Cultural Sensitivity

Cultural sensitivity training in health care providers can improve the satisfaction and health outcomes of patients from different minority groups.

*Tolerance, inter-cultural dialogue and respect for diversity are more essential than ever in a world where people are becoming more and more closely interconnected.*

—Kofi Annan, Former Secretary-General of the United Nations

**Definition**  
Cultural sensitivity begins with a recognition that there are differences between cultures. These differences are reflected in the ways that different groups communicate and relate to one another, and they carry over into interactions with health care providers. Cultural sensitivity does not mean, however, that a person need only be aware of the differences to interact effectively with people from other cultures. If health care providers and their patients are to interact effectively, they must move beyond both cultural sensitivity and cultural biases that create barriers. Developing this kind of culturally competent attitude is an ongoing process.

A culturally competent clinician views all patients as unique individuals and realizes that their experiences, beliefs, values, and language affect their perceptions of clinical service delivery, acceptance of a diagnosis, and compliance.

**Description**

Cultural competence is an important component of health care. This is especially true given America's increasingly diverse patient population and the disparities in the health status of people from different racial, ethnic, socioeconomic, religious, and cultural backgrounds. To value this diversity a clinician must respect the differences seen in other people, including customs, thoughts, behaviors, communication styles, values, traditions, and institutions.

Recognizing differences among cultures is important, but the clinician should also be aware that differences also exist within cultures. The assumption that a common culture is shared by all members of a racial, linguistic, or religious group is erroneous. The larger group may share common historic and geographic experiences, but individuals within the group may share nothing beyond that.

Culture greatly influences how people view their health and the health care services they receive. Clinicians should be aware of these differences, respect them, and work within the parameters set by the patient's
values. Clinicians must also recognize their own cultural values and draw parallels where possible; they should also identify any prejudices and stereotypes that prevent them from communicating effectively with patients from different cultures.

The language barrier

Language differences between the clinician and the patient are a further barrier to optimum health care. Where possible, professional translators should be used. It’s not always in the client’s best interest to have a family member act as an interpreter. The client may feel uncomfortable discussing personal matters in front of a relative. In addition, the interpreter may lack a medical vocabulary, or may reinterpret what the patient says in an effort to “help.” Role conflicts may further hinder translation. For example, a child or a person of the opposite sex may be embarrassed by the information or feel it improper to convey the message intended.

When using an interpreter the clinician should:

- Try to find an unrelated interpreter of the same sex as the patient, who is able to translate medical information clearly.
- Schedule more time for the appointment, if possible. Discuss the focus of the session with the interpreter before the patient arrives; be clear about what the interpreter should convey to the patient.
- Have the interpreter meet with the patient before the session to assess his or her educational level. This will determine how complex the discussion can become. If the patient has already met the clinician, the interpreter should be presented as a member of the healthcare team.
- Speak in short sentences or phrases, to make translating easier for the interpreter. Make sure the patient understands what he or she has been told by asking for him/her to repeat the message in his/her own words.
- Remember who the patient is—keep the focus on the patient, not the interpreter.
- Be sensitive to cultural differences when using nonverbal communication. For example, a touch has many cultural meanings. Clinicians must be aware that personal space has different boundaries in different cultures.

Professional implications

In order to be culturally competent clinicians need not possess full knowledge of every cultural practice and belief. Instead they should be sensitive to others’ preferences and values, and should not assume that one person’s preferences and values apply to everyone in that same group. Patients are often willing to share their customs with those who seek to understand them. Genuine concern about what is important to the client is the best way to assure that culturally competent care will be provided.

Be aware of your own potential biases and prejudices

All people can be influenced by personal biases. Such biases can take the form of conscious or unconscious prejudice and discrimination.
A first step in eliminating the possible influence of personal biases is to have a clear understanding of the meaning of prejudice and discrimination, and of the ways they can influence assessment without one’s conscious awareness.

Prejudice is a conscious or unconscious pre-judgment of others based on their real or assumed membership in a particular group (e.g., racial or cultural group). Most prejudices are against, rather than for other groups or individuals.

Discrimination is the behavioral expression of prejudice: it is the act of differential treatment of an individual or group (intentionally or unintentionally) that usually creates a disadvantage for that individual or group.

