Paso a Paso: Step by Step Toward Cultural Competence

Achieving cultural competence — the ability to communicate effectively across different linguistic and cultural traditions — is necessarily a gradual process. For clinicians, this requires close examination of health-related attitudes and beliefs — their clients’ and their own. The following articles suggest some steps that homeless health care providers can take to begin the journey. To simplify this task while illustrating its complexity, we have chosen to focus on the clinical challenges presented by homeless persons whose primary language is Spanish, and how experienced clinicians are meeting them. Many of the lessons learned from these service providers are applicable to other cultural groups.

Communication barriers are among the most serious impediments to health care for residents of the United States whose native tongue is Spanish. The medical consequences of miscommunication can be catastrophic. In a memorable episode of a popular television series, a Hispanic woman with tuberculosis misinterpreted the written instructions on a bottle of pills that read, “take once daily.” The patient took eleven pills at one time, with fatal consequences. In Spanish, “once” means “eleven.”

Miscommunication stems from misunderstanding. “Often clinicians don’t understand what their Latino/Hispanic patients are saying, even if they speak the same language,” observes Ed Scully, MD, of Greater Lawrence Family Health Center in Kingston, New Hampshire. Although most of his homeless patients are “Anglo,” a significant number are from Puerto Rico, the Dominican Republic, Guatemala, or Colombia. Even bilingual (English-Spanish) clinic staff are challenged by the variety of dialects, linguistic idioms, health beliefs, and cultural values they encounter among these Spanish-speaking clients.

“Hispanic countries are not unicultural,” Linette Martinez, MD, Homeless Coordinator at the Tom Waddell Health Center in San Francisco, reminds us. “It’s very hard, even for a Spanish-speaking clinician, to gain insight into a patient’s beliefs about health and health care.” For example, it is more shameful for Latino males than for other homeless men to admit behaviors that increase their risk for HIV. Consequently, they don’t seek screening as readily as other clients. “We see an unusual number of transgendered homeless patients from Latin America who are at huge risk for HIV,” she says. Engaging them in HIV prevention and treatment requires skillful outreach. Martinez is also seeing a growing number of young, homeless men from remote areas of Mexico such as Chiapas, who have never seen a physician before. They speak a mixture of Spanish and their indigenous language. Martinez, who is Puerto Rican, has trouble understanding these patients.

“Essential to cultural competence is learning who your clients are and where they come from,” declares Edmundo Apodaca, LMSW Albuquerque Health Care for the Homeless. Several cultures are represented among Spanish-speaking people in New Mexico — those whose Hispanic ancestors settled the northern part of the state generations ago; individuals of mixed Spanish, Mexican and Native American heritage; indigenous Mexicans and immigrants from Central or South America; a few Puerto Ricans; and Cuban refugees.

As a first-generation “Hispanic American,” Apodaca admits that he is less fluent in Spanish than his immigrant parents. Explaining the process and rationale of behavioral health care to Spanish-speaking clients of diverse backgrounds is one of the greatest linguistic and
cultural challenges he faces. “The stigma against mental illness and substance abuse is present in both American and Hispanic cultures,” he observes. “People fear disclosing their mental illness and don’t understand what it is.” Although some of his clients believe that mental illness is a result of divine providence or is caused by an external agent, only those from very isolated places without access to modern medicine believe in curses or evil spirits as sources of illness. Some traditional Native Americans still speak of “shape shifting” as an explanation of schizophrenia. Whatever their cultural background, his Spanish-speaking clients try to inform him as best they can what their problem is. Most come to the clinic expecting treatment, but many believe that substance abuse is best resolved through abstinence alone. “This isn’t particularly effective for persons with heroin addiction,” he says, which is “a big problem for clients from rural Mexico who try to cure themselves,” usually without success.

“Customs of people from rural and urban areas differ,” observes Jenny McLaurin, MD, MPH, who works for the Migrant Clinicians’ Network and two rural health departments in North Carolina. She serves migrant farmworkers, many of them homeless, typically in rural areas where there aren’t as many resources for people with different cultural and linguistic backgrounds. “Migrants tend to travel in groups with the same geographic origin,” she says. In North Carolina, most farmworkers are Mexican, but some are from Guatemala, Honduras, and Puerto Rico. “Cultural origin influences patients’ attitudes toward health care,” agrees McLaurin. “For example, patients from Guatemala don’t know the year or month of their child’s birth, are used to home births, and are not as accepting of physicians.”

Three categories of barriers contribute to the dissatisfaction of Latinos/Hispanics with health care providers and services, according to research cited by the National Council of La Raza:

- **Accessibility**: lack of transportation, health insurance, and childcare; cost of services (especially specialty care and mental health services) and fear of deportation;
- **Acceptability**: few health care personnel who speak their language and understand their culture; lack of accurately translated health information, written at appropriate literacy levels, and containing concepts that reflect their cultural norms; failure to involve the family or cultural community in health promotion and disease prevention.

All of these obstacles seriously limit access to health care. Cultural competence of service providers is only one step in assuring that the health care needs of native Spanish speakers experiencing homelessness are met.

Balancing Traditional with Modern Healing

In general, people of Latino/Hispanic origin have a more holistic understanding of health and health care than is characteristic of Western medicine. They are more concerned about how the treatment of health problems will affect the emotional and spiritual well being of both the individual and the kinship group. Depending on their cultural and educational background, they may consult traditional healers, who are sensitive to these concerns, and use home remedies as an alternative or in addition to seeing medical professionals.

