Pollard@urmc.rochester.edu](mailto:Robert.Pollard@urmc.rochester.edu)

The intended audience for this video is mental health professionals and mental health interpreters.

Content and Structure:

- This video and its accompanying curricular guide were developed as an aide to foreign language interpreters.
- The video was meant to be used in a one-to-one learning relationship with an experienced mental health interpreting mentor.

Vignettes/Case Studies portrayed:

- Introduction: The interpreter and clinician meet for the first time. It's important to have a pre-session so that the interpreter knows what to expect, and the clinician learns about how professional interpreters do their work.
- Cultural Bonds: Sometimes, immigrants feel a bond with the interpreter since they share the same language. They tell the interpreter something privately that they don't want translated, but this interferes with the interpreter's role and challenges their boundaries.
- Cultural Attitudes Toward Mental Illness-Part 1: A Vietnamese mother speaks with a doctor about her daughter's suicide attempt. The doctor tries to explain that her daughter is serious about killing herself, but the mother does not believe that her daughter wants to kill herself and thinks that if she stays at the mental health hospital, she'll only become more ill.
- Cultural Attitudes Toward Mental Illness-Part 2: In the post-session with the doctor and interpreter, the interpreter explains the cultural differences. She tells him that Vietnamese people are very private and like to keep issues like mental illness in the family. They usually only share this problem with a priest, Buddhist monk or other relative.
- I Can't Do Your Job For You: Sometimes mental health clinicians feel uneasy working with mental health patients who speak a different language, and so they ask interpreters to do something that may not be within their realm.

- **It's A Small Community:** The interpreter is meeting with her supervisor and tells her that the patient she interpreted for was lying to and withholding information from the clinician. She knows the patient and has interpreted for him in the past and felt like pulling the clinician aside and telling him the truth about this patient. The supervisor expresses the importance of confidentiality in the job and stresses the possible repercussions of divulging any information.
- **Gender, Age, and Culture:** In this pre-session, the female clinician and female interpreter get acquainted and discuss the family who is waiting to come in. The clinician tells the interpreter that there is a teenage girl, her mother, and her grandfather waiting to see them. The interpreter says they may have a problem with cooperation from the grandfather because she, herself, is a young interpreter, and the doctor is a young female.
- **Linguistic and Cultural Barriers to Translation:** A mental status exam is in progress and the interpreter identifies language and cultural factors that the clinician needs to understand. The interpreter provides helpful guidance, allowing the clinician to do his job more effectively.
- **Language and Psychosis-Part 1:** Language can be affected by a patient's mental status, due to the illness affecting certain brain functions.
- **Language and Psychosis-Part 2:** The clinician can't do his job with absolutely no help from the interpreter. This vignette shows the interpreter trying a more flexible approach.
- **Embarrassing Moments-Part 1:** Mental health work involves a lot of emotions, and the patients sometimes act in unexpected ways.
- **Embarrassing Moments-Part 2:** If the interpreter is not comfortable being very forthcoming, there's an alternative.

10. 1991 *"Racial and Cultural Bias in Medicine."*

Length of video in minutes: 30:00

Contact: American Academy of Family Physicians at 8880 Ward Parkway, Kansas, MO 64114.

This video program is designed for medical students, resident physicians, and practicing physicians, consisting of 30+ dramatized situations on a variety of issues, each of which is relevant to racial or cultural bias. Emphasis is on prejudice and stereotyping rather than clinical cultural competence.

11. *“Refugee Mental Health: Interpreting in Mental Health Settings.”* Benhamida, Laurel; Downing, Bruce; Egli, Eric; Yao, Ahu.

Length of video in minutes: 33:34

This is one in a series of videotapes produced by the University of Minnesota’s Refugee Assistant Program – Mental Health Technical Assistant Center; funding provided through a contract (Contract No. 278-85-0024 CH) with the National Institute of Mental Health in conjunction with The Office of Refugee Resettlement; distributed by Great Tapes of Minneapolis, MN. Written materials accompany the video.

This video is an introduction to interpretation in refugee mental health. The intended audience for this video is interpreters for refugee mental health professionals.

Content and Structure:

- Language and communication are key and the main task for the interpreter.
- Work, role, tasks and modes of the interpreter are discussed.
- Sometimes elaborating is necessary to the well being of the patient, but the interpreter needs to make both parties aware when he/she is stepping out of the interpreter role to elaborate in order to avoid a breakdown in interpretation.

Skills taught:

- Effective interpretation requires highly developed skills, careful preparation, intense concentration, split-second decision-making, an understanding of both cultures, continuous education, etc.

12. *“The Shaman’s Apprentice.”* Bullfrog Films: Box 149, Oley PA 19547. Tel. 610-779-8226. Fax 610-370-1978. For further information, contact them via email at [video@bullfrogfilms.com](mailto:video@bullfrogfilms.com) or visit their web site at [www.bullfrogfilms.com](http://www.bullfrogfilms.com).

Length of video in minutes: 54:0

VHS video Public Performance Purchase \$250, Rental \$85.

Directed by Miranda Smith and written by Abigail Wright.

The intended audience for this video is students in grades 10-12, college and adults. Renowned ethnobotanist Dr. Mark Plotkin first traveled to the Amazon twenty years ago seeking a cure for diabetes. There he found extraordinary biological riches and a mysterious world of shape-shifting shamans who healed with sophisticated plant medicines. Mark was to learn that the indigenous people of Suriname have an astonishing ability to

understand and manage their fragile rainforest environment – but that the people themselves are disappearing faster than the forests. Could he save their world from extinction? Beautifully filmed in the rainforests of Suriname, *The Shaman's Apprentice* is a luminous and powerful story of one man's quest to preserve both the rainforest and the ancient wisdom of our species.

“Dazzling visuals, cutting edge science and a compelling story make *The Shaman's Apprentice* a feast for the eyes, the heart, and the mind...one of the most stunning rainforest films ever made.” —Ken Cook, President, Environmental Working Group.

13. *“Through the Eyes of Others” Tape 1: General Sessions*. ROWAY Productions – 7317 Cahill Road #229, Edina, MN 55439 612-941-9337.

Length of video in minutes: 2:00:35

Jointly sponsored by Hennepin County Medical Society, United Way of Minneapolis Area, Hennepin County Medical Center Staff, and University of Minnesota.

This video is intended for health care professionals, particularly physicians and nurse practitioners.

Content and Structure:

- Their mission is to make an impact in the way they deliver health care and look at their attitudes and perceptions towards people from other cultures-both new immigrants as well as those traditionally underserved populations.
- Take time to learn about the differences in cultures and to see health care through the eyes of others.
- Patient outcomes are not as good if health care providers are not culturally competent.
- Defines culture, diversity, sensitivity and competence.
- Cultural competence involves different levels, including doctors, nurses, administration, institution, patients, training and research.
- Poor interpretation can lead to poor outcomes.
- A lawyer discusses mistreatment, informed consent, battery, negligent nondisclosure, patient bill of rights, Human Rights Act, reporting of maltreatment of minors, consumer protection laws and Title VI of Civil Rights of 1964.
- Defined the role of interpreter and compared it to that of translator.
- A skilled, qualified interpreter must be trained; being bilingual is just barely the minimum requirement of being an interpreter.

- Interpreters' Code of Ethics is guidelines for interpreters, but they're not the written word; sometimes interpreters need to make a judgment call within the code.
- A demonstration of appropriate interpreting is provided.

Skills taught:

- Be supportive and believe your patient if they tell you they're doing something traditional, and it's working.
- Trust in the physician-patient relationship is important. Small gestures to make the patient trust the doctor include: smiling, talking, looking at patients in the eye and treating patients the way they'd like to be treated.
- Doctor should respect cultural, religious and traditional beliefs, remedies and cures.
- There is no absolute knowledge or reality; try to become culturally competent in your own arena; consider who the majority of your patients are, and who you primarily serve.
- Formulate treatment plans that are culturally effective.
- Be understanding, empathetic, patient and respectful.
- Provider should talk to and look at the patient; interpreter is merely the middleman in the background.
- Interpreter needs to know when communication is not working and must address the provider.

Vignettes/Case Studies:

- SUDS (Sudden Unexpected Death Syndrome) generally occurs in young Hmong men who have been in the U.S. approximately one year. While asleep, the man will suddenly wake up, give a brief shout, and then die. A 22-year old Hmong man with SUDS was brought in with ventricular fibrillation. He had experienced SUDS, and then was revived. He refused to be monitored by the doctor and died six months later. The doctor initially wanted to have an autopsy done but decided against it after speaking with his family about his religious beliefs.
- A Hispanic woman came in, and, during the interview with the clinician, told the interpreter that she likes to try different Western medicines from different doctors and that she also uses traditional medicines, but asked the interpreter not to tell the doctor this.
- A 35-year old obese, insulin-dependent woman, who was identified on her chart as a lesbian, went to the Emergency Department because she was feeling ill.

14. *“Training for Cultural Competence in the HIV Epidemic.”*

Length of video in minutes: 45:45

Presented by: Hawaii Area AIDS Education and Training Center, University of Hawaii, John A. Burns School of Medicine. Funded in part by grant No. 5-T01 MH19263-02 with the National Institute of Mental Health.

The teaching tape is intended only as a supplement to professional training to generate discussion about issues related to HIV and culture. The intended audience for this video is health care professionals.

Vignettes/Case Studies:

These case studies portray two very different ways in which patients are treated by physicians and staff. The first vignettes show dissatisfied patients, while the following vignettes show patients who are pleased with the service and treatment they received.

