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LEGISLATION AS INTERVENTION: A SURVEY OF CULTURAL COMPETENCE POLICY IN HEALTH CARE+

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In 1978, an article published by the *Annals of Internal Medicine* outlined public perception of the health care crisis in the United States.[1] Many of the aspects of public perception noted in this article still seem relevant today: "dissatisfaction with the 'quality' of the medical encounter," "intolerable costs," "inaccessibility of medical care because of maldistribution by locality and specialty," as well as the "cultural patterning of sickness and care."[2] All of these issues form part of the rationale for cultural competence in health care.[3] A quarter century later, culturally competent care continues to be a topic of discussion and research among nurses, sociologists, physicians, medical educators, policymakers, and other professionals in the health care field.[4] The California Endowment, in an environmental scan

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1. Arthur Kleinman et al., *Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research*, 88 ANNALS INTERNAL MED. 251 (1978).

2. *Id.* at 251-52.

3. TAWARA D. GOODE & CLARE DUNNE, NAT'L CTR. FOR CULTURAL COMPETENCE, POLICY BRIEF 1: RATIONALE FOR CULTURAL COMPETENCE IN PRIMARY CARE (2003), *available at* http://www1 1.georgetown.edu/research/gucchd/nccc/documents/Policy_Brief_1_2003.pdf.

4. *See infra* notes 120-149 and accompanying text.

completed in late 2005, states that cultural competence is at a "tipping point" in the United States.[5]

Currently, one in five Americans, many of whom are minorities, experience difficulty communicating with their physicians during the provision of care.[6] As the population continues to change, it is inevitable that an increasing number of Americans will experience difficulty communicating with their physicians. The current and projected demographic changes indicate that by the year 2030, an estimated forty percent of United States citizens will self-identify as something other than White non-Hispanic individuals.[7] This number is anticipated to rise to nearly fifty percent by the year 2050.[8] Given this growing diversity, members of the health care community are presented, now more than ever, with the challenge of effectively caring for those patients with whom they share no common ancestry and/or culture.[9] Previous discussions of diversity in the health care field often focused primarily on minority and uninsured patients.[10] However, in disciplines such as anthropology and sociology, there is an understanding that many variables such as race and ethnicity, gender, socioeconomic status and age often are associated with health outcomes.[11] In order to understand a patient and his/her illness, it may be helpful for a health care provider to consider the entire patient and the many ways he/she identifies himself/herself. Each of these identities brings with it distinct and nuanced views that may inform care options as well as perceptions of health status.[12] Preliminary research suggests that if patients are not

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5. ANNA-NANINE S. POND, CAL. ENDOWMENT, SECOND LANGUAGE AND CULTURAL COMPETENCY TRAINING FOR CONTINUING MEDICAL EDUCATION (CME) CREDIT 51 (2005), *available at* http://www.calendow.org/reference/publications/pdf/cultural/Second%20LanguageCultural%20Comp.pdf.

6. Cindy Brach & Irene Fraser, *Reducing Disparities through Culturally Competent Health Care: An Analysis of the Business Case*, 10 QUALITY MGMT. HEALTH CARE 15, 16 (2002).

7. *Id.* at 18.

8. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2000, at 17 tbl.16 (2000), *available at* http://www.census.gov/prod/2001pubs/statab/sec01.pdf.

9. Kathleen Fuller, *Eradicating Essentialism from Cultural Competency Education*, 77 ACADEMIC MED. 198, 198 (2002); CARMEN J. BEAMON ET AL., NAT'L HEALTH LAW PROGRAM, A GUIDE TO INCORPORATING CULTURAL COMPETENCY INTO HEALTH PROFESSIONALS' EDUCATION AND TRAINING 3 (2006), *available at* http://www.healthlaw.org/index.cfm (search "cultural competency guide 1"; then follow pdf link).

10. *See, e.g.*, Brach & Fraser, *supra* note 6, at 15 (citing research published between 1998 and 2002 that focused on health disparities in minority populations).

11. *See* AM. ANTHROPOLOGICAL ASS'N, SOCIAL AND CULTURAL ASPECTS OF HEALTH, http://www.aaanet.org/ committees/ppc/topichlth.htm (last visited Apr. 16, 2007).

12. Petra Lukoschek, *African Americans' Beliefs and Attitudes Regarding Hypertension and Its Treatment: A Qualitative Study*, 14 J. HEALTH CARE FOR POOR & UNDERSERVED 566, 577-79 (2003); Lee M. Pachter, *Culture and Clinical Care: Folk Illness Beliefs and Behaviors and Their Implications for Health Care Delivery*, 271 JAMA 690, 690 (1994).

permitted to embrace all of their claimed identities at the same time, levels of self-esteem and life satisfaction may suffer.[13]

The changes in population characteristics may require all members of the health care community—physicians, allied professionals, and health care lawyers—to reconsider how to go about their daily business. Providers may wish to reevaluate diagnostic and treatment techniques so that these techniques may remain relevant and efficacious for their patients.[14] Beliefs about health, family, communication, and even displays of pain differ across cultures.[15] To obtain an accurate social and medical history from patients, it may be important for providers to identify and effectively participate in cross-cultural encounters. In addition, providers may need to take into account the influence of their own backgrounds, attitudes, values, beliefs, and behaviors on their relationships with patients and other health professionals.[16] Hospital lawyers may wish to consider the increased potential for patient-clinician miscommunication and any consequential quality of care and safety issues. The ability to identify cross-cultural encounters and understand the multiple ways a patient might identify himself/herself are often considered core skills for providing culturally competent care.

The concept of cultural competence is considered by many members of the health care field to be very real and critical in an ever-diversifying patient population and workforce.[17] How members of the health care community receive training to increase their levels of cultural competence is still a topic of discussion at individual and institutional levels. However, local, state, and federal legislators have begun to recognize the importance of culturally competent health care services.[18] The momentum triggered by heightened awareness of disparities in health and health care has resulted in a growing call for mandatory cultural competence training.

I. HEALTH AND HEALTH CARE DISPARITIES

The research regarding racial and cultural health disparities in the United States is mounting. The issue of disparities is related both to (a) health and (b) health care. *Health disparities*, also called health inequalities, refer to the

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13. Isiaah Crawford et al., *The Influence of Dual-Identity Development on the Psychosocial Functioning of African-American Gay and Bisexual Men*, 39 J. SEX RES. 179, 186 (2002).

14. *See* Patricia M. Cole, *When Medicine and Culture Intersect: Changing Patient Demographics Mean Traditional Approaches are Inadequate*, 112 POSTGRADUATE MED. 11, 15 (2002).

15. GERI-ANN GALANTI, CARING FOR PATIENTS FROM DIFFERENT CULTURES: CASE STUDIES FROM AMERICAN HOSPITALS 7, 31-32, 69 (2d ed., 1997).

16. Stephanie L. Taylor & Nicole Lurie, *The Role of Culturally Competent Communication in Reducing Ethnic and Racial Healthcare Disparities*, 10 AM. J. MANAGED CARE SP1, SP2 (2004).

17. *E.g.*, BEAMON ET AL., *supra* note 9, at 3.

18. *See* discussion *infra* Part IV.A-B, D.

differences in health outcomes.[19] *Health care disparities* refer to "differences in the preventive, diagnostic and treatment services offered to people with similar health conditions."[20] For example, evidence shows that African Americans are less likely than their Caucasian counterparts "to receive curative surgery for early-stage lung, colon, or breast cancer."[21]

Tables 1 and 2 illustrate the pervasiveness of health disparities across racial and ethnic lines as well as minority populations. Evidence also indicates that groups that fall outside majority culture, such as people with disabilities, deaf/hard of hearing (HOH) and the gay, lesbian, bisexual and transgender (GLBT) communities face health inequalities. Table 2 offers examples of health disparities for these and other groups.

