Culturally Competent Care Guidebook

Edited by Ramon L. Jimenez, MD and Valerae O. Lewis, MD

Companion to the Cultural Competency Challenge

American Academy of Orthopaedic Surgeons
600 North Rush Street, Chicago, Illinois 60611-4263
www.aaos.org

The Culturally Competent Care Guidebook was funded by an educational grant from Zimmer, which has provided ongoing funding to the AAOS Cultural Competency initiative.
Culturally Competent Care Guidebook

Companion to the

Cultural Competency Challenge

EDITED BY

RAMON L. JIMENEZ, MD
FORMER CHAIR, AAOS DIVERSITY ADVISORY BOARD
SENIOR ORTHOPAEDIC CONSULTANT
MONTEREY PENINSULA ORTHOPAEDIC AND SPORTS MEDICINE INSTITUTE
MONTEREY, CALIFORNIA

VALERAE O. LEWIS, MD
ASSOCIATE PROFESSOR
CHIEF, SECTION OF ORTHOPAEDIC ONCOLOGY
THE UNIVERSITY OF TEXAS, M.D. ANDERSON CANCER CENTER
HOUSTON, TEXAS

The Culturally Competent Care Guidebook was funded by an educational grant from Zimmer, which has provided ongoing funding to the AAOS Cultural Competency initiative.
**American Academy of Orthopaedic Surgeons**

**Board of Directors, 2009**

Joseph D. Zuckerman, MD  
President

John J. Callaghan, MD  
1st Vice President

Daniel J. Berry, MD  
2nd Vice President

Frederick M. Azar, MD  
Treasurer

E. Anthony Rankin, MD  
Past President

Thomas C. Barber, MD  
Chair, Board of Councilors

Richard J. Barry, MD  
Chair-Elect, Board of Councilors

David Teuscher, MD  
Secretary, Board of Councilors

William J. Robb, III, MD  
Chair, Board of Specialty Societies

M. Bradford Henley, MD, MBA  
Chair-Elect, Board of Specialty Societies

Jeffrey Anglen, MD  
Secretary, Board of Specialty Societies

Leesa M. Galatz, MD  
Member-at-Large

Michael Lloyd Parks, MD  
Member-at-Large

Michael F. Schafer, MD  
Member-at-Large

Paul Tornetta, III, MD  
Member-at-Large

George Zachary Wilhoit, MS, MBA  
Lay Member

Karen L. Hackett, FACHE, CAE  
Chief Executive Officer (Ex-Officio)

---

**AAOS Diversity Advisory Board, 2009**

Richard J. Haynes, MD  
Chair

Alberto A. Bolanos, MD  
Abhinav Bobby Chhabra, MD  
Mary Williams Clark, MD  
Daryll C. Dykes, MD, PhD  
David E. Font Rodriguez, MD  
Laura M. Gehrig, MD  
Meylyn A. Harrington, MD  
Valereae O. Lewis, MD  
William R. Martin, III, MD  
Charles L. Nelson, MD  
Norman Y. Otsuka, MD  
Darryl W. Peterson, MD  
Raj D. Rao, MD  
Erica C. Taylor, MD

---

**Diversity Advisory Board Liaison Staff**

Mark Wieting, Chief Education Officer  
Lewis Jenkins, Director of Marketing  
Maureen Geoghegan, Marketing Manager  
Tricia Arnold, Marketing Manager  
Monica Baum, Marketing Assistant
Disclosure of Potential Conflicts of Interest

Contributors in Academy programs are asked to disclose if they or their department(s) has received something of value (in excess of $500) from a commercial party or other party which relates directly or indirectly to the subject of their presentation. The Academy has identified the options to disclose as follows:

- (n) = Respondent answered ‘No’ to all items
- 1 = Board member/owner/officer/committee
- 2 = Medical/orthopaedic publications
- 3 = Royalties
- 4 = Speakers bureau/paid presentations
- 5A = Paid consultant
- 5B = Unpaid consultant
- 6 = Research or institutional support from a publisher
- 7 = Research or institutional support from a company or supplier
- 8 = Stock or stock options
- 9 = Other financial/material support from a publisher
- 10 = Other financial/material support from a company or supplier.

An indication of the contributor’s disclosure appears after his or her name as well as the commercial company or institution that provided the support. The Academy does not view the existence of any disclosed interests as necessarily implying bias or decreasing the value of their presentation. It is intended solely for information.

B. Sonny Bal, MD
(2 – Journal of Arthroplasty; Knee; 4 – DePuy, A Johnson & Johnson Company – Anterior Total Hip Symposium, 11/2/07 at AAHKS Meeting; 5A – Zimmer; AMEDICA; 7 – Zimmer; 8 – AMEDICA)

Daneca M. DiPaolo, MD
(1 – Greenwood Leflore Hospital Infection Control Committee; 10 – Smith & Nephew)

Gracia Etienne, MD
(1 – Arthritis Foundation; 5A – DePuy, A Johnson & Johnson Company)

Elaine Fiedler (n)

Steven L. Frick, MD
(1 – American Heart Association; Boston Chapter; 9 – UpToDate)

Elaine Fiedler (n)

Ronald W. Lindsey, MD

Wael F. Kaawach, MD, MBA
(1 – Orthopaedic Specialty Hospital, Jeddah, Saudi Arabia)

Andrea Kubota, RN, MSN, MBA, PNP, CMC
(8 – Pfizer; Merck)

Valeria O. Lewis, MD
(1 – Western Orthopaedic Association; American Orthopaedic Association; 2 – AAOS Now; 7 – Stryker)

Toni M. McLaurin, MD
(7 – Biomet; Smith & Nephew; Stryker; Synthes)

Ellen Raney, MD
(1 – Pediatric Orthopaedic Society of North America; Scoliosis Research Society; Western Orthopaedic Association; Hawaii Orthopaedic Association)

Fernando A. Ravessoud, MD, FACS
(4 – Nuvasive; 5A – Nuvasive)

K. Daniel Riew, MD
(1 – Cervical Spine Research Society; Scoliosis Research Society; 3 – Biomet; 7 – Medtronic Sofamor Dank; 8 – Osprey)

Mary Sobralske, PhD, MSN, RN, ARNP
(2 – Journal of the American Academy of Nurse Practitioners, Journal of Transcultural Nursing; 7 – Washington State University receives grant support for research; 9 – FA Davis)

Victoria M. Stevens, MD (n)

Kimberly J. Templeton, MD (n)

Audrey K. Tsao, MD
(4 – Zimmer; 5A – Zimmer)

James N. Weinstein, DO, MS
(1 – American Board of Orthopaedic Surgery, Inc; NIAMS Advisory Board; Blue Cross and Blue Shield Associations’ Medical Advisory Panel; 2 – Spine)

Augustus A. White, III, MD, PhD
(1 – American Orthopaedic Association; Bone and Joint Decade, USA; Cervical Spine Research Society; Clinical Orthopaedic Society; J. Robert Gladden Society; North American Spine Society; Orthopaedic Research Society; Scoliosis Research Society; 7 – Eli Lilly; Imples; Lippincott; Capstone Therapeutics (previously Orthologic); Zimmer; 8 – Capstone Therapeutics (previously Orthologic); Zimmer; 90 – Wolters Kluwer Health – Lippincott Williams & Wilkins; 10 – Capstone Therapeutics (previously Orthologic); Smith & Nephew)

Orthopaedic Association; Orthopaedic Research and Education Foundation; American Association of Latino Orthopaedic Surgeons; 2 – Orthopedics Today; Journal of Bone and Joint Surgery; Clinical Orthopaedics and Related Reports; 9 – Your Orthopaedic Connection)
Copyright 2009 American Academy of Orthopaedic Surgeons. All rights reserved. No part of this program may be reproduced, stored in a retrieval system, or transmitted, in any form, or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the American Academy of Orthopaedic Surgeons.

Educational Disclaimer
The material presented in this program has been made available by the American Academy of Orthopaedic Surgeons for educational purposes only. This material is not intended to represent the only, or necessarily best, methods or procedures for the medical and patient situations discussed, but rather is intended to represent an approach, view, statement, or opinion of the author(s), editor(s), or producer(s), which may be helpful to others who face similar situations.

Some drugs or medical devices demonstrated in AAOS courses or described in Academy print, electronic, or online publications have not been cleared by the Food and Drug Administration (FDA) or have been cleared for specific uses only. The FDA has stated that it is the responsibility of the physician to determine the FDA clearance status of each drug or device he/she wishes to use in clinical practice.

Furthermore, any statements about commercial products are solely the opinion(s) of the author(s) and do not represent an Academy endorsement or evaluation of these products. These statements may not be used in advertising or for any commercial purpose.

Contributors
Special thanks to the AAOS Diversity Advisory Board and all the volunteer contributors to this educational program, including the Culturally Competent Care Guidebook and the Cultural Competency Challenge.

