SATISFACTION snapshot
news, views & ideas from the leader in healthcare satisfaction measurement

HEARING ALL PATIENTS' VOICES

Practical Applications in Cultural Competence

Paul A. Clark, Senior Knowledge Manager
Laura Vercler, Knowledge Manager
Edited by Terry Grundy, Managing Director
Press Ganey Associates, Australia

The Satisfaction Snapshot is a monthly electronic bulletin freely available to all those involved or interested in improving the patient/client experience. Each month the Snapshot showcases issues and ideas which relate to improving patient satisfaction and customer service, improving workplace culture and improving the way we go about our work in the healthcare industry.

The Satisfaction Snapshot features:

- relevant articles from healthcare industry experts
- case study success stories
- tips and tools for quality improvement
- patient satisfaction and other industry research findings
- articles with ideas to help achieve success in your role

If you would like your colleagues to receive the Satisfaction Snapshot please send us their names and email addresses. The Satisfaction Snapshot is published by Press Ganey Associates Pty Ltd.

Subscription to the Satisfaction Snapshot is FREE!

Please direct any comments, suggestions or article submissions to:

Manager of Client Relations
snapshot@pressganey.com.au
www.pressganey.com.au
P: 07 5560 7400
F: 07 5560 7490

PRESS GANEY

Practical Applications in Cultural Competence

Best Practice Solutions for Culturally Appropriate Care

Contributors:
Paul A. Clark, Senior Knowledge Manager
Laura Vercler, Knowledge Manager
Edited by Terry Grundy, Managing Director Press Ganey Associates, Australia

Our health care systems do not treat all patients alike. Substantial evidence exists that indicates great disparities in care, treatment, and outcomes for minority patients. Socio-cultural/economic risk factors, processes, and outcomes all demonstrate significant disparities. It is clear that patients from diverse cultures and ethnic and racial backgrounds experience care differently. These differences are real and not an artifact of measurement.

Examples include higher avoidable hospital admissions and later diagnosis of treatable cancers such as breast or colorectal for minorities. It is the responsibility of every health care organisation to refine systems so all populations are effectively served. While research supports the fact that many people prefer care providers of similar race, ethnicity, or cultural background, this is usually not possible. Yet every care provider shares with their patients the experience of being part of humankind — actions of kindness and respect easily translate across cultures and languages.

This November 2007 Satisfaction Snapshot focuses on:

- Recent research on health care disparities — often caused by inadequate translation services and a lack of cultural understanding.
- Incremental actions that care providers can engage in today.
- Important aspects of culturally competent care — the first step in breaking down barriers is providing resources and sensitising frontline staff to potential cultural conflicts.

Are There Differences in Quality of Care and Patient Perceptions?

One of the most unsettling quality improvement issues surrounds the tremendous disparity that exists in the clinical and service quality rendered to minority populations. A recent, Institutes of Medicine's (IOM) report, Unequal Treatment, presents overwhelming evidence that minorities, and non-English speaking persons experience health care very differently. In addition, palpable differences in health care encounters, processes, and treatments contribute to different outcomes. These disparities are also confirmed through analysis of patients' perceptions of clinical and service quality.

Given the measurable differences across the entire spectrum of quality care — structure, process, and outcomes — it should not be a surprise when these patients' perceptions of the care experience are similarly disparate. This is a clear indication that the care experience often has not been synchronised with patients' unique ethnic/racial, cultural, and language needs. It is important to note that the entire health care system is not failing in providing patients with a positive health care experience.

Numerous studies regarding race and patient satisfaction find minimal or no differences in health care satisfaction by race[1], but this is not a universal finding[2]. Studies that focused on health care organisations with a single site were more likely to find differences in satisfaction by race[3]. Race is an inaccurate factor on which to identify cultural differences. While the predominant race is often used to describe a culture, a culture may be comprised of multiple races and not all members of a single race may ascribe to the defined culture.