Among the traditional healers preferred by native Spanish speakers are curanderas (who use herbs, teas, fetishes and prayers to cure a wide variety of illnesses), and sobradores (who repair dislocated joints, set bones, and provide massage therapy). It is important to acknowledge the patient’s explanation of illness and preferred remedies, while ensuring that the treatment modalities used are compatible and do not endanger the client’s health, according to homeless service providers. Cultural competence is key in achieving this sometimes delicate balance.

Jenny McLaurin, MD, MPH advises cooperating and collaborating with traditional healers. “If diabetic patients try to substitute their problem is. Most come to the clinic expecting treatment, but many believe that substance abuse is best resolved through abstinence alone. “This isn’t particularly effective for persons with heroin addiction,” he says, which is “a big problem for clients from rural Mexico who try to cure themselves,” usually without success.

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Building Rapport with Spanish-speaking Clients

Language and cultural barriers prevent many Spanish-speaking homeless people from seeking services. Confronting an unfamiliar health system and communicating their needs can be so daunting that they don’t seek care except in an emergency. Undocumented immigrants are particularly hesitant to seek services, even when they are urgently needed, for fear of being deported. To alleviate these fears and build rapport with native Spanish-speakers, experienced clinicians recommend the following:

- **Demonstrate respect (respeto)** by adhering to cultural norms related to age, gender, social position and authority. Be more formal in addressing and interacting with adult clients. Don’t use a child or someone of another gender as an interpreter. Be careful how you ask women questions. Asking a Latino/Hispanic woman where she spent the night (to determine homelessness) could be offensive. It suggests sexual promiscuity, which is taboo in her culture. Ask someone from the Spanish-speaking community how to phrase this question in the least offensive way.

- **Recognize the role of the family (la familia)** in making health care decisions. When a Hispanic family comes to the clinic, make all members feel welcome; this may be their only chance to see a health care provider. Ask who within the family influences health decisions for the patient. Ask how a given treatment or therapy would affect the family, and whether there are any concerns about it.

- **Invest in trained interpreters rather than relying on free interpretation services, lay people, or a family member** to interpret for your clients. If possible, hire a trained interpreter, provide training in interpretation skills for bilingual clinic staff, and educate providers about how best to utilize interpretive services. Even if you speak Spanish, know your linguistic limitations.

- **Listen to your clients; ask open-ended questions that don’t require only a yes or no answer.** Ask questions that invite clients to share their perceptions of their health status and needs. For example, “What do you think is causing this problem? What would you like for me to do? What kind of medicine do you prefer—an injection or oral medication? Who else helps you take care of your health and your children’s health problems? Under what circumstances do you feel you should bring your child to the clinic?”

**WHAT EVERY HCH PROVIDER SHOULD KNOW**

- “No person in the United States shall, on ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” (Title VI, Civil Rights Act, 1964)

- Service delivery programs of the Health Resources and Services Administration are NOT required to verify the immigration and citizenship status of their patients. (HRSA administrator, 8/8/98)

- Coverage for emergency services is available to anyone who meets Medicaid financial and categorical requirements, regardless of immigration or insurance status. Applicants may not be denied emergency services based on failure to certify or document their citizenship or immigration status. (OCR/HHS, 9/20/00)

- Federally funded health centers provide health services to … all people who face barriers to accessing services because they have difficulty paying for services, [or] because they have language or cultural differences…. All health centers must provide services that enable patients to access health center services, such as outreach, transportation, and interpretive services. (PIN 98-23; BPHC Program Expectations, 8/17/98)

- All recipients of Federal funds from the U.S. Department of Health and Human Services must take steps to ensure that persons with limited English proficiency (LEP) can meaningfully access health and social services. All health organizations must:  
  - Provide oral language assistance services, including bilingual staff and interpretive services, at no cost to LEP clients;  
  - Provide verbal and written notice to LEP persons in their preferred language of the right to free language assistance;  
  - Assure the competence of language assistance provided to LEP patients by interpreters and bilingual staff; and  
  - Make available easily understood patient-related written materials and post signage in the languages of groups commonly encountered or represented in the service area. (OCR/HHS, 8/30/00; OMH/HHS, 3/01)
Explain treatment options and medical procedures thoroughly, in a way that is understandable. If you speak Spanish, speak slowly, so clients can understand and absorb what you are saying. Patients may not express disagreement or doubt about your medical instructions out of respeto for your authority. Ascertain whether they understand your instructions through careful questioning.

Be knowledgeable about your clients’ legal options for health coverage and health care. Be familiar with your state’s eligibility requirements for public health coverage. It is against Federal law to require information about a client’s immigration or citizenship status as a condition for providing emergency services. Documentation of immigration or citizenship status is required only of applicants for non-emergency Medicaid, SCHIP, TANF, or food stamps (not of family members who are not applying for benefits). Some clients may be able to change their immigration status by applying for asylum, which could enable them to qualify for Medicaid.

Sources & Resources


Other helpful information available online:

- Center for Cross-Cultural Health: www.crosshealth.com/index.html
- Cross-Cultural Health Care Program: www.xculture.org
- Diversity Rx: http://diversityrx.org
- Ethnomed, Harborview Medical Center: www.ethnomed.org
- Migrant Clinicians’ Network: www.migrantclinician.org
- National Center for Cultural Competence: http://gucdc.georgetown.edu/nccc
- Provider’s Guide to Quality & Culture: http://erc.msh.org

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