B. Sonny Bal, MD
Daneca M. DiPaolo, MD
Gracia Etienne, MD
Leonor Fernandez, MD
Steven L. Frick, MD
Richard J. Haynes, MD
James A. Hill, MD
Ramon L. Jimenez, MD
Wael Kaawach, MD, MBA
Andrea Kubota, RN, MSN, MBA, PNP, CMC
Valerae O. Lewis, MD
Ronald Lindsey, MD
Toni M. McLaurin, MD
Ellen Raney, MD
Fernando A. Ravessoud, MD, FACS
K. Daniel Riew, MD
Mary Sobralske, PhD, MSN, RN, ARNP
Victoria M. Stevens, MD
Kimberly J. Templeton, MD
Audrey K. Tsao, MD
James N. Weinstein, DO, MS
Augustus A. White, III, MD, PhD
# TABLE OF CONTENTS

**Introduction**  
Ramon L. Jimenez, MD  
Valerae O. Lewis, MD  
Steven L. Frick, MD  

Section 1  
**Health Care Disparities**  
Leonor Fernandez, MD  
James N. Weinstein, DO, MS  
Augustus A. White III, MD, PhD  

Section 2  
**African-American Patients**  
Toni M. McLaurin, MD  
Gracia Etienne, MD  
Valerae O. Lewis, MD  
Audrey K. Tsao, MD  

Section 3  
**Asian-American Patients**  
K. Daniel Riew, MD  
Audrey K. Tsao, MD  

Section 4  
**American Indian/  
Native American Patients**  
Victoria M. Stevens, MD  

Section 5  
**Hispanic/Latino Patients**  
Ramón L. Jimenez, MD  
Fernando A. Ravessoud, MD, FACS  

Section 6  
**Gender-Based Issues**  
Kim Templeton, MD  

Section 7  
**Faith-Based Issues**  
Wael Kaawach, MD, MBA  

**Recommended Resources**  
and Additional Reading  

vii  
13  
21  
29  
37  
43  
49  
57  
65
WHY BEING CULTURALLY COMPETENT IS IMPORTANT

Communication is the cornerstone of good quality care. Effective communication between clinicians and patients leads to more accurate diagnoses, increased adherence to treatment regimens, and, as a result, decreased medical liability and, most importantly, better patient care.

A breakdown in communication is the most common cause of errors that harm patients, according to a recent American Medical Association (AMA) report. Clearly, it’s time to learn how to better communicate and interact with patients, especially with those from diverse cultural backgrounds. One of the best ways to do this is to practice culturally competent care.

When we encounter patients who are of a different “world,” with different beliefs, attitudes, and fears than our own, we must be able to make them feel comfortable in coming to and interacting with us. By responding with the key ingredients of sensitivity, compassion, and awareness, we can begin to practice culturally competent care. Imagine yourself in a foreign country surrounded by people speaking a language that you don’t understand. Imagine further that you need help because of a health problem. Think of what a difference you would feel if you got a warm smile and an attitude of compassion and concern.

There are some who say they don’t understand how cultural competence can benefit anyone. The truth is, culturally competent care can help you gain more patients, provide better care for your patients, and give you personal satisfaction, more income, and greater success.

How? When you open your arms to a broader diversity of patients, word gets around. If your patients are comfortable coming to you, they will return and recommend you to others. It’s a win-win situation. Both you and your patients will benefit.

POPULATION CHANGES BRING LICENSING CHANGES

The importance and relevance of cultural competence is paramount in view of the rapid and explosive change in the demographics of our patient population. This is reflected by the recent legislative activity in those states that are most affected by these population changes. New Jersey was the first state to pass a law that ties cultural competence education to medical licensure. California has also enacted legislation, which mandates the inclusion of cultural competence principles in all continuing medical education courses. The original proposed bill mandated 16 hours of Continuing Medical Education (CME) with licensure for all physicians. Arizona, Texas, New Mexico, and Illinois are also contemplating similar legislation.

Connecting cultural competence legislation to medical licensure is a reality. Such legislation will increase as surely as the diversity of the population increases. We feel that this guidebook can better prepare all clinicians who evaluate and treat patients for such mandates in the future. It is intended to help all those who are concerned about improving their skills in cultural competence.

RESIDENCY TRAINING PROGRAMS

Program directors in orthopaedic surgery residencies must meet requirements outlined by the Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committee (RRC) for Orthopaedic Surgery to be accredited. Satisfactory completion of an accredited residency program allows the graduate to sit for the certifying examination of the American Board of Orthopaedic Surgery (ABOS). These requirements are now grouped under six core competencies. Two of these competencies specifically address culturally competent care and diversity.

Under the core competency of patient care, residents are “expected to demonstrate the ability to practice culturally competent medicine” (www.acgme.org). Under the competency of professionalism, residents are expected to “demonstrate sensitivity and responsiveness to patients’ culture, age, gender and disabilities.”

With a growing number of state licensing boards now listing culturally competent care education as a prerequisite for licensure, programs need to offer this education to fully prepare a resident for practice in these states. In addition, the U.S. Department of Health and Human Services (HHS) Office for Minority Health has set standards for culturally and linguistically appropriate health care, and the main organization for accrediting hospitals, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is also considering incorporating cultural and linguistic competence requirements into hospital accreditation guidelines. Such guidelines are the “stick” that can be
used to mandate education regarding diversity and culturally competent care, giving regulatory bodies an opportunity to punish or prohibit from practicing those who do not comply.

However, a “carrot” exists that is more important and appeals more to our professional devotion to doing the best possible job for our patients. Our purpose as educators is to give residents the knowledge and skills to provide excellent care for their patients. Evidence is mounting that culturally competent care is optimal patient care and leads to better patient outcomes (mainly via enhanced adherence and compliance) and higher patient comfort level and satisfaction.

Residency directors now have the opportunity to redesign curricula and resident educational experiences to address these issues, and produce graduates who are culturally competent. This is especially important within academic medical centers, where many underrepresented minorities seek care.

Residents themselves feel the need for cultural competency. There are no current data regarding orthopaedic residents and culturally competent care, but a 2003 survey of residents from seven specialties published in JAMA found that 96% of residents felt cultural issues were important in providing care; up to 50% reported no culturally competent care education after medical school; and 20% to 25% reported concerns about dealing with immigrant patients and patients who had religious beliefs or cultural beliefs at odds with Western medicine.

Medical schools have recognized the need for such education. Harvard Medical School has been a leader in this area, and produced a report in June 2006 that is a valuable resource for program directors and faculty—“Culturally Competent Care Education at Harvard Medical School: Background, History and Accomplishments. Bridging the Gap One Patient at a Time”—that is accessible at www.hms.harvard.edu/cccec.

This trend will extend to graduate medical education, and is the impetus for this guidebook. In addition to the “carrot” of providing knowledge and skills that enable orthopaedic surgeons to better care for their patients, these materials can also help avoid the “stick” of regulating agency penalties by providing a method of documenting culturally competent care education.

Perhaps of even greater importance is the so-called “hidden curriculum”—the behavior of attending faculty surgeons that residents witness on a daily basis. Much of the educational process of learning to be a surgeon occurs in a master-apprentice setting, with the attending surgeon serving as a role model for the resident. Observing how attending surgeons communicate with patients and deal with patients from multicultural and multilingual backgrounds likely has a significant impact on how residents will interact with patients when they are on their own in practice. This is difficult to measure and quantify, but assessing and monitoring the hidden curriculum is a leadership issue in residency programs. As Albert Schweitzer remarked, “Example is not the most important thing in leadership—it is the only thing.”

The other issue related to culturally competent care in residency programs is the lack of diversity within our professional ranks. Orthopaedic surgery is a profession populated primarily by white males, with very few females and minority members compared to other areas of medicine, and especially related to our country’s population. In addition to the benefits to the patient, having a multicultural population of physicians provides cross-cultural education and interchange between peers, resulting in improved understanding of different cultures and their views that might influence health care decisions. The president of the Association of American Medical Colleges, Jordan Cohen, MD, has stated, “All patients, minority and non-minority alike, stand to benefit from a racially and ethnically diverse physician workforce. To the extent that diversity among physicians serves to reduce health care disparities, it serves to improve the quality of care for everyone.”

Residency program directors, chairs, and selection committee are the gatekeepers for our profession. Selection criteria for choosing applicants to interview and rank vary widely by department, but survey studies recognize audition rotations, grades in medical school, US Medical Licensing Examination board scores, and election to the Alpha Omega Alpha medical honor society as being commonly employed to sort through applicants. Augustus White, MD, PhD, has written eloquently about this process, and questions whether the current process results in selection of the best candidates for our profession, because grades and test scores do not always predict success in clinical medicine. He believes substantial changes are needed if we are to achieve humanitarian and pragmatic societal goals, and that increasing diversity and decreasing disparities will be crucial to our profession’s future success.

The goal of increasing diversity in orthopaedics is a controversial one. Many see it as implementation of a quota system that forsakes merit and qualifications as prerequisites for entry. But diversity has gained a strong foothold in many areas of our society outside of medicine, and hopefully the concept is not as objectionable as it once was. Diversity training and awareness is commonplace now in
business and educational environments, and the census changes clearly point to a need to address changing demographics in the United States. An underappreciated fact is that as medical schools become more diverse, orthopaedics will reach a smaller proportion of medical students if it remains a predominantly white, male specialty, and thus may miss out on attracting some of the best and brightest students.

