

Cultural competence and interpreters

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Introduction

We are on a journey in relation to the care of those who are not from the 'mainstream' culture of Western Medicine in New Zealand. Some years ago little attention was paid to the cultural background of the patient and the professed aim was to provide the same care to all patients. Patients for whom this approach did not work were labelled 'non compliant' and frequently ended up getting inferior care. We now understand that if there is a big cultural difference between carer and patient there is potential for significant problems. This paper will examine the development of policy around cross cultural care and how we can improve this, particularly for patients with limited English proficiency.

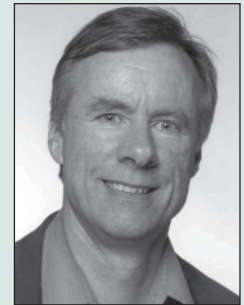
Principles of the Treaty of Waitangi

The first important step on our journey was the increasing inclusion of the Principles of the Treaty of Waitangi into our law and practice. We began to acknowledge that Maori access to health care was significantly affected by the cultural bias of the health system. Disparities in health outcomes for Maori were documented. This led to the concept of New Zealand as a 'bicultural' nation (Maori and non-Maori) and effort was put into training health professionals in Maori culture and the Treaty of Waitangi.

Health and Disability Commission Code of Patient's Rights (1996)

Arising from the Cartwright enquiry this was an important step in codify-

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ing the rights that patients should have. It listed rights:

- (1.3) to having services provided taking into account the needs, values, and beliefs of different cultural religious social and ethnic groups, including the needs, values, and beliefs of Maori.
- (5.1) The right to effective communication including the right to an interpreter.

Cultural safety

Irihapeti Ramsden developed the concept of 'cultural safety' from 1986 onwards, culminating in the publication of her thesis.¹ The Nursing Council has had a requirement² that nurses practice in a culturally safe manner as judged by the patient since 1992.³ Nurses have been taught 'cultural safety' and with the support of the Nursing Council a resource book was published: *'Cultural Safety in Aotearoa New Zealand'* edited by Diane Wepa.³

The Health Practitioners Competence Assurance Act

The Health Practitioners Competence Assurance Act 2003, section 118 *'Functions of authorities*

The functions of each authority appointed in respect of a health profession are as follows:

(i) To set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession.'

The act does not define 'cultural competence' nor give guidance on whether the 'cultural safety' of the Nursing Council is synonymous.

RNZCGP Aiming for Excellence

Aiming for Excellence versions for 1999, 2002 and 2008 have included an indicator on culture and recognising diversity, and Maori-specific cultural issues.

The Medical Council

Two statements^{4,5} released by the Medical Council in 2006 addressed these issues, one on 'cultural competence' and one on 'best practice when providing care to Maori patients and their whanau.'

RNZCGP Cultural Competence 2007

This document provides detailed guidance on cultural competence, with a significant emphasis on Maori culture.

The issues relating to cultural competence

I think there are three important issues that need addressing on the journey to reaching cultural competence:

1. Intercultural attitudes knowledge and skills

These are the generic skills that will improve the outcomes for any patient that is from a different cultural background than the clinician, well summarised in the Medical Council Statement on Cultural Competence, and covered in detail in my recently published paper.⁶

2. Culture specific knowledge

Where a clinician is caring for significant numbers of patients from a particular cultural group, care may be enhanced if the clinician becomes familiar with the beliefs of that community. A knowledge of their native language is likely to help build bridges. This knowledge without the attitudes covered in the 'intercultural' learning could make things worse by increasing stereotyping of patients.

3. Limited English Proficiency patients

The issue of providing care for 'Limited English Proficiency'(LEP) patients has, in my view, slipped below the radar up until now. The premise I have is that these patients should have the right to the same quality of health care as English-fluent patients. Nowhere in law is there any suggestion otherwise, but it is self-evident that without a competent interpreter a person with LEP cannot get even adequate care, let alone receive all the rights listed in the code of patients rights. Many of our documents in my view are deficient when seen through the eyes of an LEP patient.

Health and Disability Commission

The right to an interpreter includes the qualification 'Where necessary and reasonably practicable' even though the whole code has a similar qualification in Section 3. Why is the right to an interpreter doubly

qualified as only being available when 'necessary and reasonably practicable'? Does this imply that the right to an interpreter is less important than the other rights?