Table 1 : Examples of Health Disparities : Racial and Ethnic[22]

Blacks/ African Americans	Hispanics/ Latinos	Asian Americans/ Pacific Islanders	American Indian/ Alaska Natives	Multiple Groups
Black male death from hypertension 355% higher than whites[.] American Heart Association	Prevalence of diabetes 50% higher than for white non-Hispanics. Healthy People 2010	Vietnamese women's rates of cervical cancer five times higher than for whites—higher than any other group. OMH	Infant mortality more than double that of whites. Healthy People 2010	African Americans and Latinos account for 25% of the population but 75% of adult (81% of pediatric) AIDS cases. U.S. Department of Health and Human Services (HHS)
Higher death rate from cancer than any other racial/ ethnic group in U.S. American Cancer Society	More years of potential life lost than non-Hispanic whites for stroke, liver disease/ cirrhosis, diabetes, HIV, homicide; higher incidence for cancers of cervix and stomach (63% higher for males, 150% for females) Centers for Disease Control & Prevention (CDC)/multiple sources	Common diseases for Cambodians: tuberculosis, Hepatitis B, and intestinal parasites HRSA/BPHC Those of Hawaiian descent have highest state rates of low birth weight, adolescent pregnancy. Hawai'i State Department of Health	Incidence of diabetes more than twice that of total population. (Pima Indians of Arizona have highest known prevalence of diabetes in the world.) HHS	African Americans (15%), American Indians/Alaska Natives (17%) and Latinos (13%) rated their health as fair or poor compared to 8% of whites. HHS

19. NAT'L BUS. GROUP ON HEALTH, WHY COMPANIES ARE MAKING HEALTH DISPARITIES THEIR BUSINESS: THE BUSINESS CASE AND PRACTICAL STRATEGIES 3 (2003), *available at* http://www.wbgh.com/pdfs/business_case_analysis.pdf.

20. *Id.*

21. Stephen B. Thomas, *The Color Line: Race Matters in the Elimination of Health Disparities*, 91 AM. J. PUB. HEALTH 1046, 1047 (2001).

22. MARJORY BANCROFT & ROBERT C. LIKE, NETWORKOMNI, CARING WITH CLAS: CULTURAL COMPETENCE IN HEALTH CARE, A TRAINER'S MANUAL 21 (2006).

Table 1 : Examples of Health Disparities : Racial and Ethnic[22]				
Blacks/ African Americans	Hispanics/ Latinos	Asian Americans/ Pacific Islanders	American Indian/ Alaska Natives	Multiple Groups
Rates of death from cardio-vascular disease about 30% higher than whites. HHS	Almost twice as likely to die from diabetes complications as non-Hispanic whites. CDC 69% of Mexican American women overweight. National Institutes for Health (NIH)	Invasive cancer rates are much higher among Southeast Asian women in general than in the majority US population. Health Resources and Services Administration	Death from preventable causes double that of the general population. HHS Higher rates of depression and substance abuse. CDC	Morbidity/mortality rates for African Americans, Latinos and American Indian/Alaskan natives is 50 to 100% higher than among whites. OMH
Infant mortality 2 1/2 times higher than for whites. OMH	Higher arthritis-attributable limitations on work and severe joint pain. CDC	Disproportionately high prevalence of tuberculosis, hepatitis B and chronic obstructive pulmonary disease. CDC	Die at higher rates from alcoholism (770%), tuberculosis (750%), diabetes (420%), accidents (280%), homicide (210%) and suicide (190%). CDC	African American & Latino patients aged 65 and older less likely than whites to receive vaccinations for influenza and pneumonia. CDC
Table reprinted with permission from NetworkOmni, © 2006 NetworkOmni.				

Table 2 : Examples of Health Disparities : Other Cultural Groups[23]				
LEP (Limited English Proficient)	Low Health Literacy	Disabilities/ Mental Health	GLBT (Gay, Lesbian, Bisexual, Transgender)	Other Groups
LEP parents three times more likely than parents who speak fluent English to have a child in fair or poor health.[24] Commonwealth Fund	Almost twice as likely as those with adequate health literacy to report poor health. Robert Wood Johnson Foundation	Women with physical disabilities have higher rates of osteoporosis, diabetes, depression, obesity and hypertension. National Health Interview Surveys	Lesbians have higher rates of obesity and smoking than hetero-sexual women; gay men have higher incidence of HIV/AIDS, depression, substance abuse. Healthy People 2010	Those of lower socio-economic status (in poverty) and minorities are more likely to have late stage cancer when diagnosed. Agency for Healthcare Research and Quality
LEP patients have lower rate of patient satisfaction.[25]	Negative impact on patient management of hypertension and diabetes. Robert Wood Johnson Foundation	Of those with a mental health disorder, fewer than half of adults and only one third of children receive help. CDC	Gay male adolescents 2 to 3 times more likely to commit suicide than their heterosexual peers. Healthy People 2010	Half of homeless and drug-recovering women are depressed; 76 percent fall below psychological well being scores.[26]
Greater problems of oral health and	Illiteracy affects adherence to	Depression causes most suicides.	Smoking rates significantly higher	Children of lower SES have poorer

23. *Id.* at 22.

24. Glenn Flores et al., *Limited English Proficiency, Primary Language at Home, and Disparities in Children's Health Care: How Language Barriers are Measured Matters*, 120 PUB. HEALTH REP. 418, 423 (2005).

25. Olveen Carrasquillo et al., *Impact of Language Barriers on Patient Satisfaction in an Emergency Department*, 14 J. GEN. INTERNAL MED. 82, 84 (1999).

26. Adeline Nyamathi et al., *HIV-Risk Behaviors and Mental Health Characteristics Among Homeless or Drug-Recovering Women and Their Closest Sources of Social Support*, 46 NURSING RES. 133, 136 (1997).

Table 2 : Examples of Health Disparities : Other Cultural Groups[23]

LEP (Limited English Proficient)	Low Health Literacy	Disabilities/ Mental Health	GLBT (Gay, Lesbian, Bisexual, Transgender)	Other Groups
dental hygiene UCLA	treatment plans. Robert Wood Johnson Foundation	Multiple sources	for gay/lesbian/ bisexual adolescents and adults.[27]	dental health outcomes.[28]
Higher levels of food insecurity (which impacts health at many levels) Urban Institute and UCLA	More likely than literate patients to misunderstand medication instructions. Robert Wood Johnson Foundation	Depressed heart patients have worse outcomes. American Heart Association	GLBT youth report more high-risk behaviors, sexual and non-sexual, than heterosexual youth.[29]	Those in lowest SES have two and a half times the rate of mental disorders of those in the highest SES. Surgeon General, 1999

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While debates persist regarding the root cause of these disparities, there are undoubtedly a myriad of contributing factors. A 2004 article in the *American Journal of Public Health* revealed the impact of these health inequalities.[30] Researchers concluded that reducing the mortality rate of African Americans to the rate of Caucasians is the equivalent of saving five lives for each one currently saved by medical advances.[31] In a society that prizes technological remedies, this is an enlightening statistic.

The Institute of Medicine, in its publication, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* determined that the "development and implementation of training programs for healthcare providers [around topics of cultural competence] offers promise as a key intervention strategy in reducing healthcare disparities."[32] Recognition of health and health care disparities has contributed to a greater awareness that organizational and systemic interventions may be necessary to induce change. This perception has manifested itself in several arenas, including new legislation mandating the implementation of cultural competence training for health care professional development.[33] The increased awareness of disparities has not been the only impetus for legislative efforts, but it

27. Heather Ryan et al., *Smoking Among Lesbians, Gays, and Bisexuals: A Review of the Literature*, 21 AM. J. PREVENTIVE MED. 142, 143, 145 (2001).