One of the disconcerting aspects of prejudice is that most people will recognize its effect on human behavior, but few people are willing to acknowledge their own personal biases. For example, people tend to be more perceptive in identifying prejudices among their colleagues and friends, and less perceptive in recognizing their own prejudicial attitudes and beliefs. Difficulty in acknowledging personal prejudice can be partly attributed to systemic factors. For example, pervasive and stereotypic portrayals of certain groups in the media can reinforce the erroneous belief that one’s personal biases about these groups are not biases but an accurate reflection of reality. Personal prejudices, reinforced by systemic factors, tend to go unchallenged unless individuals actively attempt to increase their self-awareness and control these prejudicial attitudes and beliefs.

Various ways to reduce prejudice are available. For example, emotional reactions (positive and negative) can be used to alert you to the possibility that subjective values may be at play and that alternate interpretations may be possible. You can also acknowledge and seek information to disprove the stereotypes and prejudices you have about others. Voluntary attendance at a workshop or seminar on diversity, or working on a shared objective with people of other races or cultures can also provide opportunities to perceive and control biases you may hold about other groups.

In summary, most people are not completely aware of their own personal biases. As a result, a clinician with unconscious prejudices may create a barrier to effectively caring for certain people. Therefore, it is essential that those who are responsible for assessing patient’s concerns have a keen awareness of their personal attitudes about groups other than their own, and that they take steps to reduce or control the influence of such attitudes.

BOOKS


Americans with Disabilities Act (ADA) and The Civil Rights Act of 1964

CMS and NYSDOH require provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the FIDA Plan model and support better health outcomes for FIDA Plan Participants.

Communication access

Communication is an integral part of providing care to a patient. Communication may become an issue if there are barriers based on physical, social or language limitations. Fidelis Care providers may bill translator services using Code T1013. If a translator is not available, a language line or TTY line can be accessed by calling the provider call center at 1-888-FIDEALIS.

Accessibility for People with Disabilities
Accessibility of doctors’ offices, clinics, and other health care providers is essential in providing medical care to people with disabilities. Due to barriers, individuals with disabilities are less likely to get routine preventative medical care than people without disabilities. Accessibility is not only legally required, it is important medically so that minor problems can be detected and treated before turning into major and possibly life-threatening problems.

The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in every day activities, including medical services. Section 504 of the Rehabilitation Act of 1973 (Section 504) is a civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance, including health programs and services. These statutes require medical care providers to make their services available in an accessible manner. For additional detailed information on technical assistance a publication is available at http://www.ada.gov/medcare mobility ta/medcare ta.htm and provides guidance for medical care providers on the requirements of the ADA in medical settings with respect to people with mobility disabilities, which include, for example, those who use wheelchairs, scooters, walkers, crutches, or no mobility devices at all.

**Physical access**

An accessible examination room has features that make it possible for patients with mobility disabilities, including those who use wheelchairs, to receive appropriate medical care. These features allow the patient to enter the examination room, move around in the room, and utilize the accessible equipment provided. Detailed diagrams can be found on http://www.ada.gov/medcare mobility ta/medcare ta.htm. The features that make this possible are:

- an accessible route to and through the room;
- an entry door with adequate clear width, maneuvering clearance, and accessible hardware;
- appropriate models and placement of accessible examination equipment; and
- adequate clear floor space inside the room for side transfers and use of lift equipment.

New and altered examination rooms must meet requirements of the ADA Standards for Accessible Design. Accessible examination rooms may need additional floor space to accommodate transfers and for certain equipment, such as a floor lift.

The number of examination rooms with accessible equipment needed by the medical care provider depends on the size of the practice, the patient population, and other factors. One such exam room may be sufficient in a small doctor’s practice, while more will likely be necessary in a large clinic.

**Medical equipment access**

Availability of accessible medical equipment is an important part of providing accessible medical care, and doctors and other providers must ensure that medical equipment is not a barrier to individuals with disabilities. Such equipment includes adjustable-height exam tables and chairs, wheelchair-accessible scales, adjustable-height radiologic equipment, portable floor and overhead track lifts, and gurneys and stretchers.