Facilities that excel at cultural competence avoid stereotyping based on race. In fact, patients belonging to a linguistic minority report lower satisfaction compared to English speaking patients. This difference was greater than the difference between ethnic minorities and anglo/european patients.[4] Evidence suggests that language may be a better indicator of cultural difference than race. While it does not encompass all cultures, it helps to combat stereotyping and racial profiling within an organisation.

Root causes of disparities

Cultural competence within an organisation overcomes:

- Distrust of the health care system
- Distrust of health care providers
- Lack of minority health care providers (especially doctors)
- Lack of minorities in health care management
- Cultural insensitivity
- Prejudice
- Language barriers
- Social Policies

Within health care, disparities, such as language, education, cultural bias, geography, financing mechanisms and overall approach, exist because systems and processes typically favour the majority. According to a 2002 IOM report, "...although myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care" (IOM 2002).

Cultural competence is about building your organisation's human and intellectual capital to better serve the needs of your customers. The process begins with training staff so that they are culturally competent, hiring people who are members of the customer groups you are focusing on or who already exhibit exceptional cultural competence.

Differences in satisfaction based on health care provider race or ethnicity

Numerous studies have confirmed that doctor/patient similarities with regards to ethnic and cultural variables is almost always associated with higher patient satisfaction (e.g., Laveist & Nuru- Jeter 2002). Among patients who speak a first language other than English, satisfaction can sometimes be higher when the provider speaks the same language fluently. While it is preferential to have similarities among the doctor and patient, it is not realistically possible for every health care encounter.

When fundamental beliefs and values differ, it is often best to find ways to lessen the effect by creating an environment conducive to open discussions. Being willing to validate ideas of wellness, health, and body, and attempting to share decision-making power can help override cultural barriers. Attempting to attain cultural competence in the same fashion as studying chemistry only exacerbates the cultural clash. This form of learning reduces diversity to a finite subject that can be mastered.

What Can We Do About It?

Cultural competence — to provide care to patients with diverse values, beliefs, and behaviours; or, tailoring delivery to meet patients social, cultural and linguistic needs—has emerged as a promising strategy to remedy disparities on local and national scales (Betancourt et. al. 2003).

Essentially, achieving cultural competence means that an organisation has attained the requisite human capital, know-how, and service structures to deliver health care services that ensure the highest quality experience to all patients regardless of race, culture, or ethnicity. While some universals exist, each health care organisation needs to determine its own path towards achieving a culturally competent organisation based on the racial, ethnic, and cultural makeup of the patient population.

As the potency and variety of different racial/ethnic and cultural groups grow, health care providers will be less able to lump a majority of patients into a single, generic group. Sensitivity to differences and a willingness to step away from the "norm" are key to delivering culturally competent care. The health care experience is very intimate and personal to each patient.

Patients from culturally diverse backgrounds do not expect every health care provider to be multilingual and proficient in the cultural context of each patient's life. Yet providing culturally competent care involves training health care professionals to notice, understand, and respect cultural differences, and be aware of resources available to aid in mitigating them.

Awareness and openness are necessary to enhancing your staff's cultural competence. Not only will this improve the care your patient's receive but will improve staff member's confidence in the care they provide. Sensitising health care workers to the potential for cultural conflict is the first step in creating a culturally sensitive environment.

Conclusion

Cultural competence requires a constant effort to be up-to-date on the needs of your patients. Each case is different and requires a personal investment in the patient. Every effort to meet the needs of patients affects their individual lives in a powerful lasting way. A gentle word and a smile are gestures that transcend all cultural barriers.

Best Practice Solutions for Culturally Appropriate Care – Various Health Care Situations

Beyond language, health care situations arise that provide potential learning aides for cultural issues.