28. Wendy E. Mouradian et al., *Disparities in Children's Oral Health and Access to Dental Care*, 284 JAMA 2625, 2625 (2000).

29. Jennifer Feldmann & Amy B. Middleman, *Adolescent Sexuality and Sexual Behavior*, 14 CURRENT OPINION OBSTETRICS & GYNECOLOGY 489, 492 (2002).

30. Steven H. Woolf et al., *The Health Impact of Resolving Racial Disparities: An Analysis of US Mortality Data*, 94 AM. J. PUB. HEALTH 2078, 2079 (2004).

31. *Id.*

32. INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 19 (Brian D. Smedley et al. eds., 2003).

33. *See* discussion *infra* Part IV.B.

has highlighted many initiatives. The legislative efforts are discussed further in subsequent subparts of this article.[34]

II. CULTURAL COMPETENCE

The United States Department of Health and Human Services' Office of Minority Health (OMH) defines culture as "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups."[35] The term *culture* is used throughout the remainder of the article in this broader sense. While there are also differences between members of the same culture, the probability of miscommunication during clinical encounters increases when patients and providers no longer share a common culture or framework. In the realm of health care, this can result in diagnostic errors; adverse drug interactions due to concurrent use of prescription and traditional indigenous medicines/treatments; and lack of patient adherence to provider prescription recommendations, treatment plans, self-care, and follow-up visits.[36] Providers with training in cultural competence are believed to be better equipped to overcome many of these harmful situations.

The OMH defines cultural and linguistic competence as, "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."[37] In 2001, the OMH issued *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, stating that every patient should receive respectful care that is *culturally* and *linguistically* appropriate.[38] The federal government furthered this commitment in its published report *Healthy People 2010*.[39] This report unequivocally states that "every person in every community across the Nation deserves equal access to comprehensive, culturally competent, community-based health care systems that are committed to serving the needs of the individual and promoting community health."[40]

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34. *See infra* Part IV.A-B, D.

35. OFFICE OF MINORITY HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE 28 (2001), *available at* http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf.

36. Brach & Fraser, *supra* note 6, at 16; INST. OF MED., *supra* note 32, at 131-44; Nancy Kreiger, *Discrimination and Health*, *in* SOCIAL EPIDEMIOLOGY 36, 63-67 (Lisa F. Berkman & Ichiro Kawachi eds., 2000).

37. OFFICE OF MINORITY HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., WHAT IS CULTURAL COMPETENCY?, http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=11 (last visited Mar. 23, 2007).

38. OFFICE OF MINORITY HEALTH, *supra* note 35, at 3.

39. U.S. DEP'T OF HEALTH & HUMAN SERVS., 1 HEALTHY PEOPLE 2010, at 2 (2000), *available at* http://www.healthypeople.gov/Document/tableofcontents.htm#volume1.

40. *Id.* at 16.

The skills garnered through cultural competence education and training may allow health care providers to access patients more effectively and to communicate, regardless of differences in background. It is important to note that cultural competence in its truest form does not encourage or promote stereotyping, over-generalizing, or racial/ethnic profiling. Rather, it is as the OMH defines it: a set of behaviors, policies and abilities that enable efficient and efficacious cross-cultural communication.[41] Linguistic competence illustrates a commitment to effective communication, an ability to deliver information that may be easily understood by any given patient population—including, but not limited to, persons of "limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities."[42] Informed consent is of little use for a patient that is unable to understand the language used to describe the risks of treatment.

Linguistic competence also entails utilizing trained interpreters to assist in communicating throughout the care process with patients of limited English proficiency. Increasingly, health care providers in the United States are utilizing trained interpreters who adhere to the professional code of ethics and standards of practice issued by the National Council on Interpreting in Health Care.[43] However, utilizing friends, family, untrained bilingual staff, and other unqualified individuals to interpret remains common practice even though it frequently leads to miscommunication. In one incident, the incorrect interpretation of a single word ("intoxicado") resulted in rendering an able-bodied Miami high school athlete quadriplegic.[44] A medical malpractice lawsuit settlement valued at $71 million soon followed.[45]

To complicate matters further, many patients with limited English proficiency are not receiving any interpreting help whatsoever in health care facilities across the United States. A recent study, in which 2,047 resident physicians were surveyed, indicated that this lack of interpreting help may be partially due to a lack of awareness of relevant legislation mandating language access.[46] Nearly half of the respondents indicated that they were not informed of the legal right of patients with limited English proficiency to receive professional interpreting services.[47] Of the

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41. *See* OFFICE OF MINORITY HEALTH, *supra* note 37.

42. NAT'L CTR. FOR CULTURAL COMPETENCE, A DEFINITION OF LINGUISTIC COMPETENCE (2006), *available at* http://www11.georgetown.edu/research/gucchd/nccc/documents/Definition%20of%20 Linguistic%20Competence.pdf.

43. NAT'L COUNCIL ON INTERPRETING IN HEALTH CARE, NATIONAL STANDARDS OF PRACTICE FOR INTERPRETERS IN HEALTH CARE (2005), *available at* http://www.ncihc.org/NCIHC_PDF/National_ Standards_of_Practice_for_Interpreters_in_Health_Care.pdf.

44. Al Messerschmidt, *Quadriplegic to Receive Millions*, MIAMI HERALD, Nov. 4, 1983, at 1D.

45. *Id.*; Philip Harsham, *A Misinterpreted Word Worth $71 Million*, 61 MED. ECON. 289, 289-292 (1984).

46. Karen C. Lee et al., *Resident Physicians' Use of Professional and Nonprofessional Interpreters: A National Survey*, 296 JAMA 1050, 1051 (2006).

47. *Id.* at 1051 tbl.1.

resident physicians surveyed, eighty-four percent admitted to using untrained interpreters, such as friends and family members.[48] The survey results highlight not only a lack of linguistic competence among health care providers, but a lack of awareness regarding its importance.

A need for cultural competence is discussed in a 2003 policy brief prepared by Georgetown University's National Center for Cultural Competence.[49] This brief identified several potential benefits that can be achieved through cultural competence: (1) response to current and projected demographic changes in the United States;[50] (2) reduction of long-standing disparities in the physical and mental health status of individuals from differing racial, ethnic, and cultural backgrounds;[51] (3) improvement of the quality of services and primary care outcomes;[52] (4) compliance with legislative, regulatory, and accreditation mandates;[53] (5) creation of a competitive edge in the health care marketplace;[54] and (6) a decrease in the likelihood of liability and malpractice claims.[55] It may be important to include each of these rationales in the discussion at large as key reasons for emerging local, state, and federal legislative efforts toward ensuring culturally competent care.

III. POLICY INITIATIVES

Recently, a number of articles have outlined policy issues as they pertain to health disparities, laying a foundation for discussing the efficacy of policy as a strategy for reducing health disparities.[56] Despite the increasing amount of data on health disparities, however, there is little reliable indication that policy initiatives will decrease health inequalities.[57] It is possible that this evidence will come in

48. *Id.* at 1051.

49. GOODE & DUNNE, *supra* note 3.

50. *Id.* at 1.

51. *Id.*

52. *Id.* at 3.

53. *Id.* at 4.

54. *Id.* at 5.

55. *Id.*

56. *E.g.*, Mark Exworthy et al., *Evidence into Policy and Practice? Measuring the Progress of U.S. and U.K. Policies to Tackle Disparities and Inequalities in U.S. and U.K. Health and Health Care*, 84 MILLBANK Q. 75, 76 (2006); *see also* Brian K. Gibbs et al., *Reducing Racial and Ethnic Health Disparities: Exploring an Outcome-Oriented Agenda for Research and Policy*, 31 J. HEALTH POL. POL'Y & L. 185, 185 (2006) ("[I]ndividual states are on the front line of many initiatives and are often the focus of important policy efforts."); Kala Ladenheim & Rachel Groman, *State Legislative Activities Related to Elimination of Health Disparities*, 31 J. HEALTH POL. POL'Y & L. 153, 153 (2006) (discussing trends in "state legislation related to disparities in [health] care and access"); Deborah Stone, *Reframing the Racial Disparities Issue for State Governments*, 31 J. HEALTH POL. POL'Y & L. 127, 129 (2006) (outlining proposals that would reframe the health disparities issue in ways that "might frame the issue for maximum political leverage" and "might strengthen political will").