Residency program directors and chairs will need to face diversity and culturally competent care issues in the near future, not only to meet regulatory and accrediting requirements, but more importantly to meet the health care needs of our multicultural, multilingual society.

Learning Objectives

By reading this guidebook completely, you will

* Learn the necessity for culturally competent care in orthopaedics through real-life patient case examples in a clinical setting.
* Achieve a better understanding of how cultural issues and needs can impact the patient/physician relationship and increase treatment adherence.
* Learn various communication techniques as they apply to different patient circumstances and cultures.
* Identify appropriate references in order to further research items regarding culturally competent care.

How to Use This Guidebook

The AAOS Cultural Competency Challenge presents diverse patient case scenarios and interactively tests users on how they might respond to specific cultural competency issues. Reaction to that program (originally available on CD-ROM and now available online) has been so positive that we’ve created this guidebook to further explore the many issues of culturally competent care.

Our guidebook expands the scope of the Cultural Competency Challenge for group situations as well as more intensive personal learning experiences. Patient scenarios, tip sheets, annotated references, and a recommended reading section are included to encourage understanding of the principles of cultural competence in the health care setting.

This guidebook has many potential uses as well as users. It can be a personal self-assessment tool or an enhancement to the interactive Cultural Competency Challenge experience. It can be a good teaching tool for clinicians, residents-in-training, and medical students in different settings, such as grand rounds, journal clubs, or informal discussion groups. It can also be used in the training of front and back office staff—everyone who interacts with patients.

Guidelines, Not Rules

Before you begin, it’s important to keep several things in mind:

* This guidebook is not all-encompassing and encyclopedic in reference to culturally competent care issues. It cannot possibly cover all aspects of cultural competence. No book can. Culture is too complex and changeable to define.
* This guidebook contains guidelines, recommendations, and tips. It is not intended to be used as a “rule book.” More extensive resources are available, as evidenced in the list of reference materials. Hopefully this guidebook will foster discussion through which the reader can gain a higher level of awareness and sensitivity regarding these important issues.
* Never assume that an individual who comes from an ethnic culture shares the traits of that ethnicity or culture. This assumption borders on stereotyping. Every patient should be treated as an individual, not defined by race, gender, or religion. We must realize that each population group also contains many diverse groups within it.
* In the chapters on different population groups, you will find many generalizations. They are offered only as a starting point, as a way to begin to learn something about others, and to begin a discussion. In no way are they meant to be used as hard and fast definitions or descriptions for every member of a group. Some observers suggest that generalizing about diverse populations, even with the intention of improving health care, could be interpreted as more stereotyping. But stereotyping is not a way to improve understanding—stereotyping blocks understanding. We hope to encourage learning.
* As used in this guidebook, culture refers to the customary beliefs and social forms of a racial, religious, or social group. Ethnic/ethnicity refers to a group of people who are classed according to common racial, national, tribal, religious, linguistic, or cultural origin.
or background. Race refers to a group possessing distinct traits transmissible by descent. It is important to distinguish ethnic, linguistic, cultural, and racial characteristics from each other and not to correlate racial characteristics such as skin or hair color with either language preference or cultural habits.

- Regarding language and acculturation, don’t assume that Asian-Americans, Hispanic/Latino Americans, and recent immigrants can’t speak English or aren’t acculturated. At the same time, it is important to ascertain the language skills of all your patients as soon as possible.

In addition, some topics/issues appear repeatedly and require some explanation:

**Patient intake questionnaire**
You may want to consider including certain points in your patient intake questionnaire, such as:

- Asking questions regarding religion or any potentially sensitive cultural issues that the patient wants his/her health care provider to be aware of. For example, it may be practical to ask if the patient would object to blood transfusions in an emergency, as some people do for religious reasons.
- Asking patients what term they would use or prefer to describe their own ethnic background.
- Using gender-neutral questions to ask about personal information. For example, ask about significant partner rather than husband/wife.

**Comprehension check**
A comprehension check is a technique to get your patients to explain in their own words what you plan to do for them or to describe what they understand your recommendations are. It’s used to determine whether your patients understand what you’ve told them.

**Using interpreters**
It is generally a good idea to access and utilize interpreters whenever necessary to accurately communicate issues and recommendations to your patients with limited proficiency in English. There is a significant liability risk if a patient with limited English doesn’t understand your recommendations or a procedure, as a result of inadequate translation. Options include using a certified interpreter, hospital- or health care system-provided interpreters, or AT&T Interpretive Services. Hiring a bilingual or multi-lingual staff person is another strong option if your patient base warrants it. Using a patient’s family member for translation probably occurs most frequently, but is not ideal. Some patients may hesitate to tell all their medical problems to a family member and some cultures resist fully open medical discussions between generations or genders. Look into whether any community organizations make interpreter services available. Using educational materials available in other languages is also a good option.

Physicians should take into consideration the legal requirements for having access to an interpretive service for patients with limited fluency in English.

Under certain circumstances, a physician practice may be required under Title VI of the Civil Rights Act of 1964 to provide language assistance to patients who have limited English proficiency (LEP). Language assistance typically means providing an oral interpreter and/or written translation services at no cost to the patient. To assist in complying with Title VI, the US Department of Health and Human Services has issued guidelines (“Guidelines”) that urge physicians to consider the following factors in determining when language assistance is required for LEP patients:

- the number and frequency of LEP patients treated in the practice;
- the importance of the services provided to LEP patients; and
- the physician’s resources.

The Guidelines suggest that a physician document his/her analysis of these factors because providing language assistance to patients is largely dependent on the specific facts of the individual practice. If a physician concludes that language assistance is required, then the physician should develop an LEP implementation plan that should:

- identify LEP patients who need language assistance;
- determine appropriate methods of language assistance;
- provide for staff training;
- notify LEP patients; and
- monitor and update the LEP plan.

The Guidelines list some of the possible methods for providing language assistance, including hiring bilingual staff, contracting with interpreters, using telephone interpreter lines, using community volunteers, and using family or friends of the LEP patient. The physician must, however, inform LEP patients that they are not required to use family or friends and that they have the option of having the physician provide an interpreter free of charge.

It should be noted that the Guidelines probably do not apply to physicians who are enrolled only in Medicare Part B and receive no other federal funds. The Guidelines also likely do not apply to disabled patients because the Americans with Disabilities Act has different obligations for providing assistance for patients with disabilities. Finally,
Title VI sets only the minimum obligations regarding LEP patients; states may impose additional obligations for physicians.

The above summary is for informational purposes and is not intended as legal advice. You should consult a qualified attorney for details since state laws may vary. For the complete text of the HHS Guidelines, please go to http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.html.

In essence, this guidebook, together with the interactive Cultural Competency Challenge, should enable you to better provide your patients with culturally competent care. We hope that it will be used not only by orthopaedic surgeons, but also by all physicians. Clinical practitioners of all types, residents, and medical students, as well as allied health professionals, nurses, and office staff can all gain more insight and success through cultural competency. But the bottom line is that the overall winner from our efforts will be our patients.

CONTRIBUTORS

The contributors to this guidebook are all knowledgeable and experienced in the concepts of culturally competent care. They have all participated in educational endeavors such as symposia, instructional course lectures, or publications regarding all of these principles.

BIBLIOGRAPHY


Gregg J, Saha S: Losing culture on the way to competence: The use and misuse of culture in medical education. Acad Med 2006;81:542-547. Discusses how culture works in conjunction with individual, social, geographic, and economic factors and the need for a more holistic, complex approach to cultural competence and health disparities.


Ludmerer K: Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care. New York, NY, Oxford University Press, 1999. Kenneth Ludmerer discusses the importance of the hidden curriculum in his history of graduate medical education in the U.S.


Weissman JS, Betencourt J, Campbell EG, et al: Resident physicians’ preparedness to provide cross-cultural care. JAMA 2005;294:1058-67. The survey found that residents’ self-reported preparedness to deliver cross-cultural care lags well behind preparedness in other clinical and technical areas. Cross-cultural care was perceived to be important, but there was little training, formal evaluation, or role modeling for these issues.

White AA 3rd: Resident selection: Are we putting the cart before the horse? Clin Orthop Relat Res 2002;399:255-259. White recommends looking beyond grade and test scores for qualities that enable residents to communicate better and become more culturally competent.
INTRODUCTION

In the past five years, we have seen a growing professional and national awareness that our health care system does not serve all patients equally well. Ethnic and racial disparities grow out of a variety of factors: health care systems that are not organized to help all patients effectively; physicians who don't communicate well with some patients; and clinical decisions that are based, often inadvertently, on the physician's bias, stereotypes, or preconceptions about a patient. We know that racial bias in Western medical thought has a long, well-documented history. Through further research, we may come to better understand its influence.

In this chapter, we will define health care disparities and identify important themes in the medical literature about racial, ethnic, and linguistic disparities, highlighting studies that are particularly relevant to orthopaedists. We will summarize some suggested interventions that may help reduce health care disparities, focusing on cross-cultural education. We will discuss what is meant by cultural competence education for medical professionals and include several resources that are helpful for orthopaedists. And we will include a proposed curriculum for orthopaedic residents that may help improve provider-patient communication across cultural, linguistic, and ethnic differences.