Culturally sensitive health care:

- "Respects the beliefs, attitudes, and cultural lifestyles of its patients..."
- "Acknowledges that health and illness are in a large part molded by variables such as ethnic values, cultural orientation, religious beliefs, and linguistic considerations."
- "The culturally constructed meaning of illness is a valid concern of clinical care..."
- Understands that the goal is to acknowledge that health care decisions are made by individuals — not groups. "There is often as much intra-cultural variation in beliefs and behaviours as there is inter-culturally..." (Pratcher 1994)

Cultural competence comes not from the information care providers know about a given culture's practices, but rather the staff's sensitivity to the potential for difference. Patients from other cultures do not expect you to have complete understanding, but ask for your respect and compassion. While the majority of providers would like to provide culturally sensitive care, it is difficult to translate those feelings into demonstrable actions.

The following outlines potential cultural conflicts and provides action-based solutions for improvement. While many of the ideas appear simple and straightforward, conscious effort is required to ensure all patients are treated with dignity and respect:

- Be perfectly explicit upon admission and pre-admission.
- Cover the issues of precisely what treatment in the hospital means and doesn't mean in terms of patients' rights.
- Systematically address these topics as early as possible to eliminate confrontation.

Interpreting Services

Translation services (onsite and simultaneous translation) have been tested in a randomised, controlled trial have shown to improve patient satisfaction with the experience of care. Avoid using ad-hoc interpreters since their knowledge of the language and culture may not be sound.

Education and practice must accompany the offering of translation services to ensure proper use. A recent issue of Health Care Risk Management (Carbone, Gorrie & Oliver, 2003) suggests the following situations may necessitate interpreter services if a health care organisation desires to provide optimal care and reduce its exposure to adverse events and litigation:

- Determination of a patient's medical history or description of the ailment or injury;
- Provision of patient's rights;
- Informed consent or permission for treatment;
- Religious services and spiritual counseling;
- Explanation of living wills or powers of attorney;
- Diagnosis of ailments or injuries; explanation of medications prescribed (such as dosage and side-effects);
- Explanation regarding follow up treatments, therapies, tests results, or recovery;
- Discharge instructions;
- Education presentations, such as classes concerning birthing, nutrition, and weight management;

Solutions for Improvement:

- Mid-sized or larger health care organisations in extraordinarily multi-ethnic areas (e.g., certain parts of Melbourne or Sydney) can employ numerous part-time interpreters.
- The availability of direct phone translation services is another excellent option for facilities that have infrequent needs for specific language services or lack the funding to have live translators available.
- Onsite interpreter services.
- Simultaneous translation via offsite phone companies offering this service.
- Language-appropriate health educational materials preprinted for common services and populations.
- Using the Internet to host educational materials in all languages.
- Tap into members of your staff from the ethnic, racial, or socio-cultural communities who, under the direction of your QI, doctors, organisational learning or nursing leaders, can teach cultural competence and provide insight into how processes could be better structured.

Family Relationships

Because of traditional familial relationships, the authority for making the majority of health care decisions is given to the next closest relative when the patient is incapable of making the decision. In some cultures, the head of the household makes the decisions regarding health care for the entire family. These individuals are typically older and can be male or female. It is expected that all other members of the family accept the decisions made by the head of the household.

Practitioners frequently fail to recognise the impact not involving families in medical decisions may have on the patient. Fearing privacy regulations, some choose to ignore patient wishes about family involvement, which can be perceived by the patient as resistance to the family and may have negative consequences for the patient later on.

Solutions for Improvement:

- Patients should be privately asked their wishes regarding family involvement in treatment decisions. Asking the patient in the presence of the family members makes it virtually impossible for the patient to decline, especially if family hierarchy is very important.
- Patients who do wish to disclose their medical treatment should sign waiver forms.
- Health care workers have the opportunity to be the "bad guy" for patients who choose not to disclose their medical information to friends/family. Telling families they are unable to disclose the information, allows the burden to be removed from the patient.