57. Exworthy et al., *supra* note 56, at 81.

time, particularly as recent calls for policy changes have been accompanied by requests for maintenance of meaningful statistics to measure the effectiveness of cultural competency in improving health outcomes.[58]

Many complex and interrelated factors that contribute to health and health care disparities make it difficult to attribute their reduction to any one intervention. Increased public and political awareness also makes it difficult to measure the impact of singular interventions. The following survey of legislation addresses previous policy discussions, noting that there are a myriad of ways to meet the goal of reducing health inequalities, but focuses on state-level legislation mandating cultural competence training for health care professionals.

Since language access is an important component of cultural competence, legislation mandating cultural competence has an impact on the field of language access. Cultural competence training provides information to health care providers to help them implement and adhere to language access legislation. Detailed information on language access legislation has been compiled by the National Health Law Program, whose publications, such as the *Summary of State Law Requirements Addressing Language Needs in Health Care*, provide a wealth of useful information regarding language access laws.[59] Language access legislation is addressed in detail by such publications, so this article will focus exclusively on cultural competence training legislation.

IV. STATE OF THE UNION: STATE, ORGANIZATIONAL, AND NATIONAL POLICY EFFORTS

A. *State Legislation*

Because legislation is under constant revision, it is important to note that the following survey was compiled as of January 1, 2007 and does not reflect items that have been proposed or discussed during the spring 2007 legislative session.[60] It

58. THE JOINT COMM'N, HOSPITALS, LANGUAGE, AND CULTURE: A SNAPSHOT OF THE NATION, COMPILED LIST OF RESOURCES 42 (2007), *available at* http://www.jointcommission.org/NR/rdonlyres/E64E5E89-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf; MINORITY AFFAIRS CONSORTIUM, AM. MED. ASS'N, POLICY COMPENDIUM STATEMENT H-295.897 (2006), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/20/compendiumdec06.pdf; NAT'L MENTAL HEALTH ASS'N, NMHA POSITION STATEMENT: CULTURAL AND LINGUISTIC COMPETENCY IN MENTAL HEALTH SYSTEMS, http://www1.nmha.org/position/ ps38.cfm (last visited Apr. 17, 2007).

59. JANE PERKINS & JAMIE BROOKS, NAT'L HEALTH LAW PROGRAM, SUMMARY OF STATE LAW REQUIREMENTS ADDRESSING LANGUAGE NEEDS IN WOMEN'S HEALTH (2006).

60. New bills addressing the need for cultural competence awareness and training for health care professionals were introduced in early 2007 in several states: S.B 07-242, 66th Gen. Assemb., 1st Reg. Sess. (Colo. 2007); H.B. 1674, 95th Gen. Assemb., Reg. Sess. (Ill. 2007); S.B. 0545, 95th Gen. Assemb., Reg. Sess. (Ill. 2007); H.B. 524, 2007 Leg., 423rd Sess. (Md. 2007); H.B. 100, 2007 Leg., 423rd Sess. (Md. 2007); S.B. 600, 48th Leg., Reg. Sess. (N.M. 2007); S.00765, 2007 Leg. (N.Y. 2007); A.06388, 2007 Leg. (N.Y. 2007).

is also important to note that the legislation/policies under review pertain directly to the issue of cultural competence training and education and not to other related legislation including those directed at broader issues such as minority health and language access. This review is based upon the most recent information available to the public, as it appears on state legislative Web sites. At this time, eleven states have considered legislation that pertains to cultural competence training: Arizona, California, Colorado, Georgia, Illinois, Maryland, New Jersey, New Mexico, New York, Ohio, and Washington.

In 2003, California[61] and Maryland[62] both passed laws encouraging the implementation of cultural competence education. However, it was not until March, 2005 that New Jersey became the first state to pass legislation requiring cultural competence training for physicians and medical students.[63] Shortly thereafter, California, in October, 2005,[64] and Washington, in 2006,[65] both adopted laws requiring cultural competence training as a part of health education and/or licensure and accreditation. Arizona,[66] Illinois,[67] Ohio,[68] and New York[69] proposed legislation mandating cultural competency training as a condition of licensure that was referred to committee in 2005, and which is still pending. Attempts at passing similar legislation in Georgia,[70] Maryland,[71] and New Mexico[72] failed to make it

61. Cultural and Linguistic Competency of Physicians Act of 2003, ch. 510, 2003 Cal. Stat. 3166-73 (codified as amended at CAL. BUS. & PROF. CODE §§ 2198-2198.1 (West 2007)).

62. Health Care Services Disparities Prevention Act, ch. 453, 2003 Md. Laws 3074 (codified as amended at MD. CODE ANN., HEALTH-GEN. §§ 20-901 to 20-904 (LexisNexis 2006)).

63. Act of Mar. 24, 2005, ch. 53, 2005 N.J. Laws 221-22 (codified as amended at N.J. STAT. ANN. §§ 45:9-7.2 to 9-9.2 (West 2007)).

64. Act of Oct. 4, 2005, ch. 514, 2005 Cal. Stat. 3176-78 (codified as amended at CAL. BUS. & PROF. CODE § 2190.1 (West 2006).

65. Act of Mar. 27, 2006, ch. 237, 2006 Wash. Sess. Laws 1068-69 (codified as amended at WASH. REV. CODE § 43.70.615 (Supp. 2007)).

66. S. 1468, 47th Leg., 1st Reg. Sess. (Ariz. 2005); *see also* Bill Status Overview, SB1468, http://www.azleg.gov/FormatDocument.asp?inDoc=/legtext/47leg/1r/bills/sb1468o.asp (last visited Mar. 23, 2007).

67. S. 0522, 94th Gen. Assemb., Reg. Sess. (Ill. 2005); Ill. Gen. Assembly, Bill Status of SB 0522, http://www.ilga.gov/legislation/BillStatus.asp?DocNum=522&GAID=8&DocTypeID=SB&LegId=17331&SessionID=50&GA=94#actions (last visited Mar. 23, 2007).

68. S. 160, 126th Gen. Assemb. Reg. Sess. (Ohio 2005); OHIO LEGISLATIVE SERV. COMM'N, STATUS REPORT OF LEGISLATION—126TH GA (2007), http://www.lsc.state.oh.us/status/srl126.pdf.

69. S. 765, Gen. Assemb., 2007-08 Reg. Sess. (N.Y. 2007).

70. H.R. 1401, 148th Gen. Assemb., Reg. Sess. (Ga. 2006); House Committee on Health & Human Services, Georgia General Assembly, http://www.legis.state.ga.us/legis/2005_06/com/hhhs.htm (last visited Mar. 23, 2007).

71. Three separate pieces of legislation were proposed in Maryland: H.B. 1295, 2006 Leg., 422d Sess. (Md. 2006); H.B. 1455, 2006 Leg., 422d Sess. (Md. 2006); H.B. 1127, 2006 Leg., 422d Sess. (Md. 2006).

72. S. 785, 47th Leg., 2005 Reg. Sess. (N.M. 2005); 2005 Regular Session, SB 785, Health Education Cultural Competence, http://legis.state.nm.us/lcs/_session.asp?chamber=S&type=++&number=785&year=05 (last visited Mar. 23, 2007).

out of committee. The Colorado legislature passed legislation[73] that was ultimately vetoed by the Governor, for reasons discussed later in this subpart.