DISPARITIES IN HEALTH CARE

Recent studies have documented that minority Americans have worse health outcomes than Caucasian Americans in many areas, including cardiovascular disease, diabetes, cancer, asthma, and HIV/AIDS. Because ethnic minorities generally have lower socioeconomic status than Caucasians, the fact that there are systematic differences in health outcomes is unfortunately not entirely surprising. It is well documented that socioeconomic status—especially class, education, and insurance status—have powerful effects on health outcomes.

It is now clear, however, that socioeconomic status does not explain all disparities, and that the health care system itself is responsible for some of these disparities. For example, among Medicare enrollees, a recent study showed that African Americans were less likely than Caucasians to receive eye examinations for patients with diabetes, beta-blocker use after myocardial infarction, and follow-up after hospitalization for mental illness, even after adjusting for many socioeconomic variables such as income, age, and education.

In 2002, the Institute of Medicine (IOM) released its groundbreaking report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. After systematic review of the literature, they concluded that disparities in health care services and outcomes persist even when socioeconomic factors are taken into account and controlled for. The IOM report defined disparities in health care as “racial or ethnic differences in the quality of health care that are not caused by access-related factors or clinical needs, preferences, and appropriateness of intervention.”

The mounting evidence that the health care system often contributes to these disparities challenges us all to think about how we may, as clinicians, inadvertently contribute to the problem, and how we might remedy it.

Part of the problem may stem from the low levels of minorities in the health professions, an issue documented and analyzed in the Sullivan Commission's report. Having a diverse workforce of health professionals is an important component of eliminating disparities among racial and ethnic groups in the United States. Minority physicians are more likely to work in underserved areas, and many patients feel more comfortable with physicians who share their race, background, and/or language.

The chief findings from the IOM report were that:

- Racial and ethnic disparities in health care exist and, because they are associated with worse health outcomes, are unacceptable.
- Racial and ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequality, and are evidence of persistent racial and ethnic discrimination in many sectors of American life.
• Many sources—including health systems, health care providers, patients, and utilization managers—may contribute to racial and ethnic disparities in health care.

• Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care.

• A small number of studies suggest that certain patients may be more likely to refuse treatments, yet these refusal rates are generally small and do not fully explain health care disparities.

Disparities have been shown to exist in varied procedures and fields, such as in the rate of referral for cardiac catheterization and bypass grafting (African-Americans were referred less than Caucasians), in the prescription of pain medication for fractures and cancer (African-Americans and Latinos received less than Caucasians), referral for renal transplantation (African-Americans with end-stage renal disease were referred less to transplant lists than Caucasians), and less optimal treatment of pneumonia and congestive heart failure.

Language barriers have also been found to have a large impact on quality of care. Patients with lower English proficiency received less preventive care, reported less satisfaction with their care, less comprehension, less adherence to prescribed medication regimens, and longer hospital stays.

Since 2003, there have been yearly updates compiled by the Agency for Health Care Research and Quality (and available on the Internet) that provide a comprehensive national overview of disparities in health care among racial, ethnic, and socioeconomic groups in the general US population. The updates also track the success of activities to reduce disparities. Recent reports have been somewhat more encouraging. They show that some disparities are diminishing and that awareness of disparities has increased among physicians and the public. Nonetheless, disparities still exist in many clinical realms, even when factors such as insurance status, income, age, comorbid conditions, and symptom expression are taken into account.

Furthermore, a recently released study found that life-span disparities among Americans are significant and the causes may be even more complex than suspected. A 2006 study by the Harvard School of Public Health found life-span disparities so severe—as much as 30 years difference between the healthiest and least healthy—that the researchers concluded that there are “eight Americas,” in terms of how race, geography, and income relate to life expectancy:

• Asian-Americans, average per capita income of $21,566, average life expectancy of 84.9 years

• Caucasians in rural northern plains/Dakotas, $17,758, 79 years

• Mostly Caucasian “Middle Americans,” $24,640, 77.9 years

• Low-income Caucasians in Appalachia and Mississippi Valley, $16,390, 75 years

• African-American “Middle Americans,” $15,412, 72.9 years

• American Indians in the West, $10,029, 72.7 years

• Low-income rural African-Americans in the South, $10,463, 71.2 years

• High-risk urban African-Americans, $14,800, 71.1 years.

The extremes range from Asian-American women in New Jersey with a life expectancy of 91 years to American Indians in South Dakota with an average of only 58 years. Millions of Americans have the same life expectancies as those in developing countries. The study found the differences not directly related to any one factor, such as income, insurance, infant mortality, AIDS, or violence. Personal choices such as tobacco, alcohol, obesity, high blood pressure, high cholesterol, diet, and physical inactivity were major factors.

Surgical mortality overall may be higher for African-American Medicare enrollees than for Caucasians, even when other clinical factors and income are taken into account. African-Americans and Latinos also are at higher risk of undergoing some operations that are not generally desirable, such as permanent colostomy after surgery for rectal cancer, orchietomy after prostate cancer, or lower extremity amputation in vascular disease. Although some of the disparity relates to worse access and higher comorbidity, the reasons for these findings are still being investigated, and we do not yet have a full understanding of these differences. Furthermore, for some procedures, it is well established that African-American patients are more likely than Caucasian patients to undergo surgery on an urgent or emergency basis, a well-known risk factor for operative mortality.

Disparities Specific to Musculoskeletal/Orthopaedic Issues

Although less information exists about disparities in the clinical care of orthopaedic patients, a growing body of studies documents similar patterns.

Two studies showed that in the Emergency Department (ED) setting, minority patients with long bone fractures were less likely to receive analgesics. A study from the
UCLA Emergency Medicine Center showed that Hispanics were less likely to receive analgesics than similar non-Hispanic Caucasian patients in the ED, even when taking into account patient characteristics such as gender, language, and insurance status, severity of injury, physician characteristics, or a disparity in the physicians’ abilities to assess pain between Hispanic and non-Hispanic Caucasian patients.

A similar retrospective cohort study in the Emory University ED in Atlanta, Ga, found that African-American patients with isolated long bone fractures were also less likely than Caucasian patients to receive analgesics in the ED. Only one recent fracture study in a large urban ED (San Francisco General Hospital) did not show a bias.

Recent studies show that osteoarthritis occurs in similar patterns across many ethnicities. However, the rates of total knee replacement vary considerably, based primarily on geographic region and on race, more than on income. Racial disparities in arthroplasty were significant. Another study found that Latinos were significantly less likely to undergo hip replacement, independent of access to health care and socio-economic status.

The issue of health disparities is complicated, because patient-related factors may also play a role. To understand why African-American men are less likely than Caucasian men to undergo knee or hip replacement for end-stage osteoarthritis, one study looked at 600 patients in the Veterans Administration (VA) hospital system. African-American patients were less likely than Caucasian patients to have a family member or friend who had a joint replacement (52% vs. 78%; P < 0.001), and to report a good understanding of joint replacement (44% vs. 61%; P < 0.001). African-American patients were more likely than Caucasian patients to believe the hospital stay would be longer than two weeks and would entail moderate or extreme pain. This study highlights the need for orthopaedists to reach out to patients with more information and trust building.

Diversity within the health care profession is an important part of the equation, and orthopaedic residency programs face a particular challenge, because they are lacking in gender and ethnic diversity. According to one study, increasing instruction in musculoskeletal medicine during medical school may increase the amount of women and minorities entering the specialty.

---

**INTERVENTIONS TO REDUCE HEALTH CARE DISPARITIES**

There are many ways to address the racial and ethnic disparities we see in health care. The IOM report provides a series of recommendations, including:

- Legal, regulatory, and policy interventions (such as avoiding fragmentation of health plans along socio-economic lines and increasing diversity in the health care workforce)
- Health systems interventions (such as race/ethnicity data collection, broader use of evidence-based guidelines and multidisciplinary teams, and supporting interpretation services)
- Patient interventions (such as improving patient education, activation, and health system navigation)
- Provider interventions (such as cross-cultural education).

Many of these interventions will require change at national and local levels, which physicians should advocate.

Although the role of cross-cultural education is one important intervention to reduce health care disparities, it is likely that multifaceted interventions that are organizational, structural, and clinical will be necessary to lessen disparities substantially.

“**BUT I DON’T THINK THAT I DELIVER BIASED CARE…**”

Many physicians wonder how they might be capable of bias and some are skeptical that they might deliver “biased” or inappropriate care. The reason why well-intentioned physicians may end up delivering disparate care is quite complex, and often takes place during the clinical encounter. When time and specific history-taking is limited, we all tend to simplify our decision-making process by using “categories.” This subconscious process, which has been well described by social cognitive theorists, may appear in the rushed clinical encounter that is increasingly common in the busy world of medicine today. These categories, which may include subconscious ways of interpreting a patient’s symptoms or deciding upon his/her ability to manage a treatment plan, are sometimes based on stereotypes about race, class, disability, sexual orientation, immigrants, and so on. Such attributions or inductions may be inaccurate or inappropriate for the individual in question.
Our ability to create a therapeutic alliance with our patients also has a direct impact on how effectively we treat them. This is a dynamic process where we are able to convince the patient that we are competent, trustworthy, and able to understand their symptoms. Problems with either process can result in inappropriate referrals or testing, missed opportunities, and/or decreased adherence.