Male/Female Relationships

Mixed-gender relationships have different expectations and acceptance levels amongst cultures. Many cultures believe that physical touching between a man and woman should only occur in marriage. While not sexual in nature, patients may still perceive the touching that takes place in mixed-gender doctor/patient relationships to be inappropriate. Doctors or nurses who notice resistance from a female patient or obvious concern from the male family members should not immediately touch the patient.

It is important to gain the family and patient's trust prior to performing a medical intervention. Due to the volume of patients a doctor and hospital sees, it is easy to become numb to the personal invasion these actions can cause. Some cultures are very comfortable with touch while others reserve it for only the closest of friends and family.

Solutions for Improvement:

- Engage the patient in a discussion for a few minutes before beginning the any physical examination. Often in the discussion of symptoms, body language will indicate whether or not the patient would be comfortable being touched by the care provider. For example, with an injured leg the patient may lift it to show the injury — a non-verbal cue to begin the examination.

- Give a verbal indication when the exam is going to begin and wait for permission prior to touching the patient.

- If the patient resists, take several steps backward and initiate a conversation about the necessity of the exam. Ask them what would make them more comfortable. These efforts may require a more substantial investment in time, but the long-term trust developed with the patient will be mutually-beneficial.

- Never make a patient feel guilty for their discomfort. Belittling or admonishing the patient may guilt them into compliance but is damaging to the patient-provider relationship.

- Be willing to discuss patient concerns with touch or the patient-provider relationship. If gender is an issue, try to find a care provider of the same gender to aid in the examination.

Eye Contact

Eye contact is a socially trained standard and it is rarely verbally identified as either rude or appropriate. Rather, it is developed through the levels of comfort each individual feels with personal interactions in various social situations.

Solutions for Improvement:

- Health care workers should consciously take cues from patients and their families regarding eye contact. If the patient makes frequent eye contact, reciprocate. The same applies if eye contact seems to be withheld.

- Never force a patient to look you in the eye. This may be particularly tempting when trying to communicate recommended treatment. It may appear as if the patient is not listening but it may simply be a cultural difference.

- Lack of eye contact may be reflective of the type of relationship and rapport a provider has with a patient. If the patient's eye contact practices are unnerving, watch how the individual responds to another care provider. Discuss with that care provider concerns prior to approaching the patient.

Dress/Modesty

Proper examination of a patient often requires the removal of clothes. While most cultures hate this experience, they understand the medical necessity and it is an expected part of the health care experience. Other cultures, however, may not accept undressing as a standard part of the medical encounter. It creates an unequal power situation when the undressed patient is set to listen to the instructions of the carefully dressed nurse or doctor.

Care providers need to be cognisant of conflicting beliefs and create alternatives that adhere to the patient's beliefs and culture. Many concerns about modesty are amplified in mixed-gender interactions. Due to the sexual connotations of the naked body, more modest cultures are very apprehensive to expose private areas of the body to providers of the opposite sex. In some cultures, such exposure brings with it deep shame and can conflict with religious beliefs.

Solutions for Improvement:

- Patients who hesitate or refuse to undress should be asked about their preferences. If your community has a high prevalence of modest cultures, consider purchasing full-length gowns that offer complete coverage.

- Offer patients robes to wear that cover the open back of the gown.

- Allow patients to cover themselves with blankets.

- Ask patient to only remove the clothing that is absolutely necessary.
- Allow patients to remain dressed until the portion of the exam that requires the removal of clothing.
- Leave the room whenever you ask a patient to undress.
- Always have a care-provider of the same sex in the room with a patient who is undressed.
- After the physical examination, allow the patient to redress prior to a verbal consultation. A naked patient interacting with a fully dressed care provider experiences an extreme imbalance of power. Feelings of discomfort may override their ability to ask questions and willingness to be completely open with the provider.