Culture and Communication:

- What’s wrong with you people anyway? Ms. Santiago went in to the clinic for a pregnancy test. Doctor Kennedy remembered that she was in last time for treatment for a venereal disease, at which time she mentioned that her boyfriend was HIV positive.
- Not that GOMER again! A male patient, John, went to the clinic for a shot because he thought he had the clap. The doctor began interviewing him and asked him what his symptoms were, when they started and why he thought he had the clap. He told her he had it before, and he knew the symptoms well. Then, when she asked him if he had sexual relations after experiencing the symptoms, he became annoyed.
- She needs to eat. A woman complained to a health care provider that her sister no longer wanted to eat. She explained that she had been trying to feed her, but she refused to eat. The health care provider clarified that she doesn’t need to eat food because she was given medicine and food intravenously. She further explained that the doctor told her that her sister would not be hungry and that she should stop feeding her.

Culturally Effective Intervention:

- What’s important to you? Dr. Kennedy met with Ken, a male patient, and told him that his condition was very good at the moment. She then continued to tell him that she wanted to get to know him better as a patient and wanted to know what was important to him as far as his health was concerned. He mentioned that it was difficult being around his family because he hadn’t told them of his HIV status yet. He also told her that his lover had been pushing him to tell them, but he was still hesitant.

Culture and Professionals/Systems:

- Why can't they be team players? There was a planning committee meeting made up of two state workers and two local Hawaiian representatives of the community. The state presented a contract, offering \$30,000 for HIV education for minority populations. The two state workers said they planned to use the radio and newspapers to promote the outreach program and that they would be using the statistics they gathered for research purposes. The Hawaiian woman mentioned that typical grants didn't take into consideration culture, lifestyle, geographic areas or the specific needs of different cultures. She explained further that if they were going to address this population, they would need to look at those areas to make it work best. The Hawaiian man became upset because he felt that \$30,000 was just a drop in the bucket and a waste of their time.
  - This feels like reverse racism. Five physicians, two Asians and three Caucasians, met to discuss new ideas for their clinic. An Asian woman suggested they reach out to more Asian women to discuss, educate and help prevent the spread of HIV through sexual contact. The Caucasians all disagreed, saying that their patients were comfortable with them and that they already knew everything they needed to know through pamphlets and video provided by the clinic.
  - Why do we always have to change? Three clinic staff members discussed their opinions about the new clinic hours.
15. "What Language Does Your Patient Hurt In?" A Three-Tape Video Training Course for Nurses of Patients from Other Cultures. Suzanne Salimbene, Ph.D.; Inter-Face International. Workbook provided. To contact Dr. Salimbene, email her at: [IFI4you@aol.com](mailto:IFI4you@aol.com) or call 818-282-2433.

Length of video in minutes: 1:42:22

This video describes how to best serve the increasing number of diverse patients coming into the health care system. The intended audience for this video is nurses.

Content and Structure:

- *Part 1: Immigration, Culture and The Patient/Caregiver Relationship*
  - i. PowerPoint Presentation and lecture given by Dr. Suzanne Salimbene.
  - ii. She shows the present (2000) ethnic demographics in comparison to projected demographics of 2050, describing how it will impact the patients' nurses see and the care they give.

- iii. Asians are the largest, fastest increasing group to migrate to the U.S.
  - iv. She shows where immigrants are settling; many are now in the Midwest.
  - v. 1 of every 10 patients will come from another culture or language.
  - vi. Iceberg Theory: we've been focusing too much on what's on the surface (food, language and appearance), but what impacts health care even more are the communication style, beliefs, attitudes, values and perception of people.
  - vii. Culture cements a group of people together and distinguishes and separates members of one culture from another.
  - viii. Culture acts as a gatekeeper. It determines how patients expect to be treated, it tells people when it's appropriate to seek care, and it sometimes dictates that females can only see female physicians.
  - ix. Culture determines the definition a patient gives to health and illness.
- *Part 2: Culture's Impact Upon Surgery, Childbirth, and Death and Dying*
    - i. Many Asian cultures don't have a tradition of surgery, transplants, animal transplants or organ donation.
    - ii. Many cultures have taboos about organ removal, organ donation, and autopsies because they believe you need to return the body whole.
    - iii. Many Asians believe that once blood is lost, it is never replenished; and therefore, they don't like blood transfusions or blood withdrawal.
    - iv. Life support or turning off life support can be thought of as interfering with the will of God to many Middle Easterners.
    - v. Even consent forms, to Middle Easterners, are an insult because they believe their word is stronger than some signed document. While Navajo people believe signing a form explaining what may possibly go wrong, means that these things will go wrong.
    - vi. Childbirth is also determined by culture. Some believe men shouldn't be involved in labor and delivery. In Russia, the average length of stay in the hospital after giving birth is 2 weeks.

- vii. In most cultures, the patient is rarely told that he's dying. It's usually the oldest male relative that's told, and he makes the decision on how much the patient is told.
- viii. In Middle Eastern cultures, no grieving is allowed while the patient's still alive because it's considered 'tempting Allah's will' to grieve before death.

Skills taught:

- Dr. Salimbene defines Culture as the shared world views, values, beliefs, traditions and patterns of communication of a group of people.
- You need to work with the patient within their culture.
- Hispanic cultures generally like to be touched (hold hands, comfort them), while you should not touch an Asian person's head without permission.
- AMA defines Cultural Competence as a set of knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals of cultures other than their own.
- *Part 3: Becoming a Culturally and Linguistically Competent Caregiver*
  - i. Understand and accept different cultures.
  - ii. You need a cultural self-awareness (know your biases and beliefs).
  - iii. Develop and understanding basic knowledge of your patient demographics in your service area.
  - iv. Have the ability to adapt your nursing skills so they're appropriate to the patient's beliefs and values.
  - v. Learn to be a keen observer of different communication styles.
  - vi. Don't treat the patient, as you'd like to be treated! Find out how they'd like to be treated.
  - vii. Always begin by using the patient's family name; better to be more formal than too casual.
  - viii. Don't be 'put off' if the patient doesn't look you in the eye; it may be considered disrespectful for them to look at an authority figure in the eye.
  - ix. Don't make any assumptions; ask questions and try to get open, honest answers.
  - x. Find out if the patient uses any other means besides Western medicine.
  - xi. Don't discount the patient's beliefs/values.
  - xii. Find out who the decision-maker is in the family.
  - xiii. Be restrained in relaying bad news.

- With limited English proficiency patients, speak slowly, not loudly!
  - i. Face the patient and read their facial expressions and body language.
  - ii. Avoid difficult, uncommon, and unnecessary words or information be brief.
  - iii. Organize what you say, rephrase and summarize often.
  - iv. Don't ask yes or no questions.
  - v. Don't burden the patient with decisions that he/she is not prepared to make.

16. *“Culture and Religion: Impact on Health Care.”*

Length of video in minutes: 37:0

The Director/Producer of the video is Brad Taylor, R.N.; The Associate Producer is Garin Granata. This is a video by Wasatch Media.

The intended audience for this video is health care providers.

Content and Structure:

Our cultural beliefs and practices come from a long ago tradition; they tell us how we should perceive things, especially our health and illness. The following are short excerpts wherein medical staff gives case studies and their experiences with different patients:

- During childbirth in ancient times, the men were outside while the women were delivering; whereas now, they are inside and take an active role.
- Some cultures believe that shortly after someone dies, their spirit is still present. This is why a family member must see the body and say something to the person who just died before the body is taken away.
- Native Americans usually don't like seeing doctors because they don't know what's going to happen, and they don't like to undress in front of doctors.
- The poor and African-Americans sometimes don't think of going to the doctor; instead, they rely on prayer and home remedies.
- Polynesians have a high tolerance for pain, so they don't usually request pain medication. In these cases, the medical staff should offer it to them.
- A nurse offered ice to a Mexican woman after her epidural, but she refused, wanting hot tea instead.

- A Social Worker recalls a Native American man who died, and his family was wailing in the emergency waiting room. A new ER nurse called for a Social Worker and tried to sedate them and gain control of the situation, but couldn't. The Social Worker realized he needed to let them grieve in their own way. He got them into a room where they could grieve the way they needed to.
- An Ethnic Health Program Specialist says Asians and many refugee groups tend to somatise their mental illness by saying they have a headache or are in physical pain instead of saying they're depressed, unhappy, etc... Many Asian groups also believe it's improper or disrespectful to touch someone on the head.
- A Clinical Dietician doesn't discourage African-Americans from using fatty meats or salt because she knows it's impossible for them to do so. Instead, she encourages them to cut back a little by using a smaller piece of meat and only using half a teaspoon of salt per person, per day. This can be done by taking an empty saltshaker, and, for two people in the house, putting one teaspoon of salt in the shaker to use for one day.
- A Staff Development Specialist contacts Orthodox churches for help with translation for Far Easterners, like Laotian, Thai, Vietnamese, Cambodians, Serbs and Croatians.
- A Physical Therapist tells us that many Polynesians, especially Samoans and Tongans, tend to speak in their own language when talking to their families. This is not to offend anyone; they're just more comfortable speaking their own dialect, and they understand each other better.
- A nurse found out that her Polish female patient, who was a housewife, didn't understand or speak any English. This patient was very quiet, to herself, and becoming depressed. She made an effort to ask her neighbor to teach her some Polish greetings, like "hello," "good morning" and "how are you?" Her efforts turned the patient around, and it brightened up the remainder of her stay at the hospital.
- A nurse recalls a 70-year old Mexican woman who had hip replacement surgery. Initially, her son was with her, but then he had to leave for business. She was the only Spanish-speaking nurse in her department and when caring for her, the woman pointed to her I.V. and blood hanging by her bed and asked, in Spanish, why people keep taking her life's liquids away. The nurse explained that they are giving her blood and fluids because she lost some in surgery and that they're not taking it away from her.

- There are so many different beliefs, but we must remember that religion and culture go hand in hand. Many religious beliefs intersect with health care delivery. The following religious people discuss each of their beliefs and practices concerning health care, birth, diet, clergy, healing, death and special conditions: Jewish, Islamic, Catholic, Seventh Day Adventist, Mormon, Jehovah's Witness, Baptist and Buddhist.