TEACHING CULTURAL COMPETENCE AND CROSS-CULTURAL COMMUNICATION

There are several reasons to believe that these skills should be taught, modeled, and promoted, just as we do with many other clinical skills. Some surveys have documented poorer ratings in communication skills for orthopaedists than for other medical specialties. Patient-centered care is now considered a key to quality health care services. Improved communication skills have been associated with fewer malpractice claims and with increased patient satisfaction.

Evidence suggests that physician-patient communication can affect patient satisfaction and adherence to medication or treatment regimens. We believe that it is helpful for physicians to examine their own personal processes of care and consider the possibility that they may not communicate effectively with all patients. Generally, an increased emphasis on patient-centered care will help to decrease disparities and improve health care for all. Many patients have limited health literacy, so it is particularly important for physicians to improve their ability to communicate with them. Clinicians need to reduce the amount of jargon used in clinical encounters, and to check with patients, through a teachback technique, to see whether they have understood key portions of a communication. We also believe that increased emphasis on evidence-based care and quality improvement tracking data on various populations can help modify physicians’ behavior and improve their skills.

Several studies have documented that resident physicians’ self-reported preparedness to deliver cross-cultural care is assessed as significantly less than their preparedness in other clinical realms.

Many organizations, including the AMA, the American Academy of Family Physicians, and others, endorse the importance of teaching a core set of skills that will allow physicians to communicate with patients from a wide variety of sociocultural backgrounds, and some organizations have created standards requiring cross-cultural curricula as part of undergraduate medical education.

A landmark physician charter on professionalism was published in 2002 simultaneously in the Annals of Internal Medicine and the Lancet. This American and European collaboration cited the principle of social justice as one of three fundamental principles to which all medical professionals can and should aspire: “Physicians should work actively to eliminate discrimination in health care whether based on race, gender, socioeconomic status, ethnicity, religion or any other social category.” The American Board of Internal Medicine reproduces and circulates this document annually.

Several states have passed laws that require physicians to have culturally competent care education and training in order to obtain a license or to be relicensed. The ACGME has defined several core competencies for graduate medical education, including:

- interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals
- professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

At Harvard Medical School, the Culturally Competent Care Education Committee (CCCEC) was established in 2001 and (through June of 2006) was chaired by Dr. Augustus White, Professor of Orthopaedic Surgery. This committee has fostered the development of faculty and a curriculum to prepare students with knowledge, skills, and attitudes to practice culturally competent medicine. The CCCEC has established an Online Resource Center at www.hms.harvard.edu/cccec, available for use by health care providers, medical educators, students, and others interested in the teaching of cross-cultural care.

We recommend that an orthopaedic cultural competence curriculum have as a goal the improvement of the ability of orthopaedic residents to perform as effective physicians by (1) improving their understanding of health care disparities, and (2) enhancing their ability to communicate quickly yet effectively with patients of all backgrounds. We advocate a curriculum that aims to improve interpersonal and communication skills at a very practical level, while attempting to foster professionalism and reflection. We believe that it is important to focus on concrete communication skills and techniques that improve the ability to obtain a history and negotiate a treatment plan, and to develop mutually satisfying patient-surgeon relationships.
Key themes that may be helpful to address in the curriculum include:

- an overview of disparities in medicine
- possible reasons for disparities
- linguistic and literacy issues
- working with interpreters
- obtaining informed consent
- promoting trust in the medical encounter
- reflection about possible bias and stereotyping to which we are all susceptible.

It is helpful, as outlined in the Harvard Medical School CCCEC primer, to establish the importance of sociocultural factors and their effect on health beliefs, behaviors, and medical care; and learn a set of key concepts and skills that enhance the ability to communicate with, diagnose, and treat patients from diverse sociocultural backgrounds (including identifying core cross-cultural issues, eliciting the explanatory model, determining the social context, using an interpreter, and provider-patient negotiation).

SUMMARY

Disparities in health care persist. However, there has been progress in the amount of attention, awareness, research, and data gathering in this field that will help us understand the mechanisms and possible solutions for these disparities.

There is an emerging consensus that, rather than focusing on the traits of a so-called “typical” Latino or Asian or gay patient, we should recognize that culture is very fluid and may vary with socioeconomic position, education, acculturation, occupation, and many other insertions into society that create our cultural identity.

It may still be helpful to know of some specific health beliefs, customs, medications, or historical factors that are relevant for particular communities, but overall, the most effective approach may be to learn a set of skills and framework that may guide our ability to talk to individual patients. This approach focuses on the issues that arise commonly in a medical encounter between clinician and patient who have different perspectives and cultural backgrounds, and promotes skills to enable the clinician to navigate, negotiate, and transcend these differences while building trust.

We believe that one of the key roles of cultural competence education is to encourage greater thought and accountability around these issues. Having permission to talk directly about race, ethnicity, and communication barriers is a positive step toward promoting true self-reflection and improved understanding between patients and physicians.

Ultimately, our commitment as clinicians, educators, and leaders to maintain high clinical standards of care for all patients may be the most powerful tool we have to reduce disparities in health care. Our commitment to advocate for and show empathy, curiosity, and respect for all patients, including those who are vulnerable, may be the most important part of any cultural competence curriculum. Our best lessons may come from our day-to-day actions and conversations.

Our goal should be to apply the “double F criterion” as suggested by Dr. White to each and every patient, by asking ourselves as we care for them: “Is this the way I would treat my friend or my family?”

ACKNOWLEDGMENTS

J. Robert Gladden Orthopedic Society
Zimmer Holdings, Inc.
Blue Cross Blue Shield of Massachusetts
Daniel E. Hogan Family Foundation
Academy, Harvard Medical School
Oliver Wendell Holmes Society, Harvard Medical School
American Academy of Orthopaedic Surgeons

BIBLIOGRAPHY


Carrasquillo O, Orav EJ, Brennan TA, Burstin HR. Impact of language barriers on patient satisfaction in an emergency department. *J Gen Intern Med* 1999;14:82-87. In surveys, nonEnglish speakers were shown to be less satisfied with emergency departments.


African-Americans grapple with two kinds of health disparities in medical care: the disparity in their health status and the disparity in the delivery and quality of care they encounter in the doctor-patient relationship.

In general, African-Americans have a higher incidence of major diseases and lower life expectancy rates than other Americans and specifically in cases involving orthopaedic conditions, African-Americans tend to be at higher risk for functional impairment. There are a number of factors contributing to the disturbing disparity in the overall health of African-Americans, and while more research would be helpful for understanding the problem, recognizing that the problem exists is crucial.

As for the quality of care provided to African-Americans, The Institute of Medicine, in its report Unequal Treatment, states that when an African-American and a Caucasian-American with the same age, insurance, income status, education and comorbidity enter a hospital, the African-American is less likely to get effective treatment than the Caucasian. And in a review of Emergency Department patients with fractures, African-American patients also were significantly less likely to receive analgesics from the emergency physician, despite similar pain assessments recorded in the chart.

Along the same lines, even though African-Americans with severe osteoarthritis are at higher risk for functional impairment and disability than Caucasians, one VA study found that Caucasian men were three to five times more likely than African-American men to undergo knee replacement surgery (TKA). The sources of such disparity are difficult to trace, and may include lack of access and socioeconomic level, but patient choice and lack of education regarding the appropriate treatments can be a factor. Often, African-American patient choices are the result of a basic distrust of the health care system, and this can have serious ramifications.

A Diverse Population
More than 13% of the US population is African-American, and this is projected to rise to 15% by 2050 by the US Census Bureau. However, according to the Association of American Medical Colleges, only 3.3% of US physicians are African-American. Working to increase the number of African-American physicians is a critical first step toward providing culturally competent care.

The African-American population and experience is very diverse. As with any ethnic group, many factors shape African-American culture. In addition to the varied backgrounds, beliefs, and attitudes of African-Americans, there has been an increase in immigrants over the past decade from Central and South America, the Caribbean island nations, and various nations of the African continent, many of whom speak languages other than English. (See Introduction for information on using translators.)

It’s important to understand that African-Americans are not a monolithic population. They do not look alike. They vary in skin hues, hair textures, eye colors, and other physical features. They vary in socioeconomic levels, in education, and types of employment. Other variables include age, gender, the influence of family and its connections, and religious beliefs. The African-American population is deeply affected by regional differences—whether a person lives in an urban or rural environment, or in the North, Midwest, South, or other regions can affect health, income, attitudes, and use of language. The majority of the African-American population tends to be metropolitan, with middle-to-lower socioeconomic status and strong spiritual convictions, but one should never make assumptions about African-American patients. Each patient is a unique individual with his/her own characteristics, background, and health concerns.