The right solution or solutions for providing accessible medical care depends on existing equipment, the space available both within the examination room and for storage of equipment, the size of the practice and staff, and the patient population. What is important is that a person with a disability receives medical services equal to those received by a person without a disability. For example, if a patient must be lying down to be thoroughly examined, then a person with a disability must also be examined lying down. Likewise, examinations which require specialized positioning, such as gynecological examinations, must be accessible to a person with a disability. To provide an accessible gynecological exam to women with paralysis or other conditions that make it difficult or impossible for them to move or support their legs, the provider may need an accessible height exam table with adjustable, padded leg supports, instead of typical stirrups.
However, if the examination or procedure does not require that a person lie down (for example, an examination of the face or an x-ray of the hand), then using an exam table is not necessarily important to the quality of the medical care and the patient may remain seated.

Detailed diagrams and guidance covering different types of medical equipment can be found at [http://www.ada.gov/medcare_mobiity_ta/medcare_ta.htm](http://www.ada.gov/medcare_mobiity_ta/medcare_ta.htm)

**Staff Training**

A critical, but often overlooked component to ensuring success is adequate and ongoing training of medical practitioners and staff. Purchasing accessible medical equipment will not provide access if no one knows how to operate it. Staff must also know which examination and procedure rooms are accessible and where portable accessible medical equipment is stored. Whenever new equipment to provide accessible care is received, staff should be immediately trained on its proper use and maintenance. New staff should receive training as soon as they come on the job and all staff should undergo periodic refresher training during each year.

Finally, training staff to properly assist with transfers and lifts, and to use positioning aids correctly will minimize the chance of injury for both patients and staff. Staff should be instructed to ask patients with disabilities if they need help before providing assistance and, if they do, how best they can help. People with mobility disabilities are not all the same - they use mobility devices of different types, sizes and weight, transfer in different ways, and have varying levels of physical ability. Make sure that staff know, especially if they are unsure, that it is not only permissible, but encouraged, to ask questions. Understanding what assistance, if any, is needed and how to provide it, will go a long way toward providing safe and accessible health care for people with mobility disabilities.

**Commonly Asked Questions**

**Q1.** Is it OK to examine a patient who uses a wheelchair in the wheelchair, because the patient cannot get onto the exam table independently?

**A1.** Generally no. Examining a patient in their wheelchair usually is less thorough than on the exam table, and does not provide the patient equal medical services. There are several ways to make the exam table accessible to a person using a wheelchair. A good option is to have a table that adjusts down to the level of a wheelchair, approximately 17-19 inches from the floor. What is important is that a person with a disability receives equal medical services to those received by a person without a disability. If the examination does not require that a person lie down (for example, an examination of the face), then the exam table is not important to the medical care and the patient may remain seated.

**Q2.** Can I tell a patient that I cannot treat her because I don’t have accessible medical equipment?

**A2.** Generally no. You cannot deny service to a patient whom you would otherwise serve because she has a disability. You must examine the patient as you would any patient. In order to do so, you may need to provide an accessible exam table, an accessible stretcher or gurney, or a patient lift, or have enough trained staff available who can assist the patient to transfer.

**Q3.** Is it OK to tell a patient who has a disability to bring along someone who can help at the exam?

**A3.** No. If a patient chooses to bring along a friend or family member to the appointment, they may. However, a patient with a disability, just like other individuals, may come to an appointment alone, and the provider must provide reasonable assistance to enable the individual to receive the medical care. This assistance may include helping the patient to undress and dress, get on and off the exam table or other equipment, and lie back and be positioned on the examination table or other equipment. Once on the exam table, some patients may need a staff person to stay with them to help maintain balance and positioning. The provider should ask the patient if he or she needs any assistance and, if so, what is the best way to help.
Q4. If the patient does bring an assistant or a family member, do I talk to the patient or the companion? Should the companion remain in the room while I examine the patient and while discussing the medical problem or results?

A4. You should always address the patient directly, not the companion, as you would with any other patient. Just because the patient has a disability does not mean that he or she cannot speak for him or herself or understand the exam results. It is up to the patient to decide whether a companion remains in the room during your exam or discussion with the patient. The patient may have brought a companion to assist in getting to the exam, but would prefer to ask the companion to leave the room before the doctor begins a substantive discussion. Before beginning your examination or discussion, you should ask the patient if he or she wishes the companion to remain in the room.