Skills taught:

- You must learn to open your mind to culture and religion and its impact on health care.
- You should be aware that different hand gestures and different ways of pointing might inadvertently offend your patient.
- Individualize each patient; become aware of who they are and what's important to them.
- You might try to incorporate cultural and religious questions into your assessment.
- Don't make any assumptions. Instead, ask how you can best care for each patient.

Vignettes/Case Studies:

- 1857, Utah Territory – Several Native Americans heal a wounded man. They spread a powder substance on the wound and pray over the injured man all night. In the morning, the medicine man leaves and the wounded man is now healed.
- 1889, Tennessee – A man works in the fields while his wife is in labor inside the house. There is a woman inside helping the wife deliver. She's getting wet towels to wipe the pregnant woman's face and massaging her back. The man is waiting outside with his son when they hear the newborn baby cry.

17. *"Between Two Worlds: The Hmong Shaman in America."*

Length of video in minutes: 26:33

The video was directed by Taggart Siegel.

The intended audience for this video is all health care providers.

Content and Structure:

- Native-Americans believe that the mountains have a spirit, the animals are their relatives and there are unseen spirits all around.

- Ordinary men looked to their Shaman to act as the middleman between them and the spirits. Their tradition was lost when the white man came to this land, but now it's resurfacing with the coming of Southeast Asian refugees.
- Displaced refugees are America's most recent immigrants with the war in Southeast Asia.
- Shamans have a crucial role in religious practices.
- Many Southeast Asians, especially Hmongs, have died from "Sleeping Death," or "Nightmare Death." Sudden Death Syndrome usually occurs with young, healthy men, but no cause has been found, making this a very mysterious syndrome.
- St. Paul Medical Center in Minnesota recently completed its Final Report with the SUNDS Planning Project. They recommend that future researchers look into refugee stress, anxiety, tension, delayed grief and culture shock as one of the potential contributing factors. One Hmong leader reports that many Hmong elders believe that these deaths are caused because man has lost his faith and no longer continues his traditional religious practices.

#### Vignettes/Case Studies:

- There was a husband and wife Shaman team in Minneapolis that originally came from Laos. Now that they are in America, they're afraid that the sacred way of the Shaman could be lost.
- A 22-year old Hmong man, who's been in the U.S. five years, works at Burger King to support his wife and two babies, while studying Chemistry at Chicago's Northeastern University. His second son was born two months premature, and he and his wife brought a Shaman to the Intensive Care Unit to see the baby. The mother and father were hurt that many of their recently converted Christian relatives refused to attend because their Christian minister forbade them to eat the meat of sacrificed animals. The family is sad that their faith is being lost because they're converting to another religion.
- A Shaman for thirty years, a Laotian man went from respected leader in his farming village to an elementary student to learn the basics of literacy.
- A missionary speaks of how many Southeast Asians he works with and teaches about Christ as the true, living son of God and that Buddha is ancient history. The missionary tells them that if they sin and do bad things, they'll die and go to hell.

18. *“Peace Has Not Been Made.”*

Length of video in minutes: 25:20

The video was produced by Doua Vang and John Finck; directed and edited by Peter O’Neill; still photos by Ellen Kuras.

The intended audience for this video is health care professionals.

This is a case history of a Hmong family’s encounter with a hospital from their father’s perspective and the hospital’s perspective. It shows, in detail, the hospital’s records and then provides details through the father’s perspective.

19. *“Spirit Doctors.”*

Length of video in minutes: 26:20

This is a film by Monica Delgado and Michael Van Wagener. The Associate Producer is Anthony N. Zavaleta, Ph.D.

The purpose of the video is to keep a record of folk healing as we move into the new millennium. The intended audience for this video is health care professionals.

Content and Structure:

- Those perceived as controlling the balance between health and sickness, life and death have been revered and feared throughout time.
- While many people believe technological advances improve health care, others find Western medicine to be financially prohibitive and culturally alienating.
- Mexican-Americans tend to retain their traditional beliefs and values, especially when it comes to folk healing.
- A new belief emerged that combined Spanish Catholicism with Indian Shamanism, and the cultural system flourishes even now.
- They use ancient healing techniques mingled with elements of Christianity and modern medicine to heal the sick.
- Midwives aiding in childbirth is a tradition in Mexican-Americans, but recently, the government has stepped in to control and regulate this practice.
- Midwives must now pass state exams to practice this birthing method. They’re very well trained in first aid and CPR, and they don’t hesitate to call a medical professional at the first sign of a problem.

- Midwives are important in this area of economic hardship, as they provide an economic way to obtain prenatal care, deliver the baby and have follow-up visits. Many of them view their job as a spiritual calling; they believe only god can help them through each delivery, since he called them to do this for women.
- Folk healing represents a link to ancient heritage and spirit doctors are a part of ethnic identification and symbolize the cultural perseverance of Mexican-Americans.

Vignettes/Case Studies:

This video offers various vignettes/case studies showing many folk healers who cure the sick for no charge because they believe that theirs is a gift from god. They use spiritual and herbal remedies, prayer, desert plants and other forms of spirit healing techniques to heal those who are sick with disease, physically or mentally.

20. *“The Psychological Residuals of Slavery.”*

Length of video in minutes: 15:48

This is a video by Kenneth V. Hardy, Ph.D.

The intended audience for this video is therapists and human services specialists.

Content and Structure:

- African-Americans are a very diverse group and they share the following attributes:
  - i. All belong to a group that’s been devalued in society.
  - ii. All have at one time or another been targeted with racial or prejudice discrimination.
  - iii. All, regardless of class, religion or geographic location, have the legacy of slavery.
- What does slavery have to do with African-American people today? The official end of slavery was only 130 years ago; that’s only three generations ago. However, African-American people were subjugated for 300 years.
- People still struggle from the emotional and psychological trauma of slavery. The descendents of those enslaved remain enslaved emotionally and psychologically.
- It’s essential for therapists and human services specialists to understand the history of slavery when working with African-Americans.
- Silence is a precursor of rage. Since they feel they have no voice, many African Americans struggle with the management and expression of rage.

- Rage can turn into violence. Some people express rage through sports, social events, music and activism, but others use violence.
- Many physical and psychological conditions are directly tied to rage, like high blood pressure, heart disease, mental stress, alcoholism, hopelessness, performance anxiety, anger, psychological homelessness and abbreviated life expectancy.
- The legacy of slavery continues to shape the experience of African-Americans and the relationship they have with white people. Therapist and human service specialists must examine and validate this aspect of their collective past.

21. *“African-American Health Issues: A Guide to Healthy Living.”*

Length of video in minutes: 2:25

This video is sponsored by Pfizer U.S. Pharmaceuticals and Kaiser Permanente. Contact: The Ebony National Medical Association.

The intended audience for this video is health care providers.

Content and Structure:

- Risk factors include a lack of access to preventive health care, eating an unhealthy diet, teen pregnancy resulting in high rates of infant mortality, high rates of asthma and social ills, such as environmental toxins in the community, violence and drugs.
- Many diseases African-Americans get in their 40’s and 50’s started when they were younger.

22. *“Cultural Diversity of 4 Cultures – Understanding Cultural Diversity: The Perspectives of Minority Professionals.”*

Length of video in minutes: 7:30

Contact: Thomas Hixon, Director of the National Center for Neurogenic Communication Disorders, University of Arizona.

The intended audience for this video is sojourners.

It discusses features that successful sojourners possess as well as characteristics that people who are unsuccessful sojourners possess.

Skills taught:

- It’s important to know the language of the culture and its subtleties.
- Syntactic and pragmatic rules of language influence how certain meanings are expressed.
- Stereotypes about appearance of individuals from other cultures are common and often inappropriate.
- Social forces operate on language and cause us to shift how we talk in different situations.

- Shifting between two languages by bilingual speakers is called “code switching.”
- Many African-Americans are very verbal and upfront about what they’re thinking.
- No dialect of a language is better than another.
- Too often, assumptions are made about what a person’s status and role is from their skin color.
- To understand the Japanese-American culture, it’s essential to know that the culture is collectivist.
- It’s important to have information about the roles of people within the Japanese-American culture. Japanese-Americans are stereotyped as being secretive, less emotional and overly driven.

23. *“Community Voices Exploring Cross-Cultural Care through Cancer”* By Jennie Greene, MS and Kim Newell, MD, for the Harvard Center for Cancer Prevention, Produced at the Harvard School for Public Health

Cost: \$245.00

Length of video in minutes: 69:0

Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131.

Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.

Email: [fanlight@fanlight.com](mailto:fanlight@fanlight.com) Web site: <http://www.fanlight.com>

“Hear the voices and perspectives of nurses, doctors, outreach workers, medical interpreters and patients—people from a range of backgrounds, who make up today’s health care system. This innovative video offers a window into the challenges and rewards of cross-cultural health care and explores the many ways that differences in culture, race and ethnicity affect health and the delivery of health care services. With an extensive Facilitator’s Guide, it helps to integrate cultural awareness and skill building into training programs for all health professionals.” –Fanlight Productions.

24. *“The Angry Heart: The Impact of Racism on Heart Disease Among African Americans”* By Jay Fedigan.

Cost: \$195.00

Length of video in minutes: 57:0

Available from Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131. Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.

Email address: [fanlight@fanlight.com](mailto:fanlight@fanlight.com)

Web address: <http://www.fanlight.com>

“Spotlights the epidemic of heart disease among African Americans through the story of 45-year-old Keith Hartgrove, who has already experienced two

heart attacks and quadruple bypass surgery. Together with experts, he analyzes the impact of a wide variety of factors that contribute to this disease including depression, stress, diet, smoking and other lifestyle issues, but makes clear that, for African-Americans, such factors are inseparable from racism, and from the discrimination, poverty, segregation, substandard education, and day-to-day tensions which racism engenders. Also profiled are the powerful family, church and community ties which have supported him through his recovery.” –Fanlight Productions.