Dietary Practices

Food preferences vary considerably amongst religions and cultures. These considerations need to be addressed for both the inpatient stay and potential restrictions related to a special diet. While it is impossible to have options specific to every cultural/religion, there are many ways to meet dietary needs.

Solutions for Improvement:

- Upon arrival, ask all patients about food preferences. Non-medical diet restrictions (e.g., religious restrictions) should be treated with the same respect as medical restrictions.
- Always provide high-quality vegetarian options since many food restrictions are related to meat/animal products.
- Allow family members to bring food from home that complies with both medical and personal food restrictions. Dietary discussions with patients and family members offers educational opportunities and helps to ensure compliance at home.
- Take into account personal food preferences when educating patients about special diet restrictions.

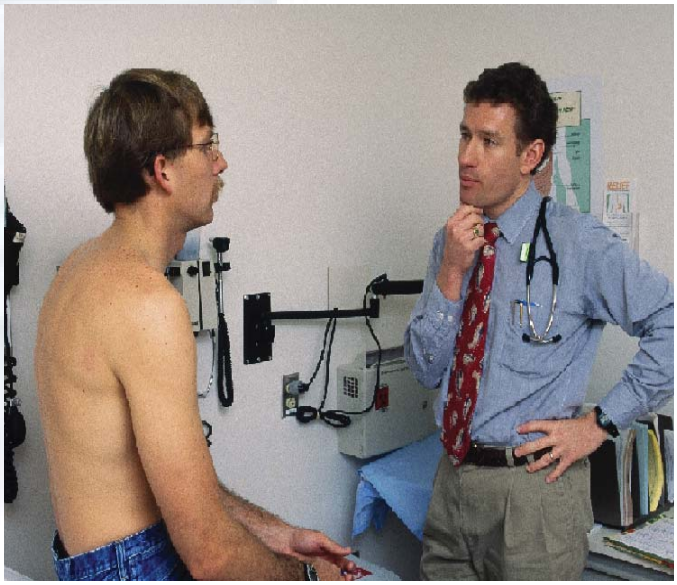
Initial Meetings

First impressions last a lifetime. Research has demonstrated the importance of first impressions in developing strong interpersonal relationships. Too often, health care providers are hurried and do not take the time to properly introduce themselves. Patients, regardless of cultural differences, want proper diligence devoted to their case. It is irrelevant to the patient if a provider has already seen 20 people that day.

In some cultures, not formally introducing oneself or making small talk at the beginning of an exchange is extremely offensive. Patients feel entitled to basic courtesies and a general interest in their personal lives. Due to the significant financial and emotional investment, it is extremely important that a care provider establishes a strong rapport with the patient. Patients want to be treated with respect and dignity.

Solutions for Improvement:

- Introduce yourself to the patient immediately upon entering the room. All staff members should introduce themselves the first time they encounter a patient, even the receptionist.
- Institute “key words at key times” for all staff members to make introductions part of the routine.
- Make sure name badges are worn by all staff — placed just below the shoulder on either the right or left side of the body. Name badges that hang low on a lanyard are difficult to read.



Death Rites

For the family and friends of a dying patient, death rites and rituals help manage the mourning and loss. Prohibiting or inhibiting these activities may cause great emotional distress.

consider cultural and religious factors that are behind noncompliance.

While care providers hold a great deal of knowledge, it is ultimately the patient's decision. Refusing treatment due to religious or cultural beliefs should not bring out hostility or indifference towards the patient. If a care provider is confronted with a noncompliant patient, time should be spent to determine the cause. This usually requires a significant time and personal investment — a challenge in a world focused on high patient volumes, limited resources, demands for productivity and efficiency.

Solutions for Improvement:

- Be willing to consider all alternatives to treatment, even ones that are deemed "less effective" than the initial recommendation. Train staff on how to empathetically listen and respect patient wishes.
- Do not assume that a belief or practice common to a particular culture is adopted by all its members — always offer the traditional treatment options.
- Patients have the right to decide what is best for their bodies. Do not make patients feel guilty for their decisions.
- Medical providers are experts and should express their opinions and recommendations, however, the final decision rests with the patient.
- Provide training to all nurses and doctors on proper procedures to legally protect the hospital when a patient refuses medical treatment. Provide access to a 24-hour hotline that staff members can use in an emergency.