There is one characteristic that many African-American patients share, however—the tendency to carry a general mistrust of doctors and the health care system into the doctor’s office with them. This mistrust is rooted in their experience, and should never be discounted. As a physician, when you face a patient who may not trust you, it is your responsibility to show him or her that you are in fact trustworthy and that you will do all you can to help.
TRUST ISSUES

It’s important to understand that African-American patients may question a physician’s motives because of their personal or group experience with discrimination, abuse, and bias. This is true whatever their income or educational level may be. One infamous case that substantiated their mistrust is the Tuskegee Study of Untreated Syphilis in the Negro Male conducted by the US Public Health Service from 1931 to 1972. Infected African-American men (including controls newly infected during the study) were observed but never treated—despite the introduction of penicillin in 1943 as an inexpensive and effective treatment for syphilis—as the natural history of syphilis was recorded. This study continued for 40 years until a Senate investigation resulted in its termination in 1972. Obviously, your African-American patient may be highly sensitive to questions about participation in clinical trials or experimental research.

Be aware that African-Americans may be very sensitive to what is perceived as discrimination, even if it is not intentional. African-American patients may feel that physicians do not listen to them or understand their life experience enough to relate to them. Patients may believe that physicians often give priority to other considerations (research, self-promotion, insurance rules) before addressing their medical needs. This belief originates from reports of misuse of science for personal gain.

In addition, because of health care disparities, African-Americans are less likely to have known someone who has undergone successful orthopaedic procedures, such as surgery for hip and/or knee pain. This tends to result in less favorable expectations of the efficacy of treatment options that may be proposed and adds to the overall sense of mistrust. This sense of mistrust toward the health care system generally leads to non-adherence to treatment and a lack of continuity of care, especially when the result is not immediate. It is therefore essential to avoid any appearance of arrogance and to be prepared to explain the rationale for your recommendations for surgery or the reasons for your questions during an examination, such as asking your patient direct questions about physical activity.

Some African-Americans may distrust surgery so much that they avoid it even when other options are no longer working for them. African-American patients with osteoarthritis, for example, believe much more in the efficacy of physical therapy, massage, acetaminophen, herbal medicine, and prayer.

GREETINGS AND COMMUNICATION

The key to communicating with your African-American patients is to avoid terms or gestures that have a possible negative connotation. In your greeting, it is advisable to use Mr., Mrs., or a professional title to convey respect and to continue doing so during your relationship with your patient. It is also important to acknowledge everyone present when entering the examination room. Your patient may want extended family to participate in the consultation.

You can counter mistrust by the way you present yourself to your patient. Sit down with your patient—don’t stand. Before addressing your patient’s health issue, it would help to engage him or her in some small talk. African-Americans tend to prefer to “break the ice” first before discussing their health problem. Avoid focusing on time or multitasking when conversing with your patient. He or she will quickly classify you as impersonal and inconsiderate. Physicians who appear to be unconcerned or uninterested will tend to be rejected and their instructions will be ignored.

Physical interaction is also very important to the African-American patient. Handshakes should be firm and intentional. Making direct, steady eye contact can be extremely important, especially when first meeting and shaking hands. Appropriate physical contact may be considered a display of affection, especially for the older African-American patient. Just as when you take time during a consultation, your comforting touches can demonstrate compassion and care to the African-American patient.

A sincere display of emotions should guide your communication. Simply acknowledge the emotions. If a conflict arises, it should be handled quickly with definite resolution. African-
Americans are usually very receptive to another person’s attempt to reach out. Conflicts are easily resolved when they perceive the respect as mutual.

Inform your patient that you may need to take notes during the examination in order to better understand the problem at hand. When addressing your patient, stop and look at him/her while putting down your pen. It’s important to convey that you are listening and paying attention. Some African-Americans speak with a dialect or use slang. Ask if you’re uncertain about what they’re saying. Don’t assume they are uneducated or unintelligent because of their patterns of speech. Give all your patients time to tell their stories in their words. Listen, be clear and accurate, and don’t use technical words or jargon.

Your patient may consider face-to-face conversations more sincere, and, consequently, even though many issues can be solved on the phone or by fax or e-mail, give your patient the options of hearing results over the phone or during an additional office visit. Be personally available to give them results or to call them with results. Give them a number to reach you and be available to them if they call or call them back. It requires extra effort, but it can make an important difference to your patient and influence choices he or she makes.

Orthopaedists need to look at the patient’s whole health care picture, not just orthopaedic problems. Often, communicating about medical issues other than orthopaedic ones is a sign of growing trust with your African-American patients. You should continue to show interest in these other issues, even if they are outside your area of expertise.

In effect, the old adage about treating all patients the same may be misguided. Physicians may need to treat their African-American patients differently in order to give them more effective care. Even beyond their prevalent mistrust of doctors, African-American patients have distinctive needs, beliefs, and communication styles influenced by many factors. And it’s the physicians’ responsibility to extend themselves, to learn more about their patients and about how to communicate with them, and to show that they are trustworthy, caring, and accessible.

FAMILY

Female-headed and single-parent households may be common in the African-American population, but you should not assume that this is always the case. You should also be aware of the important role of grandparents. Regardless of the socioeconomic status, the elders are highly revered in the African-American community. In addition it is important to acknowledge the concept of extended family in the African-American community, which often includes neighbors, fellow church members, and friends. Although many friends and family members may be available for support, it is appropriate to inquire who will be the ultimate decision-maker.

It is also appropriate to discuss who will be providing care-giving and transportation. Often church members or grandparents or grandchildren may be the active caregivers. Planning ahead this way can help remove the guilt or stress your patient might feel about continued visits to your office.

PHYSICAL EXAMINATION

Physical interactions are encouraged during the examination to reflect acceptance and a caring attitude. You should avoid concentrating on body parts without conversing with the patient. Occasional eye contacts and a smile can break the awkward silence.

Other important aspects of the examination of an African-American patient are worth mentioning. For example, color change on body parts may be less apparent. A bruise may not be readily visible in a dark-skinned patient. Another possible characteristic of African-American patients is the tendency to be very expressive in describing and responding to pain. You should be aware of your patient’s apprehension. Some patients will physically reach for the examiner’s hands in anticipation of or as a response to pain.

Discussing a patient’s obesity has its own set of issues. Being overweight often doesn’t carry the same stigma it has for Caucasians. In fact, extra weight may actually be considered attractive and desirable. Instead of focusing on the obesity itself, you may need to readdress it. For example, you could explain the weight-bearing problems that may come with surgery on the lower extremities.

African-Americans with severe osteoarthritis are at higher risk for functional impairment and disability. Taking the time to educate your patient about osteoarthritis and treatment therefore is especially important.

Checking vital signs for hypertension and screening for latent diabetes and sickle cell disease should be discussed. Most orthopaedists can direct their patients to a primary care physician for screenings.

RELIGION AND SPIRITUALITY

Religion is an integral part of the African-American community. Regardless of the belief system or religious affiliation, most African-Americans are extremely spiritual.
Consequently, faith in God, the Bible, and prayer are important factors to consider when treating an African-American patient. The clergy and fellow church members may play significant roles in decision-making. Everything, including health, is considered a gift from God. Therefore, illness is sometimes viewed as a discordance with the will of God. The physician should acknowledge the patient’s faith and work with it—and not against it—when discussing diagnosis and treatment.

Recent immigrants (Haitians, for example) may consider some illnesses as supernatural (work of the devil). When a patient deems an illness supernatural, he or she will undoubtedly consult a clergyman/woman or a voodoo priest before or in conjunction with seeing a medical provider. These patients may be reluctant to undergo invasive tests and reject surgical options for fear of giving the devil direct access to the blood or fear of being attacked while under anesthesia. Even if you do not fully understand the rationale for a specific belief, you should never disregard your patient’s beliefs.

Be aware of the possibility that your patient may be a Jehovah’s Witness, a denomination not uncommon among African-Americans. The use of blood, blood products, and transfusions is forbidden because of their Biblical beliefs. Although Witnesses accept surgery, they do not accept the use of blood transfusions during it. They also allow biopsies and medications not derived from blood products.

If you have assessed that your patient is religious or spiritual, you should remember that religious faith may play an important role in his or her life. When you encourage your spiritual patients to pray and to use their church, Bible study, or other faith-centered group as a support system to cope with chronic illness, your patients often may feel a greater comfort level and adhere more to their treatment plans. Older patients who need total joint surgery, for example, often will undergo surgery earlier if they feel their doctor is participating with them in this way.

**ALTERNATIVE MEDICINE**

Alternative medicine, in the form of tea and other drinks, is very common in the African-American community. The use of these home remedies may not only delay treatment, but they may also introduce products that are not accounted for in the treatment. Many people will seek medical attention only after exhausting traditional home remedies.

Spiritual healers are an integral part of the lives of many African-American immigrant communities. Some people will not reject remedies provided by a spiritual healer even when under the care of a medical doctor. Some immigrants may use laxatives to cleanse the blood. Dreams are also very important among many African-Americans in interpreting illnesses. You could possibly learn something significant related to the problem at hand by paying attention to anything your patients might say about their dreams.