An examination of each of these states' legislative initiatives illuminates the great deal of variance between them. This variation may eventually serve to inform decisions regarding which policies are best designed to address health and health care disparities. However, given the complex and diverse nature of disparities, a more comprehensive approach may ultimately be more efficacious. Such an approach could involve an analysis of racial and ethnic data within each state, and an examination of the workforce demographics within that state's health care professions, to ensure collaboration in and among the various governmental and private organizations that provide health care throughout the state.

This proliferation of state legislation has garnered much attention. Some researchers have opined that institutional problems experienced in American health care must be addressed on the national rather than state level.[74] This opinion is grounded in the fact that states lack the far-reaching power necessary to implement broad systemic change.[75] Debates regarding state versus federal powers fall outside of the scope of this article, but it is important to consider that the boundaries between state and federal powers, and even between governmental agencies, may impact attempts at policy change.

For example, the Colorado legislature passed cultural competence legislation that was ultimately vetoed by the Governor over the issue of overreaching powers, rather than an aversion to imposing cultural competence requirements.[76] The Governor stated that the Senate Bill surpassed the "authority and responsibility of our institutions of higher education to determine specific curricula."[77] Other concerns may include how to identify the persons or entities that should be determining professional requirements and content related to licensure and medical education. This dilemma of roles and responsibilities seems to be at the heart of the debate for those individuals who do not support legislatively-mandated cultural competence training.[78]

Many state policies may be inspired by the advances made at the federal level. State policies related to minority health have been reported to "both anticipate and echo federal attention to the issue."[79] Evidence of this is seen in

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73. Letter from Bill Owens, Governor, State of Colorado, to Colo. State Senate (May 26, 2006), *available at* http://www.colorado.gov/governor/press/may06/sb111.html.

74. Stone, *supra* note 56, at 149.

75. *Id.* at 129.

76. *See* Letter from Bill Owens to Colo. State Senate, *supra* note 73.

77. *Id.*

78. *Id.*

79. Ladenheim & Groman, *supra* note 56, at 168.

states' reactions to the creation of the OMH in 1986.[80] A majority of states responded by creating state level offices of minority heath.[81] Federal policies discussed earlier in this article, such as the CLAS Standards[82] and Healthy People 2010,[83] were both issued within the last six years and are still relatively recent. The inclusion of cultural competence education and training as a component of licensure or accreditation by many national professional health care organizations and accreditation bodies is also a recent phenomenon guiding state action.[84] The following subpart explores the evolutionary process of policy development, organizational, and institutional policy, as well as existing and pending policy as it relates to cultural competence.

B. State Level: New Jersey's Legislative Efforts

In any discussion of pending or recently passed state legislation, it is important to contemplate the evolutionary process for developing new policy agendas and moving them forward. Because New Jersey was the first state to pass legislation mandating cultural competence training as a part of physician licensure and re-licensure, there is illustrative historical information available to describe its development path.

A series of Minority Health Summits—organized by the New Jersey Office of Minority Health, starting in 1999—eventually led to the 2005 New Jersey law.[85] These summits were held in response to a 1993 publication outlining New Jersey's health disparities among minority populations.[86] The summits focused on the needs of the three largest minority populations in the state, African Americans, Latinos, and Asian-American/Pacific Islanders.[87] The summits identified three primary needs to aid in the reduction of health care disparities among minority patients in New Jersey: (1) increased access to health care; (2) improved data collection; and

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80. OFFICE OF MINORITY HEALTH, MISSION, http://www.omhrc.gov/templates/browse.aspx?lvl=1&lv lID=7 (last visited Mar. 23, 2007).

81. *E.g.*, Office of Minority Health, Ala. Dep't of Pub. Health, http://www.adph.org/minorityhealth (last visited Mar. 23, 2007); Office of Multicultural Health, Cal. Dep't of Health Servs., http://www.dhs.ca.gov/director/omh/default.htm (last visited Mar. 23, 2007); Office of Minority Health, Fla. Dep't of Health, http://www.doh.state.fl.us/minority (last visited Mar. 23, 2007); Office of Minority Health, Ind. State Dep't of Health, http://www.in.gov/isdh/programs/omh/index.htm (last visited Mar. 23, 2007); Md. Dep't of Health & Mental Hygiene, Health Disparities Initiative, http://mdhealthdisparities.org (last visited Mar. 23, 2007); Office of Minority Health, Neb. Health & Human Servs. Sys., http://www.hhs.state.ne.us/omh (last visited Mar. 23, 2007).

82. Office of Minority Health; National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care, 65 Fed. Reg. 80,865 (Dec. 22, 2000).

83. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 39.

84. *See* H.B. 1674, 95th Gen. Assemb., Reg. Sess. (Ill. 2007).

85. Debbie Salas-Lopez et al., *Cultural Competency in New Jersey: Evolution from Planning to Law*, 18 J. HEALTH CARE FOR POOR & UNDERSERVED 35, 39-40 (2007).

86. *Id.* at 36-37.

87. *Id.* at 37.

(3) development and implementation of cultural competency standards and curriculum for health care providers.[88]

Following these summits, the New Jersey Office of Minority Health supported legislation to change the name of the office to the more descriptive New Jersey Department of Health and Senior Services, Office of Minority and Multicultural Health (OMMH).[89] This change, implemented in 2001, reflected the growing number of diverse communities in New Jersey.[90] Additionally, with the new name came the increased ability to identify goals and objectives for the office and to earmark funds to assist in meeting these goals.[91]

Another recommendation established as a result of these summits, the promotion of culturally competent standards and curriculum efforts, was launched from a variety of sources.[92] Initial efforts included the development of medical interpreter training for volunteer bilingual hospital employees, a resource inventory of existing curricula in the state's health professional schools, and a survey of public hospital language services.[93] These efforts increased awareness of the issue of cultural competence among New Jersey citizens.[94] In 2002, New Jersey's Governor issued an Executive Order convening the Hispanic Advisory Council, which aimed to advise the state on public and health policy issues.[95] In its initial report to the Governor, the Council recommended universal training in cultural and linguistic competence for health care professionals.[96]

The Council also approached New Jersey Senator Wayne Bryant with the results of the various resource inventories, needs assessments, summit findings, and the Council's final report, demonstrating the need for recommended training.[97] An advocate for minority health, Senator Bryant had proposed legislation regarding cultural competence in 1999, 2000, and 2002, but this legislation remained stymied in committee each time.[98] In 2005, though, the combined efforts of the Senator and

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88. *Id.*

89. *Id.* at 38.

90. *Id.*; Gen. Assemb. 2204, 209th Leg., Reg. Sess. (N.J. 2001); Press Release, N.J. Dep't of Health & Senior Servs., Department of Health and Senior Services Unveils Minority Health Month Calendar for September (Aug. 14, 2001), *available at* http://www.state.nj.us/health/news/p10814a.htm.

91. Salas-Lopez et al., *supra* note 85, at 38-39.

92. *Id.* at 39-40.

93. *Id.*

94. *Id.* at 40.

95. Exec. Order No. 17, 34 N.J. Reg. 1571(b) (May 6, 2002).

96. HISPANIC ADVISORY COUNCIL, 2003 POLICY REPORT: LATINOS AND THE STATE OF NEW JERSEY: A PROMISING PARTNERSHIP FOR A BETTER FUTURE 24 (2003), *available at* http://www.state.nj.us/personnel/publication/pdf/HispanicAdvisoryCouncil2003.pdf.