Accident Compensation Corporation

ACC does not pay for an interpreter 'as of right' although if it is necessary it can be arranged through a case manager. This means that all of the forms that LEP patients sign without the benefit of a competent interpreter are void, let alone the fact that they do not get adequate or equitable care for their accidents.

Medical Council Statement on Cultural Competence

The only mention of interpreters in the *Cultural Competence* document is a single line under 'Skills (h) work effectively with interpreters when required.' There is no discussion at all about the circumstances when an interpreter should be used. I see this as an important issue in the 'Cultural Competence' Statement.

RNZCGP Cultural Competence

There is no mention of the use of interpreters in this document. The issues around LEP patients are not addressed at all.

RNZCGP Aiming for Excellence

*Aiming for Excellence*⁸ seen through the eyes of a LEP patient has several sections which in my view need additions:

- A. 1.7-1 The practice must provide 'services that are responsive to the cultural needs of diverse patient groups' and further information lists 'Internal Affairs Translation Service'. However, there is no explicit reference in this section on providing interpretation.
- A. 2.3-3 recognises the needs of LEP patients in the statement 'Information about the practice services is available on request in languages other than English and other formats if necessary' al-

though it is silent on how an LEP patient might request this without an interpreter.

- A.3.1-1 in the overall section 'Patients can easily access the practice using its telecommunications system' has the standard 'The practice makes provision for hearing, sight or speech impaired people to communicate with the practice'. Again there is no mention of how LEP patients can communicate.
- D. 9.1-1 on 'Content of medical records', the list of required demographic information includes ethnicity but not what language the patient speaks or whether the patient needs an interpreter.
- D 9.1-8. The section on what referral letters should contain makes no mention of language or need for interpreter. Clearly if the referral does not ask for an interpreter when it is needed then an interpreter will not be provided.

There are many reasons behind this disparity of care available to LEP patients, not least of which is the almost complete lack of funding for interpreting services in primary care, and the limited availability of affordable quality interpreting services. This has now significantly changed with the launch of 'Language Line' which can provide affordable telephone interpreting services to member PHOs. This means that PHOs could now meaningfully use some 'Services to Improve Access' funding on interpreting. However we are a long way off the situation in Sweden⁹ where the government funds face-to-face interpreters (3000 hours a day in 100 working languages in 2006) or in Australia¹⁰ where they have a free 'Doctor's Priority Line' telephone translation service.

Language Line is significantly subsidised by central government, but only provides telephone interpreting during business hours. The cost of face-to-face interpreting or interpreting outside of business hours is substantially more. My interpreter colleagues argue that a professional interpreter should be used in all cir-

cumstances with an LEP patient and that it is not acceptable to use friends or family members because of the risks to accuracy, confidentiality and consequent risks of medical error. The costs of employing interpreters for all health consultations at all times would be prohibitive and the workforce to provide the interpreting probably does not exist.

We need to look at a process of how to move from where we are at present to a better place. We need to lobby the funders, particularly ACC, to point out the inconsistency of care that results if they do not fund interpreting. A good starting point is to review all our quality documents through the lens of an LEP patient. We need to include in our learning

about cultural competence issues around how to manage consultations with LEP patients; how to recognise the need for an interpreter, when an interpreter is essential and how to fund those essential interpreters.

Competing interests

My PHO is a member of Language Line and I use their services occasionally.

References

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COMMENTARY

The College agrees that it is important for health professionals to be aware when a patient does not understand because of language difficulties. There is no doubt that knowing when an interpreter is needed would have a direct impact on the outcome of care provided. Practice managers and administrators can play an important role in ensuring interpreting or

translations services are obtained when they are needed.

Aiming for Excellence, The RNZCGP standard for New Zealand general practice, draws attention to the importance of translation and interpreter services in a number of indicators and provides linkages for practices to follow. However, the College agrees that it could

provider better guidance to practice teams and intends to incorporate information in the record review section of *Aiming for Excellence*.

Maureen Gillon

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What happens if you pay doctors according to patient satisfaction scores?

'We know enough about contractual frameworks that set goals to predict that paying doctors according to patients' scores will result in behaviours changes to maximise financial rewards. But unless we fully understand what is being measured and, critically, how to help professionals improve, we run the risk of superficial modification and gaming to attain high scores. We also need to be aware that the motivators for good practice go far beyond externally set goals (targets and financial rewards) which, although successful in the short term, often have perverse effects.'

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