25. “*Anemia Falciforme: Los Rostros de Nuestros Niños*” (“*Sickle Cell Disease: The Faces of Our Children*”) From the Minority Coalition of the United Food and Commercial Workers Union

Cost: \$145.00 each, English or Spanish; \$220.00 for both versions  
Length of video in minutes: 14:00  
Spanish Language Version available

Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131.  
Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.  
Email address: [fanlight@fanlight.com](mailto:fanlight@fanlight.com) Web address: <http://www.fanlight.com>

“This Spanish language video examines the devastating impact of sickle cell disease on young people and their families and caregivers. The children and young people seen in this moving documentary appear healthy, yet they live with the daily threat of excruciating pain and hospitalization.” –Fanlight Productions.

26. “*Nuestra Salud: Lesbianas Latinas Rompiendo Barreras*” A video series on *Lesbian Latina Health*. Produced by Teresa Cuadra, MD & Suzanne Newman

Cost: \$99.00 each or \$299.00 for 4-part series  
Length of video in minutes: 4-part series, 15 minutes each  
In Spanish, with English subtitles  
Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131.  
Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.  
Email: [fanlight@fanlight.com](mailto:fanlight@fanlight.com) Web site: <http://www.fanlight.com>

“*Nuestra Salud* is a compassionate, peer-based, Spanish-language video series aimed at promoting preventive care and wellness for Latina Lesbians. Each video is made up of vignettes, stories and anecdotes told and shared by women who have faced challenges within the health care system and gained knowledge through their struggle. Professionals in the field add their insights and put these issues in a broader context.” –Fanlight Productions.

27. “*Grief in America*” By Bert Atkinson, with narration by Anthony Edwards

Cost: \$245.00

Length of video in minutes: 55:0

Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131.

Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.

Email: [fanlight@fanlight.com](mailto:fanlight@fanlight.com) Web site: <http://www.fanlight.com>

“A comprehensive, multi-ethnic perspective at the ways Americans deal with grief and loss in all their forms.” –Fanlight Productions.

28. “*Despair*” Produced by Harriet Koskoff in association with PBS affiliate Connecticut Public Television. To order, contact: 415-864-0927.

Length of video in minutes: 57:0

“Despair” is the first documentary about depression to consider the pervasive mood disorder from multicultural viewpoints. In personal portraits and interviews with experts from diverse racial and ethnic backgrounds, the documentary explores depressive illness from traditional and non-traditional perspectives.

29. “Building a Diverse Work force for the Global Millennium.”

Cost for Preview: Free

Rental: \$225 for the first program

Rent each additional program for \$100

Sale: \$395 for the first program, \$175 for each additional program

Purchase the entire 20-program series: \$3,450

Length of video in minutes:

For questions, free previews or orders, call 800-423-6021 or visit their website at [www.enterprisemedia.com/diversity.html](http://www.enterprisemedia.com/diversity.html).

These videos focus on work force diversity, but may be useful for health care managers. This is a 20-volume series that covers a huge variety of diversity issues. Each program also presents critical business concepts like building trust and respect, performance appraisals, team building and leadership. Each program comes with a detailed Facilitator’s Guide. You can also purchase enhanced print material, participants workbooks and more.

- Program 1: Do We Speak the Same Language? Should Language and Cultural Style Impact Performance Evaluations?
- Program 2: Double Standards in Performance Appraisals  
Balancing Work, Family and global Travel
- Program 3: Why Can’t We Attract and Keep People of Color?  
Recruiting and Retaining People of Color

- Program 4: Will My Mentor Make A Difference? Mentoring People of Color for Successful Careers
- Program 5: Is It the Cement Ceiling or Is It Me? Career Issues for Non-Management People of Color
- Program 6: What About Me? Diversity's Impact on The Careers of Non-Management White Males
- Program 7: I Deserved It Didn't I? Diversity's Impact on The Careers of White Male Managers
- Program 8: Disbanding The "Good Old Boy Network" The Inclusive vs. Non Inclusive Organization – BEST SELLER
- Program 9: Old School vs. New School: How Much Change Is Too Much, Too Fast?
- Program 10: But We've Always Done It That Way! How Much Change Is Too Much, Too Fast? (Management Setting)
- Program 11: The Fatal Interview: Recruiting People of Color
- Program 12: The Balancing Act Gender Issues and Career Development...Work versus Family
- Program 13: Worlds Apart: Building Effective Teams Globally
- Program 14: Making A Good Impression: Cross-Cultural Conflicts in Global Interviews and Recruitment
- Program 15: It's All in the Presentation: A Double Standard for Women?
- Program 16: You Don't Fit My Style: Cross-Cultural Challenges in Performance Evaluations
- Program 17: You're Making Me Uncomfortable: Gender Conflicts in Cross-Cultural Global Communications
- Program 18: Sexual Harassment? Are You Serious? Gender Issues in the Plant and in the Office
- Program 19: The Skip-Level Meeting: When You Want to Talk to the Manager's Manager
- Program 20: Building Teams in the Global Marketplace: Overcoming Cultural Conflicts in the European Community

30. "Where's Shirley?" A Video Production About Breast Cancer

Available from the Women's Cancer Screening Project, 3 Cooper Plaza, Suite 220, Camden, New Jersey 08103; Tel. 609-968-7324, Fax 609-338-0628.

31. CD-ROM: Ohio Department of Health, Columbus, OH; Medical College of Ohio, Toledo, OH. Contact: Olga Alvarez-Ott, PROFED and QA Coordinator at Breast and Cervical Cancer Project, Ohio Department of Health, Columbus, OH.

*Abstract:*

This CME Program is intended for primary care physicians (including obstetrics and gynecology), nurses and other health care providers involved in detection, diagnosis and treatment of breast cancer.

32. CD-ROM: 2000 Ohio Department of Health and Medical college of Ohio. *Cultural Competence in Breast Cancer Care*. Vertigo Productions LTD., 3634 Denise Drive, Toledo, OH 43614. Tel. 877-385-6211, Fax 419-385-7170.

33. “*Quality Care for Diverse Populations*.” The American Academy of Family Physicians.

The program is available in two formats to suit group training and self-learning needs. Both formats can be ordered either online ([www.aafp.org/catalog](http://www.aafp.org/catalog)) or via telephone (1-800-944-0000). The item number is Cs 723 and the title is Cultural Competency Videotape.

The group-training program includes the video vignettes on VHS videotape included in a binder containing the written materials separated into facilitator and user guides. The group training program package is priced at \$150. The self-learning program is packaged on a single, all-inclusive CD-ROM and is priced at \$100.

Quality Care for Diverse Populations is a new training program developed by the American Academy of Family Physicians to assist physicians and other health care professionals in becoming more culturally proficient in the provision of care to their patients. The program, which was partially funded by the Bureau of Primary Health Care, Health Resources and Services Administration, includes five video vignettes depicting simulated physician-patient visits in an office setting as a means to explore ethnic and sociocultural issues found in today’s diverse health care environment. Written collateral materials, including learning objectives, tools/tips, discussion questions and cultural determinants for each vignette complement the video elements.

This list is presented alphabetically and is intended to be a helpful resource. While every attempt has been made to make this list as complete as possible at the time of publication, it is not exhaustive. Web sites are generally quite dynamic and, therefore, tend to change or update content, navigational tools, and structure on a regular basis. In addition, the web sites listed below offer varying degrees of information related to cultural competency—some are, of course, more comprehensive than others.

1. Accreditation Council for Graduate Medical Education  
[www.acgme.org](http://www.acgme.org)

“The Accreditation Council for Graduate Medical Education is a private professional organization responsible for the accreditation of post-MD medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.”

The site includes general standards in which cultural competence is embedded.

2. Administration on Aging. *Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families*.  
<http://www.aoa.dhhs.gov/minorityaccess/guidebook2001/default.htm>

This guidebook is designed for use by providers of services to racially and ethnically diverse older populations. There is growing interest in learning how effective, culturally appropriate services can be provided by professionals who have mastered culturally sensitive attitudes, skills and behaviors. It is only an introduction and not intended to substitute for more rigorous and on-going study. For readers who have taken more formal courses to acquire cultural competence, this guidebook might serve as a review. The guidebook is divided into six chapters and five appendices. Each of the first three chapters takes a particular perspective or point of view critical to understanding cultural competence. For example, in Chapter Two they explore the meaning of cultural competence. Part A provides a definition of culture and discusses the intervening factors that determine the impact of culture. Part B provides a definition of cultural competence, Part C outlines the barriers to accessing services experienced by minority elders and Part D gives an overview of research accomplished in this area.

3. American College of Emergency Physicians  
[www.acep.org/1,4890,0.html](http://www.acep.org/1,4890,0.html)

The American College of Emergency Physicians (ACEP) exists to support quality emergency medical care, and to promote the interests of emergency physicians.

This web site discusses Cultural Competence and Emergency Care and also

recent policy statements. It contains valuable links to practice resources, government and advocacy, news and publications, meetings and CME and health information.

4. The American College of Obstetricians and Gynecologists (ACOG) – Women’s Health Care Physicians  
<http://www.acog.org>

- a. *When An Infant Dies: Cross Cultural Expressions of Grieving and Loss.*

[http://www.acog.org/from\\_home/departments/dept\\_notice.cfm?recno=10&bulletin=797](http://www.acog.org/from_home/departments/dept_notice.cfm?recno=10&bulletin=797). The panel and this Bulletin were produced in partnership with the Association of the SIDS and Infant Mortality Programs (ASIP). For more information, contact: Kathleen at [kbuckley@acog.org](mailto:kbuckley@acog.org) or Amy at [ahereford@acog.org](mailto:ahereford@acog.org).

This bulletin summarizes a panel presentation at the National Fetal and Infant Mortality Review Program, Third National Conference, held July 16-18, 1998, in Washington, D.C. The bulletin reviews cultural traditions of Latino, African American, North America tribal and Muslim families grieving the loss of an infant. It identifies simple strategies health care providers can use to begin the process of providing culturally competent support to them. It also aims to encourage networking and sharing among providers who assist the bereaved.