97. Salas-Lopez et al., *supra* note 85, at 40.

98. *Id.*

key stakeholders from the Minority Health Summits resulted in the proposal of a unique bill, the first of its kind in the country.[99]

The New Jersey bill required that each medical school in the state provide coursework in cultural competence, that all future medical professionals complete cultural competence training as a condition of licensure, and that practicing physicians who graduated prior to the effective date of the Act receive training in cultural competence for re-licensure.[100] The Senate considered Senate Bill 144 in January 2004.[101] The bill underwent additional refinement, but was ultimately passed by the New Jersey legislature and signed into law by Acting Governor Richard Codey on March 23, 2005.[102] The resulting Act charged the State Board of Medical Examiners with the task of implementing and establishing the relevant curricular and licensure requirements, such as the required number of training hours.[103] These requirements are currently being finalized, following the end of the public comment period in August 2007.

C. Organizational and Accrediting Bodies

Three national organizations play a key role in guiding and accrediting medical education and hospitals in the United States: the Association of American Medical Colleges (AAMC), the Liaison Committee for Medical Education (LCME), and The Joint Commission. Each of these organizations has made cultural competence training a part of its organizational missions. State efforts to mandate cultural competence training may serve to complement and further enhance the requirements set forth by these organizations. The following discussion offers a brief overview of these national organizations and the requirements they have established in the area of cultural competence.

AAMC is a non-profit organization whose membership includes all accredited medical schools in Canada and the United States, nearly 400 teaching hospitals, and a host of academic and professional societies.[104] AAMC also represents the nation's 67,000 medical students and 104,000 resident physicians.[105] The organization has "recognized that, in order to communicate effectively with patients, physicians will need to understand how a person's spirituality and culture affect how they perceive health and illness, and particularly their desires regarding

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99. *Id.*; S. 144, 211th Leg., 2004 Sess. (N.J. 2004).

100. N.J. S. 144.

101. *Id.*

102. N.J. STAT. ANN. § 45:9-7.2 (West Supp. 2006).

103. Salas-Lopez et al., *supra* note 85, at 40.

104. ASS'N OF AM. MED. COLLS., ABOUT THE AAMC, http://www.aamc.org/about/ (last visited Mar. 24, 2007).

105. *Id.*

end of life care."[106] AAMC has also developed the Tool for Assessing Cultural Competency Training (TACCT), in recognition of the importance of quality training in this area.[107]

The LCME is the nationally recognized accrediting authority for medical education programs that lead to Doctorate of Medicine degrees in medical schools in the United States and Canada.[108] The LCME is sponsored by the AAMC and the American Medical Association (AMA).[109] All physicians educated in the United States must graduate from an LCME accredited school to practice medicine in the United States.[110] The LCME specifies that:

> All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on their health. To demonstrate compliance with this standard, schools should be able to document objectives relating to the development of skills in cultural competence, indicate where in the curriculum students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.[111]

The Joint Commission is the national evaluative and accrediting body for hospitals in the United States[112] and currently accredits nearly 15,000 health care organizations and programs across the country.[113] It is an independent non-profit organization, as well as the primary body for establishing compliance standards for delivery of safe, high quality health care.[114] The Joint Commission views the provision of culturally and linguistically appropriate health care services as an important quality and safety issue and a key element in individual-centered care.[115] In The Joint Commission's view:

> It is well recognized that the individual's involvement in care decisions is not only an identified right, but is a necessary source of accurate assessment and treatment information. The Joint Commission has

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106. ASS'N OF AM. MED. COLLS., REPORT III: CONTEMPORARY ISSUES IN MEDICINE: COMMUNICATION IN MEDICINE 2 (1999), *available at* http://www.aamc.org/meded/msop/msop3.pdf.

107. Ass'n of Am. Med. Colls., Tool for Assessing Cultural Competence Training (TACCT), http://www.aamc.org/meded/tacct/start.htm (last visited Mar. 23, 2007).

108. LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE ii (2006), *available at* http://www.lcme.org/functions2006june.pdf.

109. *Id.*

110. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK: PHYSICIANS AND SURGEONS (2006-2007), *available at* http://www.bls.gov/oco/ocos074.htm.

111. LIAISON COMM. ON MED. EDUC., *supra* note 108, at 13.

112. THE JOINT COMM'N, FACTS ABOUT THE JOINT COMMISSION, http://www.jointcommission.org/AboutUs/joint_commission_facts.htm (last visited Mar. 24, 2007).

113. *Id.*

114. *Id.*

115. THE JOINT COMM'N, HOSPITAL LANGUAGE AND CULTURE, http://www.jointcommission.org/HLC/ (last visited Mar. 24, 2007).

several standards that support the provision of care, treatment, and services in a manner that is conducive to the cultural, language, literacy, and learning needs of individuals.[116]

In March 2007, The Joint Commission issued a report on national strategies to better serve an increasingly diverse patient population.[117] From a study of sixty hospitals across the country, it identifies the challenges of providing care and services to a population that may not share the same language or customs, as well as practices that hospitals should implement to provide culturally and linguistically appropriate health care, including the establishment of a centralized program to coordinate services relating to language and culture; implementation of unified frameworks for systematic collection of data on race, ethnicity and language to identify and address health disparities; provision of cultural competency training to hospital staff; and a formalized process for translation of patient education materials and the use of health care interpreters and cultural brokers to facilitate communication.[118] The Joint Commission also offers a published document that contains a crosswalk between the federal CLAS standards and The Joint Commission's standards.[119]

Beyond the efforts of AAMC, LCME, and The Joint Commission, there is also extensive support for cultural competence training among the numerous professional associations for health care providers. Many associations have issued policy statements, position papers, guidelines, or other forms of organizational support for cultural competence training and culturally competent health care services.

In the realm of associations for physicians, support for cultural competence has been made public by the AMA,[120] the American Academy of Family

116. DIV. OF STANDARDS & SURVEY METHODS, JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., JOINT COMMISSION 2006 REQUIREMENTS RELATED TO THE PROVISION OF CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE 1 (2006), *available at* http://www.jointcommission.org/NR/rdonlyres/1401C2EF-62F0-4715-B28A-7CE7F0F20E2D/0/hlc_jc_stds.pdf.

117. *See* THE JOINT COMM'N, *supra* note 58.

118. News Releases, The Joint Commission, Joint Commission Report: National Strategies Needed to Better Serve Increasingly Diverse Patient Populations in American Hospitals (Mar. 29, 2007), *available at* http://www.jointcommission.org/Newsroom/newsreleases/jc_report_032907.htm.

119. DIV. OF STANDARDS & SURVEY METHODS, JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., OFFICE OF MINORITY HEALTH NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) STANDARDS, CROSSWALKED TO JOINT COMMISSION 2006 STANDARDS FOR HOSPITALS, AMBULATORY, BEHAVIORAL HEALTH, LONG TERM CARE, AND HOME CARE (2006), *available at* http://www.jointcommission.org/NR/rdonlyres/5EABBEC8-F5E2-4810-A16F-E2F148AB5170/0/hlc_omh_xwalk.pdf.

120. AM. MED. ASS'N, H-295.897: ENHANCING THE CULTURAL COMPETENCE OF PHYSICIANS, http://www.ama-assn.org/apps/pf_new/pf_online (enter "cultural competence of physicians") (last visited Mar. 24, 2007).

Physicians,[121] the American College of Physicians,[122] the American Medical Women's Association,[123] the National Medical Association,[124] the National Hispanic Medical Association,[125] and the National Center for Primary Care (NCPC),[126] as well as the American College of Emergency Physicians (ACEP),[127] the American Academy of Pediatrics,[128] the American College of Obstetricians and Gynecologists,[129] and the American Osteopathic Association.[130] Some of these associations acknowledge the practical need for cultural competence to communicate with the patient, as in the ACEP's statement that "[c]ultural competency is directly related to the physician's ability to understand a patient's history and presenting symptoms and to prescribe a treatment plan mutually agreed upon by the patient and physician."[131] Others urge the medical professional to humanize the health care experience to optimize care, as in the NCPC's call for "[u]nderstanding that demonstrations of respect are more important than gestures of affection or shallow intimacy, and finding ways to learn how to demonstrate respect in various cultural contexts."[132]

Associations for psychiatrists and other mental health professionals, such as the American Psychiatric Association (APA),[133] the American Psychological

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121. AM. ACAD. OF FAMILY PHYSICIANS, CULTURAL PROFICIENCY GUIDELINES (2001), http://www.aafp.org/online/en/home/clinical/publichealth/culturalprof/cpguidelines.html.