Alternative Medicine

Many different cultures engage in medical practices that are labeled as "alternative medicine". Webster's defines alternative medicine as "a variety of therapeutic or preventive health care practices, such as homeopathy, naturopathy, chiropractic, and herbal medicine that do not follow generally accepted medical methods and may not have a scientific explanation for their effectiveness."

Generally, health care providers only deal with the alternative practices with which they are familiar. While current medical practices draw a strong line between traditional and alternative medicine, it is important that practitioners take a thorough medical history that includes alternative medicine. Patients should be asked about herbs and supplements, in addition to medications.

Asking the patient questions about how they treat pain or illness creates a deeper understanding of the patient and the proper course of treatment. Pachter's 1994 work in the Journal of the American Medical Association reviews cultural belief systems, explanatory models, and folk illnesses. The author presents a model for negotiating between biomedicine and folk medicine. Doctor knowledge, inquiry, and nonjudgmental acceptance of folk illness beliefs "enhance the quality of the interaction between the patient and the health care system."

One does not necessarily need to believe in the existence of the folk illness to "work collaboratively with the family toward the goal of more successful health care." Pachter makes several recommendations for what doctors (or any provider) can do to better handle culturally-based folk medicine beliefs.

Solutions for Improvement:

- Become aware of cultural, ethnic, and folk medicine beliefs through books;

  Assess the likelihood that a patient may act on folk beliefs. Possible indicators include those individuals who:

  - Are recent migrants
  - Live in ethnic enclaves
  - Prefer to use their native tongue
  - Were educated in their country of origin
  - Migrate back and forth from their country of origin
  - Are in constant contact with older individuals who maintain a high degree of ethnic identity

- Consider broaching the topic of a folk belief or illness with a nonjudgmental inquiry that provides a non-threatening framework for communication, "Some of my patients have told me that there is an illness called -------- that doctors don't know about but that people get. Have you ever heard of --------?" If answered in the affirmative, follow with: "Do you think that you (or your child) may have -------- now?"

- When taking a medical history, ask questions that are more open to encourage disclosure of all medical practices. Understanding what patients' believe is the cause of their illness can open doors to understanding their beliefs about medicine. Asking them about what they think caused their illness and potential treatments.

  Example questions:

  - What things do you usually do to treat illness?
  - What do you think will be helpful in treating your current problems?

References

1 Barr, D. A. (2004). "Race/ethnicity and patient satisfaction. Using the appropriate method to test for perceived differences in care." J Gen Intern Med 19(9): 937-43.

Shi, L. and G. D. Stevens (2005). "Disparities in access to care and satisfaction among U.S. children: the roles of race/ethnicity and poverty status." Public Health Rep 120(4): 431-41.

van Zanten, M., J. R. Boulet, et al. (2004). "The influence of ethnicity on patient satisfaction in a standardized patient assessment." Acad Med 79(10 Suppl): S15-7.

2 Haviland, M. G., L. S. Morales, et al. (2005). "Race/ethnicity, socioeconomic status, and satisfaction with health care." Am J Med Qual 20(4): 195-203.

Weech-Maldonado, R., L. S. Morales, et al. (2003). "Race/ethnicity, language, and patients' assessments of care in Medicaid managed care." Health Serv Res 38(3): 789-808.

3 Baider, L., P. Ever-Hadani, et al. (1995). "The impact of culture on perceptions of patient-physician satisfaction." Isr J Med Sci 31(2-3): 179-85.

Cook, C. T., O. Kosoko-Lasaki, et al. (2005). "Satisfaction with and perceived cultural competency of health care providers: the minority experience".J Natl Med Assoc 97(8): 1078-87.