- b. *Female Circumcision/Female Genital Mutilation (FC/FGM) Fact Sheet.*

[http://www.acog.org/from\\_home/departments/dept\\_notice.cfm?recno=18&bulletin=1081](http://www.acog.org/from_home/departments/dept_notice.cfm?recno=18&bulletin=1081). For further information, contact: Lisa at [lgoldstein@acog.org](mailto:lgoldstein@acog.org) or Janet at [jchapin@acog.org](mailto:jchapin@acog.org).

Female Circumcision/Female Genital Mutilation (FC/FGM) is culturally determined ritual that has been practiced on an estimated 130 million women and girls worldwide. Because of global immigration patterns, obstetrician-gynecologists in the United States and Canada will increasingly encounter women who have been circumcised.

5. American Medical Association – Cultural Competence Compendium: Contents  
[www.ama-assn.org/ama/pub/category/4848.html](http://www.ama-assn.org/ama/pub/category/4848.html)

The contents of the Cultural Competence Compendium include cultural competence articles in American medical news and related cultural competence links. There is a link to the table of contents for the Cultural Competence Compendium. You can also find links to professional organizations, resources emphasizing communication skills and curriculum and training materials. Needs and resources for specific populations can be found, specifically for underserved and underrepresented racial, ethnic and socioeconomic groups. You can find information on

complementary and spiritual practices and their impact on effective care, relevant materials from nursing and other health professions, patient support materials, including self-help group resources and representative cultural competence publications.

6. American Psychological Association: APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. Guidelines approved by the APA Council of Representatives in August 1990.

[www.apa.org/pi/guide.html](http://www.apa.org/pi/guide.html)

This public interest directorate consists of guidelines, illustrative statements and references. The Guidelines represent general principles that are intended to be aspirational in nature and are designed to provide suggestions to psychologists in working with ethnic, linguistic, and culturally diverse populations. There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services. This increased motivation for improving quality of psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs, and cultural expectations have been introduced into educational, political, business and health care systems by the physical presence of these groups. The issues of language and culture impact on the provision of appropriate psychological services.

The site further explains that psychological service providers need knowledge and skills for multicultural assessment and intervention, including abilities to: (1) recognize cultural diversity; (2) understand the role that culture and ethnicity/race play in the sociopsychological and economic development of ethnic and culturally diverse populations; (3) understand that socioeconomic and political factors significantly impact the psychosocial, political and economic development of ethnic and culturally diverse groups; and (4) help clients to understand/maintain/resolve their own sociocultural identification and understand the interaction of culture, gender and sexual orientation on behavior and needs.

7. Amherst H. Wilder Foundation – Research Center Home Page

[www.wilder.org/research/index.html](http://www.wilder.org/research/index.html)

The Wilder Foundation has grown and prospered largely because of its innovative services and commitment to continually respond to the changing needs of the community. This web site offers employment, volunteer work, a research center, publications, consulting and training, where structured educational programs and culturally-specific teaching tools are used to teach.

8. Association of American Indian Physicians Home Page [www.aaip.com](http://www.aaip.com)

AAIP members are very active in medical education, cross-cultural training between western and traditional medicine and assisting Indian communities. This web site features legal and political information regarding Indian health care policies and current issues, herbal knowledge and workshops for traditional medicine. Current issues in Indian health are discussed, such as diabetes, fitness and nutrition, health and information resources. You can also locate traditional medicine links, services and transcripts.

9. Beth Israel Deaconess Medical Center  
[www.bidmc.harvard.edu/community/cci.htm](http://www.bidmc.harvard.edu/community/cci.htm)

This site consists of an institutional-wide commitment to improve organizations and to give providers the ability to supply exceptionally culturally competent health care to a diverse patient population. It describes one major medical center's cultural competence initiative.

10. The California Department of Mental Health Office of Multicultural Services  
[www.dmh.cahwnet.gov/multicultural](http://www.dmh.cahwnet.gov/multicultural)

This site provides leadership guidance to DMH in promoting culturally competent mental health services.

11. The California Endowment  
<http://www.calendow.org>

“The California Endowment is committed to working with organizations and institutions that directly benefit the health and well-being of Californians. Their mission is to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians.”

The California Endowment offers many different publications including the Annotated Bibliography and Standards for Health Care Interpreters. The California Endowment also offers numerous training videos on cultural competency. On their web site, you can apply for a grant, visit their pressroom, see publications and review reports, and the web site also offers valuable links to other resources. The California Endowment is committed to providing a wide-ranging variety of up-to-date resources and being a clearinghouse of information for the health community of California.

12. California HealthCare Foundation

<http://www.chcf.org>

The California HealthCare Foundation (CHCF) is an independent philanthropy committed to improving California's health care delivery and financing systems. Their goal is to ensure that all Californians have access to affordable, quality health care. Their work focuses on informing health policy decisions, advancing efficient business practices, improving the quality and efficiency of care delivery and promoting informed health care and coverage decisions. CHCF commissions research and analysis, publishes and disseminates information, convenes stakeholders and funds development of programs and models aimed at improving the health care delivery and financing systems. Visit their web site and browse through topics, order publications, and review their grants, RFPs and other programs.

13. The Center for Cross-Cultural Health (CCCH)

Web site: [www.crosshealth.com/index.html](http://www.crosshealth.com/index.html)

Email: [ccch@crosshealth.com](mailto:ccch@crosshealth.com)

“The mission of the Center for Cross-Cultural Health is to integrate the role of culture in improving health. Their vision is to ensure that diverse populations receive culturally competent and sensitive health and human service. The center is actively involved in the education and training of health and human service providers and organizations in the State of Minnesota and beyond. The center is also a research and information resource. Through information sharing, training and research, the Center works to develop culturally competent individuals, organizations, systems, and societies.”

14. The Center for Effective Collaboration and Practice

Web site: [www.air.org/cecp](http://www.air.org/cecp) or <http://cecp.air.org/cultural/resources.htm>

The Center is dedicated to improving services for children and youth with emotional and behavioral problems and to supporting effective collaboration at a local, state and national levels. They are also committed to helping communities create schools that promote emotional well-being, effective instruction and safe learning.

The web site provides a collection of online resources, which include articles, resources and reports. It also consists of a list of resources that provides information about cultural competence health care to diverse populations.

15. The Center for the Health Professions  
University of California, San Francisco  
Web site: <http://futurehealth.ucsf.edu/cnetwork/resources/curricula/diversity.html>  
Email: [chpnews@itsa.ucsf.edu](mailto:chpnews@itsa.ucsf.edu)

“The mission of The Center for the Health Professions is to assist health care professionals, health professions schools, care delivery organizations and public policy makers respond to the challenges of educating and managing a health care work force capable of improving the health and well being of people and their communities.”

On this web site, you can view, download or order reports about California health professions work force, financing and organization of health care systems, health professions education and training and regulation and legislation of health professions. In addition, you can learn about their programs on community-campus partnerships, leadership development, physician and nursing education, supporting innovative program models and work force policy and research. You can also order their 170-page curriculum, which is “organized into eleven sections that focus on teaching clinicians to recognize cultural differences in patient interactions and use specific communication skills to improve patient care. The materials organized can be adapted for sequential one-hour sessions or for daylong seminars.”

16. Center for Healthy Families and Cultural Diversity  
Email: [like@umdnj.edu](mailto:like@umdnj.edu)  
Located at: Department of Family Medicine, University of Medicine and Dentistry of New Jersey – Robert Wood Johnson Medical School, 1 Robert Wood Johnson Place, New Brunswick, NJ 08903.  
(732) 235-7662 Tel.; 732-246-8084 Fax

The Center for Healthy Families and Cultural Diversity offers customized cross-cultural training, as well as instruction in working with interpreters. Training may run from half a day to a full day or longer. Rates vary. A day’s training costs up to \$5,000.

17. The Center for Research on Ethnicity, Culture and Health (CRECH)  
University of Michigan, School of Public Health  
[www.sph.umich.edu/crech/about/](http://www.sph.umich.edu/crech/about/)

The Center for Research on Ethnicity, Culture and Health provides a forum for basic and applied public health research on relationships among ethnicity, culture, socioeconomic status and health. The Center seeks to develop new interdisciplinary frameworks for understanding these relationships while promoting effective collaborations among public health academicians, health providers and local communities.

18. The Commonwealth Fund

One East 75th Street, New York, NY, 10021. Tel. 212-606-3800

Fax 212-606-3500.

Web site <http://www.cmwf.org/>

Email [cmwf@cmwf.org](mailto:cmwf@cmwf.org)

The Commonwealth Fund is a New York City-based private foundation supporting independent research on health and social issues. You can read, order and download publications on various subjects, including: academic health centers, health care quality, international health policy, managed care, Medicaid, Medicare, minority health, quality of care for underserved populations and men's and women's health. You can also sign up for an e-mail alert, obtain information for grant seekers and learn about recent grants.

19. Chinese American Medical Society Home Page

[www.camsociety.org](http://www.camsociety.org)

The Society is incorporated as a non-profit, charitable, educational, and scientific society. This web site gives background on the Medical Society, discusses health issues and news and offers related links and a search site. It contains information on raising awareness in health care in the immigrant community, women's health, disease in the Asian population and Chinese diet in medicine and as medicine. It has materials on traditional Chinese medicine and other practical resources on illnesses and research. The site also discusses psychiatric care for Chinese Americans, pain management, diabetes, cancer and advancement in therapy.

20. Cross Cultural Health Care Program

[www.xculture.org](http://www.xculture.org)

Since 1992, the CCHCP has been addressing broad cultural issues that impact the health of individuals and families in ethnic minority communities in Seattle and nationwide. Through a combination of cultural competency training programs, interpreter training programs, translation services, research projects, community coalition building, and other services, the CCHCP serves as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate. They offer assessment tools and update their site monthly with recent news. Many of the trainings and materials can be downloaded using Adobe Acrobat Reader.