122. Am. Coll. of Physicians, *Racial and Ethnic Disparities in Health Care: A Position Paper of the American College of Physicians*, 141 ANNALS INTERNAL MED. 226, 227-28 (2004).

123. Elena V. Rios & Clay E. Simpson, Jr., *Curriculum Enhancement in Medical Education: Teaching Cultural Competence and Women's Health For a Changing Society*, 53 J. AM. MED. WOMEN'S ASS'N 114, 116-18 (1998).

124. NAT'L MED. ASS'N, CULTURAL COMPETENCY (2002), *available at* http://nmanet.org/images/uploads/Cultural_Competency.pdf.

125. NAT'L HISPANIC MED. ASS'N, PROGRAMS: CULTURAL COMPETENCE, *available at* http://www.nhmamd.org/culturalcompetence.htm (last visited Feb. 21, 2007).

126. NAT'L CTR. FOR PRIMARY CARE, CULTURAL COMPETENCY: BRIDGING CULTURES WITH HEALTH TO ENSURE OPTIMAL CARE, http://www.msm.edu/ncpc/crash/crash_index.htm (last visited Feb. 21, 2007).

127. AM. COLL. OF EMERGENCY PHYSICIANS, CULTURAL COMPETENCE AND EMERGENCY CARE (2001), http://www.acep.org/webportal/PracticeResources/PolicyStatements/hlthcaredel/CulturalCompetenceEmergencyCare.htm.

128. Comm. on Pediatric Workforce, *Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy*, 114 PEDIATRICS 1677 (2004).

129. Comm. on Health Care for Underserved Women, Am. Coll. of Obstetricians & Gynecologists, *Cultural Competence in Health Care*, 62 INT'L J. GYNECOLOGY & OBSTETRICS 96, 97 (1998).

130. AM. OSTEOPATHIC ASS'N, POSITION STATEMENT ON MINORITY HEALTH DISPARITIES (2005), *available at* https://www.do-online.org/pdf/cal_hod05memores302ff.pdf.

131. AM. COLL. OF EMERGENCY PHYSICIANS, *supra* note 127.

132. NAT'L CTR. FOR PRIMARY CARE, *supra* note 126.

133. AM. PSYCHIATRIC ASS'N, APA HANDBOOK FOR THE DEVELOPMENT OF PUBLIC MANAGED CARE SYSTEMS (1998), http://www.psych.org/psych_pract/handbook.cfm; Jim Rosack, *Cultural Competence Critical As Minorities Become Majority*, PSYCHIATRIC NEWS, July 7, 2000, at 31, 31, *available at* http://www.psych.org/pnews/00-07-07/cultural.html.

Association,[134] and the National Mental Health Association[135] have also demonstrated commitment to cultural competence at an organizational level. The APA defines a culturally competent mental health agency, in part, as one that incorporates "vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge and the adaptation of services to meet culturally unique needs."[136] These mental health professional organizations also acknowledge the importance of respect for people's dignity, and the American Psychological Association cautions that the way in which respect is shown is "highly dependent upon an individual's cultural background and setting."[137]

Other health professional associations that have issued statements in support of cultural competence include the American Nurses Association (ANA),[138] the National Association of Social Workers (NASW),[139] the American Pharmacists Association,[140] the American Physical Therapy Association,[141] the American Academy of Physician Assistants,[142] and the Oncology Nursing Society.[143] The ANA holds that "[k]nowledge 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."[144] This knowledge is proactively addressed by the NASW, which "supports and encourages the development of standards for culturally competent social work practice . . . and the

134. AM. PSYCHOLOGICAL ASS'N, APA GUIDELINES FOR PROVIDERS OF PSYCHOLOGICAL SERVICES TO ETHNIC, LINGUISTIC, AND CULTURALLY DIVERSE POPULATIONS (1990), http://www.apa.org/pi/oema/guide.html.

135. NAT'L MENTAL HEALTH ASS'N, NMHA POSITION STATEMENT: CULTURAL AND LINGUISTIC COMPETENCY IN MENTAL HEALTH SYSTEMS (2006), http://www1.nmha.org/position/ps38.cfm.

136. AM. PSYCHIATRIC ASS'N, APA HANDBOOK FOR THE DEVELOPMENT OF PUBLIC MANAGED CARE SYSTEMS (1998), http://www.psych.org/psych_prac/handbook.cfm.

137. APAOnline, *Ethics Rounds: Notes from the 2007 Multicultural Conference and Summit*, 38 MONITOR ON PSYCHOLOGY 58 (2007), *available at* http://www.apa.org/monitor/mar07/notes.html.

138. AM. NURSES ASS'N, ETHICS AND HUMAN RIGHTS POSITION STATEMENTS: CULTURAL DIVERSITY IN NURSING PRACTICE (1991), http://www.nursingworld.org/readroom/position/ethics/etcldv.htm.

139. NAT'L ASS'N OF SOCIAL WORKERS, NASW STANDARDS FOR CULTURAL COMPETENCE IN SOCIAL WORK PRACTICE (2001), http://www.socialworkers.org/sections/credentials/cultural_comp.asp.

140. AM. PHARMACISTS ASS'N, 2005 ACTION OF THE APHA HOUSE OF DELEGATES 2 (2005), http://www.aphanet.org/AM/Template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=3149.

141. AM. PHYSICAL THERAPY ASS'N, TIPS ON HOW TO INCREASE CULTURAL COMPETENCY, http://www.apta.org/AM/Template.cfm?Section=Cultural_Competence1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=48&ContentID=20219 (last visited Mar. 24, 2007).

142. Kathy J. Pedersen et al., *A Report on the Findings of the Ad Hoc Committee on International Physician Assistant Education*, 14 PERSPECTIVE ON PHYSICIAN ASSISTANT EDUC. 220, 224 (2003).

143. Debora A. Boyle et al., *A Multifocal Education Strategy to Enhance Hospital-Based Cultural Competency in Professional Staff*, 29 ONCOLOGY NURSING FORUM 764 (2002).

144. AM. NURSES ASS'N, ETHICS AND HUMAN RIGHTS POSITION STATEMENT, CULTURAL DIVERSITY IN NURSING PRACTICE (1991), http//www.nursingworld.org/readroom/position/ethics/prtetcldv.htm.

advancement of practice models that have relevance for the range of needs and services represented by diverse client populations."[145]

Additionally, students, faculty, and educators in the health professions schools have demonstrated support for cultural competence, in the form of official guidelines and position papers issued by the American Medical Student Association,[146] the Society of Teachers of Family Medicine,[147] the Society for Public Health Education,[148] and the American Association of Diabetes Educators.[149] These associations acknowledge the need for cultural competence skills in light of the expectation that future medical professionals can expect a large percentage of their patients to come from minority cultures.[150]

Cultural competence requirements recommended by professional and accreditation organizations for health education institutions also are reflected in complementary or supplementary legislation proposed at the state level.[151] The significance of these combined legislative and policy attempts, as well as the implications for health care professions educators within each state, remain to be seen. However, lessons can be gleaned from previous implementation requirements for curricula and continuing education.