Nelson, C. W. (1985). "Does ethnicity matter? Utilization, responses to medical problems, attitudes and satisfaction in a medically underserved community".J Ment Health Adm 12(1): 34-41.

Woods, S. E., R. Bivins, et al. (2005). "The influence of ethnicity on patient satisfaction".Ethn Health 10(3): 235-42.

4 Weech-Maldonado, R., L. S. Morales, et al. (2003). "Race/ethnicity, language, and patients' assessments of care in Medicaid managed care". Health Serv Res 38(3): 789-808.

Useful Online Resources

Research Organisations and Information Clearing houses:

The National Center for Cultural Competence. Georgetown University (Washington, D.C.) Available from: http://www.georgetown.edu/research/gucdc/nccc/index.html

The Commonwealth Fund. (Washington, D.C.) Available from: http://www.cmwf.org/programs/

Office of Minority Health. United States Department of Health and Human Services (Washington, D.C.) Available from: http://www.omhrc.gov/omh/programs/2pgprograms/cultural.htm

Indian Health Service. United States Department of Health and Human Services (Washington, D.C.) Available from: http://www.ihs.gov/

Closing the Health Gap. United States Department of Health and Human Services (Washington, D.C.) Available from http://www.healthgap.omhrc.gov/

National Asian Women's Health Organization (San Francisco, CA). Available from: http://www.nawho.org/

Regulations:

Guidance Memorandum: Title VI Prohibition Against National Origin Discrimination— Persons with Limited-English Proficiency. Washington, D.C.: Department of Health and Human Services, 2003. Available from: http://www.hhs.gov/ocr/lepfinal.htm

Reports:

Andrulis, D.A., Goodman, N., & Pryor, C. What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency. Boston, MA: The Access Project, Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University, 2002. Available from: http://www.accessproject.org/downloads/c_LEPresources.pdf

Press, E. A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics. Washington, D.C.: National Alliance for Hispanic Health, 2001. Available from: http://www.hispanichealth.org/pub_cultural.lasso

Torres, B. Best Practice Recommendations for Hospital-Based Interpreter Services. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Massachusetts Department of Public Health, 2001. Available from: http://www.state.ma.us/dph/bhqm/2bestpra.pdf

Policies:

American College of Emergency Physicians. Cultural Competence and Emergency Care. October, 2001. Available from: http://www.acep.org/1,4890,0.html

American College of Medical Quality. Professional Policies: Language Barriers in Physician- Patient Communication. February 22, 2003. Available from: http://www.acmq.org/profess/policy38.htm

Examples of what other health care organisations are doing:

Patient Education: Cultural Competency. Ann Arbor, MI: University of Michigan Health System, 2003. Available from: http://www.med.umich.edu/pteducation/cultcomm2.htm

Florek, R. Cultural Competency Module. Lexington, KY: University of Kentucky Chandler Medical Center, 1999. Available from: http://www.mc.uky.edu/familypractice/preceptordevelopment/culturalcompetencymodule.html

International Patient Services. Orlando, FL: Orlando Regional Healthcare, 2003. Available from: http://www.orlandoregional.org/services/international/index.cfm

Examples of cultural competence failures leading to litigation:

Carbone, E.J., Gorrie, J.J., & Oliver R. Without proper language interpretation, sight is lost in Oregon and a $350,000 verdict is reached. Health Care Risk Management, May 2003. Available from: http://www.findarticles.com/cf_dls/m0KGX/5_25/101762839/print.jhtml

Office of New York State Attorney General Eliot Spitzer. Attorney general's settlement with two Utica hospitals guarantees enhanced language assistance services for patients with limited English proficiency. Albany, N.Y.: Department of Law. September 22, 2003. Available from: http://www.oag.state.ny.us/press/2003/sep/sep22a_03.html