The web site lists various cultural resources. Their products consist of publications and videos for purchase, while their Links and Resources section contains lists of national resources on cultural competency, interpretation and translation and health organizations. The site also offers an online library of literature pertaining to cross cultural

health information on immigrant communities, reference materials and current government publications relating to health care of diverse communities. There is a list of books recommended by the CCHCP staff, which can be ordered directly through Amazon.com.

21. Cultural Competence Activities in the Bureau of Primary Health Care  
<http://www.bphc.hrsa.dhhs.gov/cc/cc-activities.htm>

The Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) works to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and uninsured populations. This is accomplished through the involvement of a network of approximately 700 community and migrant health centers (C/MHCs). It is important to note that 65% of all C/MHC system users are from ethnic/racial/cultural groups. BPHC recognizes that fulfillment of its mission requires that it provide leadership in ensuring high quality health care for these diverse populations.

BPHC recognizes that linguistically and culturally appropriate services for ethnic, racial and cultural populations remain a significant health disparity issue for their diverse citizenry. There is a universal need to provide health services in linguistic and culturally appropriate ways. Language (to understand and to be understood by others with whom we communicate) is universal. Culture (those shared beliefs, attitudes, values and behaviors about health and illness that are shaped and influenced by our history, folklore, customs, traditions and institutions) also is universal. While many of their citizens receive linguistically and culturally appropriate health services as a matter of course, many more do not. Those populations whose language and culture of orientation are not within the dominant Western European American mainstream (often ethnic and racial populations) experience severe health service disparities.

This web site offers opportunities, definitions, lessons learned and some questions to consider in assessing cultural competency and discusses the present and near future of their work in cultural competence.

22. *Cultural Competence: A Journey*, Bureau of Primary Care, Health Resources and Services Administration, Department of Health and Human Services.  
<http://bphc.hrsa.gov/culturalcompetence/#1>

The web site takes you on a cultural journey celebrating cultural and linguistic competency. It discusses seven domains of cultural competence, from values and attitudes and communication styles to policies and procedures and training and professional development. The publication summarizes the evolving experiences of community programs affiliated with the Health Resources and Services Administration's Bureau of Primary Health Care providing services to culturally diverse populations.

This is geared toward professionals devoted to the promotion of health and the prevention, early intervention and treatment of acute and chronic diseases.

23. Cultural Competence Continuum, Cross, Terry L.  
New York State Citizens' Coalition for Children, Inc.  
Web site: <http://www.nysccc.org/T-Rarts/CultCompCont.html>  
Email: [office@nysccc.org](mailto:office@nysccc.org)

Terry Cross, M.S.W., discusses cultural competence, cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence and advanced cultural competence. Cross concludes, "The degree of cultural competence an agency achieves is not dependent on any one factor." Cross believes that "attitudes, policies, and practice are three major arenas where development can and must occur if an agency is to move toward cultural competence."

24. Cultural Competence Standards Home Page  
Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda - Recommendations for National Standards and a National Public Comment Process.  
[www.omhrc.gov/clas/](http://www.omhrc.gov/clas/)

This project makes recommendations for national standards for culturally and linguistically appropriate services (CLAS) in health care. Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. Each standard is accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards and offers recommendations for implementation and oversight to providers, policymaker and advocates.

25. Directory of Resources in Cultural Diversity and Cultural Competence  
[www.aucd.org](http://www.aucd.org)

This site facilitates collaboration among people with disabilities, families, educators and researchers and offers the opportunity to bring people together to share different perspectives.

26. Diversity Rx Home Page  
[www.diversityrx.org](http://www.diversityrx.org)

Promotes language and cultural competence to improve the quality of health care for minority, immigrant and ethnically diverse communities. This web

site offers a table of contents, glossary, models and practices to help you design programs that address linguistic and cultural barriers to health care, such as bilingual interpreter services and interpreter practice. It discusses policy and legal issues and lets you network by signing their guest book and joining their Listserv. This site allows you to register for national conferences, view the draft agenda, and look into abstracts, biographies and contact information from previous meetings. It also offers links to web sites on health, policy and culture. The medical interpretation resources and references guide with information on training, interpreter associations, standards, research and policy is available to print out online. You can also sign up to be a part of their email news list and stay current on Diversity Rx and cross-cultural health care news.

27. EatEthnic Home Page

[www.eatethnic.com](http://www.eatethnic.com)

This web site has everything about ethnic foods and ingredients, holiday food traditions, religious dietary practices, regional food customs, recipes, fun facts and cultural nutrition resources. You can also find links and resources on the site as well. They even have enjoyable items like food quizzes, prizes and short quizlets. You can order food items, cultural nutrition products, browse through their food video selection and visit their bookstore. You can even obtain resources on cultural nutrition and get ethnic health data. You can sign their guest book, receive their newsletter and read what others have to say about this site.

28. EthnoMed – Ethnic Medicine Guide

<http://healthlinks.washington.edu/clinical/ethnomed/>

The EthnoMed site contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants to Seattle, many of whom are refugees fleeing war-torn parts of the world. You can find a summary of these groups at their link, *Features of Major Refugee and Immigrant Groups Seen at Central Seattle Health Clinics*. They present cultural profiles and medical topics on Chinese, Amharic, Somalians, Vietnamese and more. They also offer documents you can download online like a Chinese/English brochure on “*Pap Testing: A New Step to Women’s Health*,” as well as translated patient education materials on Tuberculosis, diaper rash, fever, vomiting/diarrhea and cough/cold. This site also features articles or Clinical Pearls in Cross Cultural Medicine that focus on anything from *Ramadan* and *Skin Decorations in East African Patients to Compliance with INH Prophylaxis for Tuberculosis and Naming in Cambodian Culture*. They discuss cross-cultural health and immigration issues while presenting their research and programs they’re working on. The site offers an A to Z search link, as well as links to library, online, journal, textbook and course references. They have numerous links (*Toolkits*) for care providers, grant seekers, patients, students and more.

29. George Washington University – Module 2: Cultural Competence  
<http://learn.gwumc.edu/iscope/Cultcomp.htm>

This web page details a specific outline, for George Washington University School of Medicine students. It provides learning objectives, definitions, case histories, examples of potential differences in values, references and links. It presents general information about cultures, minority populations and recently immigrated minorities; it compares and contrasts non-verbal communication, such as distance, eye contact, and body language, to verbal communication, and offers self-reflection and team exercises.

30. The Health care Collaborator  
[www.healthcarecollaborator.com](http://www.healthcarecollaborator.com)

The Health care Collaborator is a monthly, online newsletter that helps health care professionals communicate more effectively with each other, their patients and other organizations—contributing to greater efficiencies, improved relationships and smoother running practices. Subscribers may access all past issues of the newsletter, including our issue on “Intercultural Communication,” at any time. A sample issue on leadership communication is complimentary to visitors. More information is available on the site.

31. The Henry J. Kaiser Family Foundation  
[www.kff.org](http://www.kff.org)

“The Kaiser Family Foundation is an independent philanthropy focusing on the major health care issues facing the nation. The Foundation is an independent voice and source of facts and analysis for policymakers, the media, the health care community, and the general public. Their work is focused in three main areas: Health Policy, Media and Public Education, and Health and Development in South Africa.”

32. Indiana University  
Tran cultural and Multicultural Health Links  
<http://www.lib.iun.indiana.edu/trannurs.htm>

33. Institute for Diversity in Health Management Home Page  
[www.institutefordiversity.org](http://www.institutefordiversity.org)

The Institute’s web site is made up of information, education and value-added products, programs and services. It reflects the Institute’s commitment to expanding leadership opportunities to ethnic minorities in health services administration by increasing the number of qualified minorities in the field and improving opportunities for professionals already in the health field.

The web site is linked to a new career development resource from the Institute, DiversityConnection.org™, providing candidates and health care organizations a new way to reach one another. Diversityconnection.org™ is a user-friendly highly interactive web site with a searchable database of abstracted confidential resumes from qualified minority candidates. You can even access an electronic version of the Institute's newsletter, Bridges.

34. La Frontera Center, Inc.  
[www.lafrontera.org/competence-tool.asp](http://www.lafrontera.org/competence-tool.asp)

La Frontera is a nationally recognized leader in providing culturally competent behavioral health services. In 1995, with funding from the U.S. Office of Minority Health, the agency developed and published *Building Bridges: Tools for Developing an Organization's Cultural Competence*. Now in its second printing, the manual is available for \$2.50 per copy, which includes shipping and handling. To purchase copies, send check or money order to Director of Communications, La Frontera Center, Inc. at 502 W. 29th Street, Tucson, AZ 85713.

35. Landon Pediatric Foundation  
Located at: 3400 Loma Vista Road, Suite 1, Ventura, CA 93003  
Fax number: 805-289-3310  
[www.rain.org/~landon/Cultural%20Competence/](http://www.rain.org/~landon/Cultural%20Competence/)

The Landon Pediatric Foundation's web site discusses what cultural competence is to them and how they provide and promote it. A section describing lay healers details things such as *curanderos*, *sobadors* and *parteras*, while other sections talk about illnesses, such as *empacho*, *ojo*, *caida de la mollera* and *susto*. The site also offers resources, definitions and even a checklist for communities.

36. McGill Home Page – Search “Transcultural Psychiatry”  
<http://www.mcgill.ca> or <http://ww2.mcgill.ca/Psychiatry/transcultural/tprr.html>  
Transcultural Psychiatry provides a forum of communication for psychiatrists and other mental health practitioners as well as social scientists around the world concerned with the relationship between culture and mental health. The journal is committed to the most comprehensive coverage of the social and cultural determinants of psychopathology and psychosocial treatments of the entire range of mental and behavioral problems in individuals, families and communities.