**CASE EXAMPLES FROM THE CULTURAL COMPETENCY CHALLENGE**

**Case 2: Joe Williams**

1. A 28-year-old African-American man is in the emergency department with a leg injury and inability to ambulate. Radiographs show a spiral, mildly displaced mid-shaft tibia fracture and there is no evidence of compartment syndrome. His complaints of pain have been documented by the Emergency Department physician and nurse. Joe asks for pain medication. According to his chart, he has received none. African-American patients are statistically less likely than Caucasians to receive pain medication for similarly documented assessments of pain, indicating that a physician’s perception and treatment of patients can be influenced by ethnicity.

2. Joe is worried about the possibility of amputation. Although his anxiety is not warranted by the injury, his concern is based on real-life perceptions. African-Americans with diabetes and/or peripheral vascular disease are more likely than Caucasians to be treated with amputation than limb salvage with similar diseases. It’s important to explain to the patient that his injury is different from such conditions and does not require amputation.

3. As treatment options, including surgery, are discussed with Joe, he says that he has “low blood.” This is a term for anemia used in the African-American community. It does not refer to low blood pressure or low blood sugar.

4. The physician decides that surgery is unnecessary and discusses a nonoperative treatment plan. Even though Joe says that he understands what he has to do to follow the recommendations, the physician expresses concerns that he won’t follow through. Such concerns may be based on the physician’s attitudes toward African Americans, not reality, and could result in a “self-fulfilling prophecy.”

5. It’s important to practice empathy, engagement, education, and enlistment. Communicating and connecting with the patient can improve his overall satisfaction and outcome.
Case 8: Etta Moss

1. A 73-year-old African-American woman has severe bilateral knee pain, as well as hypertension, diabetes, and other conditions. She has been seeing other doctors, but doesn’t feel they listened to her or took her problems seriously. In the meantime, she’s been treating the pain herself. When entering the examination room, the physician addresses the woman by a title such as Mrs., Ms., or Miss, and not by her first name, which she may consider disrespectful and condescending. She will also want direct eye contact as a sign of trustworthiness.

2. Many African-American patients are not comfortable answering personal or private questions. It’s a good idea to give reasons for the need to know answers for diagnosis and treatment. When family is present, the interaction should be with the patient, and not filtered through the family.

3. Patients in general tend to be more satisfied with doctors who share their own racial/ethnic background. African-American patients tend to consider African-American doctors more respectful, more attentive, more accessible, and better at explaining health problems than non-African-American doctors.

4. When the suggestion is made that she could benefit from participating in an arthritis study, she refuses and questions the direction her treatment is taking. She may be suspicious of clinical studies because of the history of unethical research done with African Americans, such as the Tuskegee Study.

5. The patient may resist a total knee replacement, saying that the few people she knows who have had knee surgery were not satisfied with the results. African-American patients are less likely than Caucasian patients to know someone with knee or hip surgery. They also have a lower opinion of how effective joint replacement or surgery is for knee or hip pain.

BIBLIOGRAPHY


Blake VA, Allegrante JP, Robbins L, et al: Racial differences in social network experience and perceptions of benefit of arthritis treatments among New York City Medicare beneficiaries with self-reported hip and knee pain. Arthritis Rheum 2002;47:366-371. African-Americans with severe osteoarthritis are at higher risk for functional impairment and disability than Caucasians. However, African-American patients are less likely than Caucasian patients to know someone who has had surgery for knee pain (32% vs. 41%) or hip pain (25% vs. 57%) and, in part because of this, have a lower perception of the benefit of joint replacement or surgery for hip or knee pain in general.

Brawley OW: The study of untreated syphilis in the Negro male. Int J Radiation Oncol Biol Physics 1998;40:5-8. Brawley succinctly reviews the facts and historical context of one of the most egregious examples of unethical treatment of African-American research subjects, “The Tuskegee Study of Untreated Syphilis in the Negro Male”, a prospective study conducted by the US Public Health Service following the natural history of untreated syphilis that continued from 1931-1972. African-American males with a known history of syphilis were enrolled along with uninfected controls, and both groups were followed annually. The infected men (including controls newly infected during the study) were observed but never treated?despite the introduction of penicillin in 1943 as an inexpensive and effective treatment for syphilis?as the natural history of syphilis was recorded. This study continued for 40 years until a Senate investigation resulted in its termination in 1972.


Cooper-Patrick L, Gallo JJ, et al: Race, gender, and partnership in the patient-physician relationship. JAMA 1999;282:583-589. African-American patients were found to rate their physician office visits as significantly less participatory than Caucasian patients did. This remains true even after adjusting for potential confounding variables such as: patient age, gender, education, marital status, health status, and length of the patient-physician relationship.

Ferguson WJ, Candib LM: Culture, language, and the doctor-patient relationship. Fam Med 2002;34:353-361. Ferguson et al showed that minority patients are “less likely to engender empathic responses from physicians, less likely to establish rapport with physicians, less likely to receive sufficient information, and less likely to be encouraged to participate in medical decision making.” However, the participatory nature of the interaction is significantly greater in race-concordant versus race-discordant pairings for both Caucasian and African-American patients.


Ibrahim SA, Siminoff LA, Burant CJ, Kwoh CK: Variation in perceptions of treatment and self-care practices in elderly with osteoarthritis: A comparison between African American and Caucasian patients. Arthritis Care Res 2001;45:340-345. Despite an equal prevalence of osteoarthritis in all ethnic and demographic groups, there is an ethnic disparity in utilization of joint replacements, independent of socioeconomic status. In this VA study (which assumes equal access), Caucasian men were 3 to 5 times more likely than African-American men to undergo TKA.


Ng B, Dimsdale JE, Rollnik JD, Shapiro H: The effect of ethnicity on prescriptions for patient-controlled analgesia for post-operative pain. Pain 1996;66:9-12. The influence of ethnicity on the physicians’ perception and treatment of patients’ pain was seen in this study evaluating patient-controlled analgesia dosing and usage. Although Ng et al showed no differences in narcotic usage among patients of different ethnicities, Caucasian patients were prescribed greater doses of narcotic than African-American and Hispanic patients.


Saha S, Komaromy M, Koepsell TD, Bindman AB: Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med* 1999;159:997-1004. The effect of race-concordant patient-physician pairings was seen in this survey where “Black [survey] respondents with black physicians were more likely than those with non-black physicians to rate their physicians as excellent, … to report receiving preventive care and all needed medical care,” and described their physicians as treating them with respect, listening to their concerns, explaining problems, and being accessible.


Shafer JK, Uilton LJ, Gleeson GA: Untreated syphilis in the male Negro: A prospective study of the effect on life expectancy. *Public Health Rep* 1954;69:684-690. This article is one of more than a dozen peer-reviewed papers from the Tuskegee study published from 1933 to 1965. These papers explained that the results were from a longitudinal study in which the patients were being observed but not treated.

Smedley B, Stith A, Nelson A: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine, Washington, DC, National Academics Press, 2003. This report outlined many issues that contribute to health care disparities, and also examined the different perceptions of health care among different ethnicities. African-American patients were likely to perceive their physician interactions differently than Caucasian patients, with African Americans being four times more likely than Caucasians to believe racial discrimination is common in doctors’ offices and nearly three times as likely as Caucasians to believe African Americans receive a lower quality of health care than Caucasian patients.


Todd KH, Deaton C, D’Adamo AP, Goe L: Ethnicity and analgesic practice. *Ann Emerg Med* 2000;35:11-16. This retrospective review of patients with isolated long-bone fractures treated in an emergency department showed Caucasian patients were significantly more likely than African-American patients to receive analgesics from the emergency physician (74% vs. 57%), despite similar assessments of pain recorded in the chart. The authors concluded that their findings “suggest that patient ethnicity affects decision-making, independent of objective clinical criteria.”


Imagine you are a Caucasian-American doctor living in Southeast Asia, and you are asked to sum up what it’s like to take care of the “typical” Caucasian American. How would you go about making recommendations for the culturally competent care of the following: a 73-year-old recent Sicilian immigrant living in Queens; a 42-year-old Swedish-American attorney from Iowa; and a 37-year-old Polish herbalist from San Francisco? It’s easy to see that their differences far outweigh anything they have in common as Caucasians.

In the same way, individual Asian-Americans are also different from each other. Their educational level, religious background, command of the English language, socioeconomic status, country of ancestry or origin, and the number of generations since immigration are just some of the factors differentiating one Asian-American from another.

Perhaps the most important thing you can learn about Asian-American patients is that they are no more of a homogeneous group than any other patient population that you might see in your office.

Population and Location
Asian-Americans are an extremely diverse group from countries in the Far East, Southeast Asia, the Indian subcontinent, and the Pacific Islands. They represent more than 50 different countries and speak more than 100 languages and dialects; hence, they are as diverse and as different as Caucasian Americans.

There are approximately 14 million Americans of Asian descent representing almost 5% of the US population, according to the US Census Bureau. Of these, the majority, approximately 8.7 million, were born in Asia. This represents the highest foreign-born percentage among all racial and ethnic groups in America. Because the majority are recent immigrants, language and cultural barriers confront them, and Asian traditions and attitudes often are prevalent and remain alive for them.