During the last two decades, various health professions schools have implemented curricula for spirituality and medicine courses, communication skills, (bio-) ethics, and medical humanities, as well as complementary and alternative medicine (CAM).[152] Each of these implementations can be considered a component of cultural competence. It is worthwhile to question whether, or how, the content of those courses might relate to cultural competence courses. However, it is important to note that cultural competence training is not analogous to taking courses in other specific or narrow content areas, given the broader issues that cultural competence training encompasses, as well as its connections to human and civil rights.

Medical school curricula are generally developed in-house, but all medical schools—the allopathic ones—develop curricula to meet the national standards set

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145. NAT'L ASS'N OF SOCIAL WORKERS, *supra* note 139, at 7.

146. AM. MED. STUDENT ASS'N, CULTURAL COMPETENCY IN MEDICINE, http://www.amsa.org/programs/gpit/cultural.cfm (last visited Mar. 24, 2007).

147. Robert C. Like et al., *STFM Core Curriculum Guidelines: Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care*, 28 FAM. MED. 291 (1996).

148. SOC'Y FOR PUB. HEALTH EDUC., RESOLUTION FOR ELIMINATING RACIAL AND ETHNIC HEALTH DISPARITIES, http://www.sophe.org/content/ethnichealth.asp (last visited Mar. 24, 2007).

149. Leonard Jack, Jr. et al., Am. Ass'n of Diabetes Educators, *Cultural Sensitivity: Definition, Application, and Recommendations for Diabetes Educators*, 28 DIABETES EDUCATOR 922, 924-25 (2002).

150. AM. MED. STUDENT ASS'N, *supra* note 146.

151. *See supra* notes 61-73.

152. *See* SOC'Y OF TEACHERS OF FAMILY MED., SOCIETY OF TEACHERS OF FAMILY MEDICINE STRATEGIC PLAN, http://www.stfm.org/strategicplan.html ("Develop faculty development programs in medical education that can be applied across disciplines.").

forth by the AAMC and the LCME.[153] Osteopathic medical schools, by contrast, follow guidelines set forth by the AAMC as well as the American Osteopathic Association's Commission on Osteopathic College Accreditation.[154] Curriculum changes in any discipline necessitate a slow process; this is particularly true within medical education due to an already full curriculum.[155]

In order for state policymakers to gain support from the institutions impacted by legislation and to ensure proper implementation, the impetus and rationale behind the adoption of guidelines must be clearly documented. Many institutions, as previously described, are already required by national accrediting bodies to provide cultural competence training. If new state policies require substantial changes to existing and recently redesigned curricula, these institutions may be reluctant to support such new legislation. By gaining a greater understanding of these dynamics, state policymakers can work collaboratively with local institutions to gain the support that will be needed to ease implementation.

D. National Policy

On September 29, 2006, Senators Frist, Kennedy, Obama, and Bingaman introduced the Minority Health Improvement and Health Disparity Elimination Act in the United States Senate.[156] The legislation establishes five Titles to improve the health care of racial and ethnic minorities and other populations affected by health disparities, including Education and Training; Care and Access; Research; Data Collection, Analysis, and Quality; and Leadership, Collaboration, and National Action Plan.[157] Title I, Education and Training, offers two subsections that would support the inclusion and implementation of cultural competence training for health care providers.[158]

This is not the first legislation of its kind to be put forth at a national level. It is, though, the first legislation proposed following the groundswell of state level efforts. The progression of this legislation may offer great insight into how to proceed with future cultural competence legislation at the state level. It will also be necessary for state policymakers to determine how this legislation will be interpreted and implemented at the state level if passed and signed into law.

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153. LIAISON COMM. ON MED. EDUC., *supra* note 108, at 1-3.

154. AM. OSTEOPATHIC ASS'N, OSTEOPATHIC COLLEGE ACCREDITATION OVERVIEW, http://www.osteopathic.org/index.cfm?PageID=ost_comacc (last visited Mar. 24, 2007).

155. BEAMON ET AL., *supra* note 9, at 18.

156. S. 4024, 109th Cong. (2006).

157. *Id.*

158. *Id.*

CONCLUSION

Cultural competence educators, practicing physicians, and state legislators all play a part in creating and implementing cultural competence curricula. To ensure that such policies are effective, each party must clearly define its criteria for success, as well as a plan to achieve its goals. What amount of training will be considered sufficient? Will the required training be administered live, via the Internet, or a combination of both? The answers to such questions will determine the ultimate costs of these mandates. These costs will be balanced against the goal of improving our nation's health, which would ultimately result in cost savings. When medical treatment and health care services are ineffective, a higher level of care is required, which in turn carries higher costs for organizations, taxpayers, and society at large. Cultural competence may allow services to be delivered more effectively, saving money and increasing capacity.

However, these are long term benefits. In the immediate future, states willing to mandate cultural competence training will also need to consider issues surrounding financial support for development and implementation of these training programs. Culturally relevant materials and policies can only be developed after determining what should and should not be included. It is critical that members of the community, their caregivers, and their representatives, develop strategies for effective communication regarding health care.

To truly affect change, the outlook of all of our health care institutions—public and private, academic and applied—must continue evolving to reflect a culturally relevant and sensitive format.[159] This evolution is ongoing and long term. As with many areas of education, budgets, and resources are overextended in medical education, and the creation of cultural competence curricula may require support from various funding sources. The legislation of such requirements, however, goes a long way toward legitimizing them. Without careful thought to andragogy (teaching adults),[160] content, implementation, evaluation of effectiveness, and other surrounding issues, the guarantee of culturally competent care can easily become an empty promise.[161]

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159. Gregory Juckett, *Cross-Cultural Medicine*, 72 AM. FAM. PHYSICIAN 2267, 2267 (2005); Robert C. Like, *Culturally Competent Family Medicine: Transforming Clinical Practice and Ourselves*, 72 AM. FAM. PHYSICIAN 2189, 2190 (2005).

160. MALCOLM S. KNOWLES, THE MODERN PRACTICE OF ADULT EDUCATION: ANDRAGOGY VERSUS PEDAGOGY 38 (1970).

161. Brenda L. Beagan, *Teaching Social and Cultural Awareness to Medical Students: "It's All Very Nice to Talk About It in Theory, But Ultimately It Makes No Difference"*, 78 ACAD. MED. 605, 614 (2003); *see also* Mary Catherine Beach et al., *Cultural Competence: A Systematic Review of Health Care Provider Education and Interventions*, 43 MED. CARE 356, 366-67 (2005); Eboni G. Price et al., *A Systematic Review of the Methodological Rigor of Studies Evaluating Cultural Competence Training of Health Professionals*, 80 ACAD. MED. 578, 578 (2005).

Policies that address the need for cultural competence are emerging across the country at every legislative level, as well as among accreditation bodies and professional associations. This is largely in response to a greater recognition of the role that cultural competence training may play in addressing health and health care disparities and in helping health care providers offer services that are culturally and linguistically appropriate, allowing them to comply with related legislation. Cultural competence is a complex and far-reaching concept that extends beyond the lines of race, ethnicity, class, language, and other such categorizations. It may therefore enable health care providers to work more effectively in all encounters, improving the overall health and well-being of an entire society. In order to allow cultural competence training to reach this enormous potential, policymakers, health care professionals, and attorneys must work hand-in-hand to ensure that legislation takes into account the needs of all stakeholders, thereby closing the gap between policy and practice.

> At the end of the day, physicians need a practical set of tools and skills that will enable them to provide quality care to patients everywhere, from anywhere, with whatever differences in background that may exist, in what is likely to be a brief clinical encounter. Call it what you will, the field of cultural competence aims quite simply to assure that health care providers are prepared to provide quality care to diverse populations.[162]

162. Joseph R. Betancourt, *Cultural Competence and Medical Education: Many Names, Many Perspectives, One Goal*, 81 ACAD. MED. 499, 501 (2006).