You can find recent issues, see highlights of recent issues, take a look at upcoming thematic issues, view recent thematic issues, subscribe to the publication online and see the Editorial Board.

37. Medical Hispanic Center of Excellence  
The University of Texas Health Science Center at San Antonio  
[www.uthscsa.edu/hcoe/page4.html](http://www.uthscsa.edu/hcoe/page4.html)

Medical Hispanic Center of Excellence (MHCOE) is collaborating with the Departments of Family Practice and Internal Medicine. Together they are developing and implementing a strategic plan to ‘infuse’ cultural competence into the medical school curriculum. As part of this project, the MHCOE is developing information resources such as a library of case vignettes that can be requested by all UTHSCSA faculty.

38. Medical Mutual of Ohio  
Located at: 01-5B-3983 2060 East 9th Street, Cleveland, OH 44115-1355  
Fax number: 216-687-6558  
[www.mmoh.com/provider/provnet/culturalcomp.asp](http://www.mmoh.com/provider/provnet/culturalcomp.asp)

The Medical Mutual of Ohio (MMO) web site has a section on cultural competence and provides an example of how a health plan announces its intention to provide culturally competent care. Medical Mutual proposes to provide culturally sensitive services to help ensure access of both clinical and non-clinical services to covered persons. In countries or regions where there is a large population who speak a primary language other than English, MMO will seek to provide health plan information in that language. Other than English, primary languages in the State of Ohio are Spanish, German, Italian, Polish and Slavic. Further, MMO will attempt to link covered persons with practitioners who can address their special cultural needs and preferences by developing and maintaining a network appropriate to the population.

39. Michigan State University College of Human Medicine  
Center of Excellence in Minority Medical Education and Health  
Consortium for Institutional Cooperation’s Health Web Project  
<http://www.msu.edu/user/coemmeh/>

40. Minority Health Program  
University of North Carolina at Chapel Hill  
<http://www.minority.unc.edu>

41. The National Alliance for Hispanic Health  
[www.hispanichealth.org](http://www.hispanichealth.org)

The National Alliance for Hispanic Health is the oldest and largest network of health and human service providers servicing over 10 million Hispanic consumers throughout the U.S. Their mission is to improve the health and well-being of Hispanics in the United States. Since 1973, they have represented all Hispanic groups. They do not accept funds from tobacco or alcohol companies, and they are dedicated to community-based solutions.

To bring the community closer together, this site can connect you to a chat room that is available 24-hours a day. The web site also offers resources, such as health facts, help lines, publications and web links dedicated to health.

42. National Council on Interpreting in Health Care (NCIHC)  
<http://www.ncihc.org/index.html>

The National Council on Interpreting in Health Care is a multidisciplinary organization whose mission is to promote culturally competent professional health care interpreting as a means to support equal access to health services for individuals with limited English proficiency. NCIHC's goals include: 1) establishing a framework that promotes culturally competent health care interpreting that includes standards for provision of interpreter services in health care settings and a code of ethics for interpreters in health care; 2) developing and monitoring policies, research, and model practices; 3) sponsoring a national dialogue of diverse voices and interests on related issues; and 4) collecting, disseminating and acting as a clearinghouse on programs and policies to improve language access to health care for LEP patients. Some of their working papers include: *The Role of the Health Care Interpreter: An Evolving Dialogue*, *Guide to Initial Assessment of Interpreter Qualifications* (May 2001), *The Terminology of Health Care Interpreting: A Glossary of Terms* (October 2001), *A Code of Ethics for Health Care Interpreters: A Working Paper for Discussion* (October 2001), *Recommendations for the Ethical Involvement of Limited English-Speakers in Research*, *Models for the Provision of Health Care Interpreter Training* (March 2002), *Models for the Provision of Language Access in Health Care Settings and Linguistically Appropriate Access and Services: An Evaluation and Review for Health care Organizations*.

43. National Hispanic Medical Association Home Page  
[www.home.earthlink.net/~nhma](http://www.home.earthlink.net/~nhma)

The National Hispanic Medical Association was organized in 1994 to address the interests and concerns of licensed physicians and Hispanic medical faculty dedicated to teaching medical and health services research. As a rapidly growing national resource, NHMA provides policymakers and health care providers with expert information and support in strengthening health service delivery to Hispanic communities across the nation. In their Resident Physician Database Project they are interested in recruiting young Hispanic physicians into their organization; applications can be completed online. They also discuss their non-profit, student-run free clinic. There are links to other Hispanic medical sites on their web site. They announce upcoming conferences and provide information on prior conferences as well.

44. National Center for Cultural Competency  
Georgetown University Center for Child and Human Development  
3307 M Street N.W., Suite 401  
Washington, DC 20007-3935  
800-788-2066 or 202-687-5387  
[www.georgetown.edu/research/gucdc/nccc/cultural5.html](http://www.georgetown.edu/research/gucdc/nccc/cultural5.html)

The National Center for Cultural Competency conducts a wide variety of on-site trainings and can create training for a variety of health care professional audiences. It maintains a consultant bank archived by U.S. geographical areas and training specialty and a *Cultural and Linguistic Competence Resource Database*. Additional resources include *A Guide to Planning and Implementing Cultural Competence Organizational Self-Assessment* and *A Planners Guide for Infusing Principles, Content and Themes Related to Cultural and Linguistic Competence Into Meetings and Conferences*, both of which are available on their web site. Their Policy Briefs 1 through 4, also on the web site, address major policy issues in the provision of culturally competent health care.

45. National Asian Women's Health Organization  
[www.nawho.org](http://www.nawho.org)

NAWHO was founded in 1993 in order to achieve health equity for Asian women and families. The site discusses women's health issues, domestic violence, cancer, substance abuse and mental health. There is also information on the NAWHO leadership network, partnership initiatives, policy and advocacy. There is even a career center with listings of current job openings and also information on events and links to resources.

46. National Center for Child Health and Mental Health Policy  
Georgetown University Child Development Center  
<http://www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html>.

47. National Multicultural Institute, Washington, DC  
<http://www.nmci.org>

The National Multicultural Institute's (NMCI) mission "is to work with individuals, organizations, and committees in creating a society that is strengthened and empowered by its diversity. Through its initiatives, NMCI leads efforts to increase communication, understanding and respect among people of diverse backgrounds and addresses some of the important issues of multiculturalism facing our society. We accomplish this through our Conferences in the Spring and Fall, individualized Organizational Training and Consulting interventions, Publications, and Leading Edge Projects."

On the NMCI web site, information about their various projects, conferences and training programs are readily available.

48. Nova Southeastern University College of Allied Health. "Culture, Ethnicity & Health (Physician Assistant Program) Webliography 2000."  
<http://www.nova.edu/~stevec/webliopa.html>

This web site provides other web sites and links as resources that contribute to the knowledge about cultural diversity in health care. The sites were researched and reviewed by members of the Class of 2002 at the Nova Southeastern University PA Program. Sites range in topics from acupuncture, herbal and traditional medicines to health care information on Cubans, Arabs, Asians, Somalians, Japanese, Gypsies and even tribal communities.

49. Office for Civil Rights (OCR) – Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency [www.hhs.gov/ocr/lep/guide.html](http://www.hhs.gov/ocr/lep/guide.html)

In the course of its enforcement activities, OCR has found that persons who lack proficiency in English frequently are unable to obtain basic knowledge of how to access various benefits and services for which they are eligible. For example, many intake interviewers and other front line employees who interact with LEP individuals are neither bilingual nor trained in how to properly serve an LEP person. As a result, the LEP applicant all too often is either turned away, forced to wait for substantial periods of time, forced to find his/her own interpreter who often is not qualified to interpret or forced to make repeated visits to the provider's office until an interpreter is available to assist in conducting the interview. When these types of circumstances are encountered, the level and quality of health and social services available to persons of limited English proficiency stand in stark conflict to Title VI's promise of equal access to federally assisted programs and activities. Accommodation of these language differences through the provision of effective language assistance will promote compliance with Title VI. This article offers background, legal authority, policy guidance, promising practices, a model plan, compliance and enforcement and technical assistance.

50. Office of Minority Health - *Cultural Competence Works*.  
<http://www.haa.omhrc.gov/HAASidebar/cultural3.htm>  
[www.omhrc.gov](http://www.omhrc.gov) - provides publications and resources on minority health issues.

"HRSA offers a new tool to help health care professionals become more culturally and linguistically competent in the delivery of health care to individuals and families from diverse backgrounds. Called 'Cultural Competence Works' and subtitled 'Using Cultural Competence to Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements,' the publication shows that practicing cultural competence – the set of behaviors, attitudes, skills and policies that help

organizations and staff work effectively with people of different cultures – can help expand and improve access to quality health care.”

Visit <http://www.hrsa.gov/financeMC/cultural-competence.pdf> for information on this new HRSA 79-page document.

51. Office of Minority Health Resource Center  
Health Resources and Services Administration (HRSA)  
[www.omhrc.gov](http://www.omhrc.gov) or email [imosby@omhrc.gov](mailto:imosby@omhrc.gov)  
Located at: PO Box 37337, Washington, DC 20013  
800-444-6472 Toll Free; 301-589-0884 Fax

The Office of Minority Health Resource Center offers a vast repository of cross-cultural documents, books, audiovisual aids, organizations, programs and funding opportunities, courtesy of the US Department of Health and Human Services. Documents and audiovisual aids are offered for African Americans, Asians, Hispanics/Latinos, Native Americans and Native Hawaiians/Pacific Islanders.