Q5. Can I decide not to treat a patient with a disability because it takes me longer to examine them, and insurance won’t reimburse me for the additional time?

A5. No, you cannot refuse to treat a patient who has a disability just because the exam might take more of your or your staff’s time. Some examinations take longer than others, for all sorts of reasons, in the normal course of a medical practice.

Q6. I have an accessible exam table, but if it is in use when a patient with a disability comes in for an appointment, is it OK to make the patient wait for the room to open up, or else use an exam table that is not accessible?

A6. Generally, a patient with a disability should not wait longer than other patients because they are waiting for a particular exam table. If the patient with a disability has made an appointment in advance, the staff should reserve the room with the accessible exam table for that patient’s appointment. The receptionist should ask each individual who calls to make an appointment if the individual will need any assistance at the examination because of a disability. This way, the medical provider can be prepared to provide the assistance and staff needed. Accessibility needs should be noted in the patient’s chart so the provider is prepared to accommodate the patient on future visits as well. The medical provider can provide the assistance and staff needed. If the medical provider finds that it cannot successfully reserve the room with the accessible exam table for individuals with disabilities, then the provider should consider acquiring additional accessible exam tables so that more exam rooms are available for individuals with disabilities.

Q7. In a doctor’s office or clinic with multiple exam rooms, must every examination room have an accessible exam table and sufficient clear floor space next to the exam table?

A7. Probably not. The medical care provider must be able to provide its services in an accessible manner to individuals with disabilities. In order to do so, accessible equipment is usually necessary. However, the number of accessible exam tables needed by the medical care provider depends on the size of the practice, the patient population, and other factors. One accessible exam table may be sufficient in a small doctor’s practice, while more will likely be necessary in a large clinic.

Q8. I don’t want to discriminate against patients with disabilities, but I don’t want my staff to injure their backs by lifting people who use wheelchairs onto exam tables. If my nurse has a bad back, then she doesn’t have to help lift a patient, does she?

A8. Staff should be protected from injury, but that doesn’t justify refusing to provide equal medical services to individuals with disabilities. The medical provider can protect his or her staff from injury by providing accessible equipment, such as an adjustable exam table and/or a ceiling or floor based patient lift, and training on proper patient handling techniques as necessary to provide equal medical services to a patient with a disability.

Q9. What should I do if my staff does not know how to help a person with a disability transfer or know what the ADA requires my office to do? Also, I am unsure how to examine someone with spasticity or paralysis.

A9. To provide medical services in an accessible manner, the medical provider and staff will likely need to receive training. This training will need to address how to operate the accessible
equipment, how to assist with transfers and positioning of individuals with disabilities, and how not to discriminate against individuals with disabilities. Local or national disability organizations may be able to provide training for your staff. This document and other technical assistance materials found on the ADA Website (www.ada.gov) can be used in conjunction with live training to train medical staff. The U.S. Department of Justice ADA Information Line is another resource. Anyone can call the Information Line at 800-514-0301 (voice) or 800-514-0383 (TTY) to speak with an ADA Specialist to get answers to questions about the ADA. Additionally, when preparing to assist a patient with a disability, it is always best to ask the patient if assistance is needed and if so, what is the best way to help. If the provider is unsure of how to handle something, it is absolutely OK to ask the patient what works best.

Q10. If I lease my medical office space, am I responsible for making sure the examination room, waiting room, and toilet rooms are accessible?

A10. Yes. Any private entity that owns, leases or leases to, or operates a place of public accommodation is responsible for complying with Title III of the ADA. Both tenants and landlords are equally responsible for complying with the ADA. However, your lease with the landlord may specify that, as between the parties, the landlord is responsible for some or all of the accessibility requirements of the space. Frequently, the tenant is made responsible for the space it uses and controls (e.g., the examination rooms and reception area), while the landlord is responsible for common space, such as toilet rooms used by more than one tenant.

Other resources: A free, self-paced course on federal disability rights laws. The course takes approximately 90-120 minutes to complete. All you need is a computer and an internet connection. The information below provides details about the course and will help you determine if this program is right for you.

http://www.humancentereddesign.org/neada/disabilityrights/Welcome.html