52. Office of the Surgeon General; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. “Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General.”  
<http://www.surgeongeneral.gov/library/mentalhealth/cre/>

This report is a supplement to the first ever Surgeon General’s Report on Mental Health, *Mental Health: A Report of the Surgeon General* (DHHS, 1999), which is also included on this web site. The full report on Culture, Race, and Ethnicity is provided and is printable and downloadable with Adobe Acrobat. You can also order a printed copy of the report online or by telephone. This 217-page publication makes clear that the tragic and devastating effects of mental illnesses touch people of all ages, colors and cultures. It informs us that there are effective treatments available for most disorders. It discusses the origins and purposes of the supplement, scope and terminology, and the influence culture and society has on mental health. There are sections on mental health care for African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders and Hispanic Americans. The publication then addresses their vision for the future and how they plan to continue to expand the science base, improve access to treatment and reduce barriers to treatment. They also discuss their proposal to improve the quality of care, support capacity development and promote mental health. This supplement sets a foundation for national efforts to provide racial and ethnic minorities affected by mental disorders with effective and affordable treatments tailored to their specific needs. Culturally specific resources and links on mental health are offered on this site in English and Spanish.

53. Office Support Agency, Inc.  
Substance Abuse and Mental Health Services Administration  
Web site: [www.samhsa.gov](http://www.samhsa.gov)  
Email: [OSA1mch@aol.com](mailto:OSA1mch@aol.com)

This site provides publications discussing cultural competence issues in substance abuse and mental health.

54. Ohio Department of Mental Health, Office of Mental Health Services  
[www.mh.state.oh.us](http://www.mh.state.oh.us)

The department holds public forums and offers publications addressing the development and accomplishments of a culturally competent Mental Health System.

55. Pacific Interpreters  
Web Site: [www.pacinterp.com](http://www.pacinterp.com)  
Email: [information@pacinterp.com](mailto:information@pacinterp.com)  
Located at: 1020 SW Taylor, Suite 280, Portland, OR 97205  
800-870-1069 Toll Free; 503-223-8899 Tel.; 503-223-1336 Fax

Pacific Interpreters offers document-translation services and nationwide telephone and videoconference interpreting, as well as on-site interpreting in the Pacific Northwest, in more than 100 languages. Interpreters and translators are trained in clinical terminology. The rate for telephone interpreting: \$1.95 per minute – 24 hours a day, seven days a week, regardless of the language. Interpreters are usually immediately available.

56. The Park Ridge Center for the Study of Health, Faith, and Ethics  
[www.parkridgecenter.org/cgi-bin/showpage.dll?id=1880](http://www.parkridgecenter.org/cgi-bin/showpage.dll?id=1880)

The Park Ridge Center provides ethics consultation services and publications to health and human service organizations, such as health care networks, hospitals, long-term care facilities, home health and home care agencies and child and family service agencies. The Park Ridge Center explores and enhances the interaction of health, faith and ethics through research education and consultation to improve the lives of individuals and communities. The Center is an independent, nonprofit, nonsectarian organization affiliated with Advocate Health Care. Consultation and associated educational services address patient and client care issues as well as organizational ethics concerns. Fees are structured according to hourly rates or through contractual arrangements. For information, call Mary Ann Clemens at 312-266-2222, extension 240.

Some of the web site explores “religiously informed cultural competence.” Authors examine the competencies needed to address cultural diversity in a health care setting. Religion and spirituality are significant aspects

of cultures, and authors show how health care professionals address that relationship. This issue also features “After September 11,” a collection of essays by four scholars of religion who reflect on how the agenda for health, faith and ethics has been affected by recent events.

57. Patient and Family Education Services, University of Washington Medical Center

<http://depts.washington.edu/pfes/pdf/cclue-albanian.pdf>

<http://depts.washington.edu/pfes/pdf/cclue-africanamerican.pdf>

<http://depts.washington.edu/pfes/pdf/cclue-chinese.pdf>

<http://depts.washington.edu/pfes/pdf/cclue-korean.pdf>

<http://depts.washington.edu/pfes/pdf/cclue-latino.pdf>

<http://depts.washington.edu/pfes/pdf/cclue-russian.pdf>

<http://depts.washington.edu/pfes/pdf/cclue-vietnamese.pdf>

These web sites consist of Culture Clues,, which are “tip sheets for clinicians designed to increase awareness about concepts and preferences of patients from the diverse cultures served by UWMC. Currently there are seven cultures represented, with additional ones in progress.”

58. The Provider’s Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

This web site is designed to assist health care organizations throughout the U.S. in providing high quality, culturally competent services to multi-ethnic populations. It discusses quality and culture topics, defines cultural competence, provides an assessment tool and offers a quality and culture quiz and links to additional resources.

The Guide includes: (1) full-color photographs; (2) improved navigation and visual appeal; (3) enhanced information on 5 major cultural groups in the U.S. with pertinent links to related information in other parts of the site; (4) excerpts from selected chapters of the 10 volume Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA) and the United States Department of Health and Human Services (DHHS) Office of Minority Health (OMH) cultural competence monograph series presented in short pieces of text for easy on-screen reading with full references for all of the material; (5) additional resources and links; and (6) a fully-functional search engine.

59. Race, Health Care and the Law

University of Dayton School of Law

<http://www.udayton.edu/~health/>

60. Society for Medical Anthropology

<http://www.people.memphis.edu/~sma/>

61. Society of Teachers of Family Medicine

<http://www.stfm.org/corep.html>

Developed by the STFM's Task Force on Cross-cultural Experiences, Group on Multicultural Health Care and Education, and Group on Minority Health Care, these guidelines are recommended core curriculum guidelines on culturally sensitive and competent health care. They are recommendations for helping residency programs train family physicians to provide culturally sensitive and competent health care. They provide a background on their recommendations and their work in progress. They also discuss the attitudes that residents will develop, the knowledge residents will acquire and the skills they will gain in many areas. The implementation of the core curriculum is discussed in depth. Several cross-cultural health care resources and experiential exercises, games, simulations and videos are also recommended.

62. Stanford Geriatric Education Center, c/o VAPAHCS, 3801 Miranda Avenue, Room A-236, (182B-SGEC), Palo Alto, CA 94304 or call 650-494-3986. <http://www.stanford.edu/group/ethnoger/target.html>.

*Abstract:*

Multidisciplinary ethnogeriatric education, focusing on faculty development, training for health care providers, research and policy analysis. The Stanford Geriatric Education Center provides a variety of ethnogeriatric programs and curriculum resource materials to educate health care professionals on the cultural issues associated with aging and health. The SGEC promotes cultural sensitivity and cultural competence to improve the quality of health care delivered to the rapidly growing population of ethnic minority elders in the United States.

63. Tamanawit Unltd.

[www.tamanawit.com/index.html](http://www.tamanawit.com/index.html)

“Trained as a traditional Native American Storyteller, Dr. Terry Tafoya is a Taos Pueblo and Warm Springs Indian who has used American Indian ritual and ceremony in his work as a Family Therapist at the Interpersonal Psychotherapy Clinic, part of the University of Washington's School of Medicine in Seattle. The Harbourview Community Mental Health Center, the site of the Interpersonal Psychotherapy Clinic, was responsible for having the Washington State Department of Social and Health Services designate Dr. Tafoya as the first formally recognized Native Healer for the state as an Ethnic Minority Mental Health Specialist.”

The site consists of biographies, resources and materials, scheduled events and workshops.

64. Transcultural and Multicultural Health Links

<http://www.iun.edu/~libemb/trannurs/trannurs.htm>

This web site has numerous resources and links. The bibliography includes a reading list concerning specific conditions and populations, such as African Americans, Asians/Pacific Islanders, Gays/Lesbians, Hispanics/Latinos and Native Americans. There are links to resettlement agencies and refugee statistic web sites as well. There is a section on essays and surveys, which includes articles and web sites that provide topical information on multiple populations. Provided are essays, charts, links, articles, and reports on age, gender, religious factors and research examining Vietnamese, Lebanese and Italians. Information on government offices, research institutes and professional associations is also offered. Their health profiles describe sites providing summaries of the health beliefs and practices of multiple populations.

There are also IUN library materials online, such as encyclopedias, reference materials and journals, communication issues, workbooks and training materials.

Links to and descriptions of articles addressing research issues in multicultural health research are also accessible. This site has data on ethnic groups such as African Americans, Native Alaskans, Asians and Pacific Islanders, Chinese, Cambodians, Hispanics, Hmong, Indians, Japanese, Koreans, Native Americans, Tibetans and Vietnamese. Furthermore, it contains information on religious groups such as the Amish, Buddhist, Christian Science, Hindu, Hutterite, Islam, Jehovah Witness, Judaism, Mormon, Quaker and Seventh Day Adventist. Special populations (women, gays, lesbians and bisexuals) are also included in this site. Web sites are recognized for their superiority in health care and cultural competence in the 'Awards' portion of the web site.

65. Transcultural Nursing Society Home Page

[www.tcns.org](http://www.tcns.org)

The society's mission is to ensure that the culture care needs of the people in the world will be met by nurses prepared in transcultural nursing. They discuss culture care and health beliefs, values and practices of people from diverse and similar cultures, while promoting, advancing and disseminating transcultural nursing knowledge in education and practice worldwide. You can obtain the current issue of the Transcultural Nursing Society Newsletter and get up-to-date information from the web site. In addition, the full index for the Journal of Transcultural Nursing, 1989 to present, is available online. There is also a bookstore and an online village to browse through as well.

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66. University of Pennsylvania Health System  
Contact: The Institute on Aging, University of Pennsylvania Health System at 3615 Chestnut Street, Philadelphia, PA 19104  
[www.uphs.upenn.edu/aging/diverse/intro.shtml](http://www.uphs.upenn.edu/aging/diverse/intro.shtml)

The web site is devoted to exploring current developments at the Institute on Aging in the conceptualization of cultural competence for health systems. Providers, researchers and policy-makers should find these materials useful to their own work in this area.

67. Window on the World  
<http://www.windowontheworldinc.com/mission.html>

Window on the World's site contains information on their mission and their services, and it even includes an online training demo and tips on conducting business around the world. There is also a special section on cross-cultural teams.

**[www.calendow.org](http://www.calendow.org)**

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