At the same time, there are millions of Asian-Americans, born in the United States, whose ancestors immigrated several generations ago. While they are as “American” as any other, they often complain of strangers complimenting them for being able to “speak English without an accent.” Because so many Asian-Americans are foreign-born and speak with an accent, it may be understandable why such confusion arises. However, as the percentage of American-born Asian-Americans increases and more people have contact with them, such insensitive comments are likely to decrease.

Seventy-five percent of Asian-Americans live in just ten states, and 51% live in just three—California, New York, and Hawaii. California alone numbers 4.6 million. However, the most recent census data reveal that the highest population growth among Asian-Americans has occurred in the South and the West.

Economic Status and Access
The socioeconomic status of the Asian-American population can be a paradox. As a group, Asian-Americans enjoy the highest median income of all racial and ethnic groups. Despite this, there are subgroups that also suffer the highest poverty levels of all groups. Among these are the Hmong, the Cambodians, and the Bangladeshis. In general, they represent the most recent wave of immigrants, who tend to join the economic ladder at the lowest rungs.

Because strong family ties, emphasis on education, and a strong work ethic are prized in many Asian cultures, the second generation of immigrant parents have often found educational and economic success in the United States. Although education levels are among the highest of all minority groups, once again, some subgroups have education levels lower than the average.

Income and education tend to bring better access to health care, and Asian-Americans in general enjoy excellent access. While the percentage of Asian-Americans with health insurance is among the highest of all groups in the United States, there are certain groups, including Hmong and Laotians, who have poor access to medical care and low levels of insurance.
TRUST ISSUES

Patient satisfaction with doctors tends to be lower among Asian-Americans than Caucasian-Americans. The language barrier may be partly to blame. Many Asian-Americans do not have a comfortable command of conversational English, let alone medical terminology. But not all of the lowered perceptions that Asian-Americans have of doctors can be attributed to language. Even with a translator who is culturally competent, inherent biases on the part of both the physician and the patient may interfere with treatment. Adjusting for language and socioeconomic variables, Asian-Americans still have a lower satisfaction rate with physician interactions than any other group. Asian-Americans tend to be more comfortable being treated by one of their own, perhaps because an Asian-American physician won’t completely dismiss traditional Asian practices and “home remedies.”

Often, if you explain the rationale for the treatment plan and its demonstrated effectiveness, your patients will be swayed toward adherence. In addition, it would be helpful to remember that older Asian-Americans may prefer seeing an older physician and may place more trust in him/her than in a younger one.

GREETINGS AND INTRODUCTIONS

When you come into a room with people of different ages, greet elders first as a sign of respect. You should also address your patients formally, using titles such as Mr. or Mrs. Addressing them by their first name is considered a sign of contempt in many Asian cultures. While making eye contact, offer a handshake or a short bow to your patient, and make eye contact as you greet everyone accompanying them. Often your patients will cue you or indicate what they prefer.

Asian-Americans value courtesy and respect. “Taking time” is seen as a sign of respect for the patient. Physicians who do not act rushed or hurried are viewed as being more thorough and complete in their evaluations and diagnosis. This also extends to the entire culture of the office. It is important for the office staff to show respect to Asian-Americans by acknowledging their presence in the office—for example, addressing them without being on the phone or letting other tasks interrupt the greeting.

COMMUNICATION

Verbal

How can you improve your communication and interaction with Asian-American patients? Your first clue will come when you determine how well your patient speaks and understands English. If you need to use an interpreter, speak directly to the patient—not to the interpreter. If you are dealing with an American-born patient who speaks English well, your interaction will likely be very similar to relating to most other patients.

You should be aware of some possible cultural differences, however. In Jane Lin-Fu’s study comparing the core values of Asian and Caucasian medical students, Asians tended to have the following characteristics:

- group oriented
- considerate of others
- modest
- hierarchical
- formal

In contrast, Caucasians were seen to have these characteristics:

- individualistic
- assertive
- self-confident
Asians are often taught to be active listeners, to develop consensus, to not show off or embarrass themselves, to respect substance and to distrust “style”—what might be considered flair or flamboyance. On the other hand, Caucasians are often taught to be outspoken, to take charge, to stand out, to learn by mistakes, and to value style as well as substance.

In light of such findings, how might a Caucasian doctor or care provider perceive an Asian patient’s behavior?

<table>
<thead>
<tr>
<th>Asian Behavior</th>
<th>Caucasian Perception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quiet</td>
<td>Not assertive</td>
</tr>
<tr>
<td>Modest</td>
<td>Doesn’t stand out</td>
</tr>
<tr>
<td>Formal</td>
<td>Ill at ease</td>
</tr>
<tr>
<td>Asks few questions</td>
<td>Not inquisitive</td>
</tr>
<tr>
<td>Respects the doctor</td>
<td>Not independent thinking</td>
</tr>
</tbody>
</table>

Although these were characteristics seen in medical students, similar characteristics and misunderstandings could just as easily occur in your office.

The importance of “saving face” cannot be overemphasized. Many Asian-Americans are taught to avoid overt conflict in polite company. If you ask, “Do you understand?,” you may often get a positive response even if your patient has no clue what you’re talking about. Your patient may perceive that saying “no” would be an insult to you and your ability to explain things. Instead, after giving your analysis or explanation to your patient, say, “Tell me in your own words about your problem.”

For many Asian-Americans, communication is indirect. They may smile and nod as a sign of respect for the physician, or if they are embarrassed or do not understand. Don’t misjudge a smile and a nod for comprehension or agreement. Often they will not directly question you about the treatment plan unless you offer them the opportunity to discuss it with you.

Asian-American patients may be stoic and tend to minimize their symptoms. Be aware that often Western medicine is a last resort for them, especially in the Emergency Department. Ask them about daily activities such as caring for grandchildren, involvement in a family business, types of exercise, and physical activity. Such things may influence what they report about their symptoms.

**Nonverbal**

Etiquette and manners differ tremendously among different cultures. What is polite in one may be the worst form of insult in another. When you deal with older Asian-American or recent immigrants, be aware that:

- Crossing the legs or leaning back against a table or desk in front of an elder may be misconstrued as a sign of contempt.
- Pointing with the foot or exposing the sole of the foot is considered ill-mannered.
- In many South Asian cultures, the left hand is considered unclean. Therefore, it is advisable to use the right hand for prescriptions and samples.
- Patients may avoid eye contact as a sign of respect in certain Asian cultures and should not be misinterpreted as disrespect.

**Family**

Asian-American patients may tend to have several family members come along to see a physician and prefer being examined with a family member present. Elder family members are held in high regard. Wives may defer to husbands.

Be aware of gender-related issues that may affect interaction. For example, a female patient may first speak to a male family member, who then communicates with you. You should also be sensitive to gender differences between your patient and any family present that could affect what your patient feels comfortable in discussing.

Ask other family members to leave when screening for substance abuse, mental health problems, or other personal questions. Because psychiatric conditions are considered shameful by many Asian-Americans, they often appear as somatic symptoms.

Involve other family members who are present in treatment planning. Although the traditional family will often step in as caregivers, your patient may not wish to be a burden on the family. Decisions are often made in the context of family and not as an individual. For example, uninsured elderly patients with a hip fracture, or in need of a hip replacement, may refuse treatment, not because they don’t want it, but because they don’t want to become a financial or care burden on their family. They are sacrificing themselves so that their children will not have to spend valuable family resources on them.
In considering surgical intervention, especially in elderly Asian-Americans, recognize that a Western diet may not be well tolerated. For example, many Asian-Americans are lactose-intolerant. Because of this, family members will bring in food to the hospital. Normal visiting hour restrictions may cause a burden for the family bringing food, and certain adjustments might need to be made.

**Physical Examination**

Ask permission before examining your patient physically; it can be considered offensive when physical contact is made before permission is given. Most Asian-American women will allow physical contact when asked permission. Most elderly Asian-American women, however, are more comfortable remaining clothed and revealing various body areas for examination in sequence. For example, the doctor can examine one leg at a time, or the spine, while keeping the other body areas covered. Having a female chaperone present, whether a family member or medical personnel, is a good idea. A woman may not be comfortable with a stranger in a strange country touching her if she is unsure of the expertise of the physician.

**Health Issues**

Osteoporosis is common among Asian-Americans. At the same time, many Asian diets tend to be low in calcium, and dairy products are avoided because of the high rates of lactose intolerance. Before recommending a higher intake of dairy products, you should ask your patients if they have lactose intolerance.

Tobacco use is a growing problem. Asian-Americans have seen the sharpest increase in high school tobacco use among all races. Most commonly, they are recent immigrants who tend to be on the lower rungs of the socioeconomic ladder. Often they are poorly integrated into American culture and have limited English skills and poor knowledge of the health consequences of tobacco abuse.

Hepatitis B is a serious problem for Asian-Americans. In the United States, more than 50% of the 1.25 million chronic carriers of hepatitis B virus are of Asian descent. In the general US population, the incidence of chronic hepatitis B is 0.3%. However, in Asian-Americans it is between 8% and 15%. This varies significantly depending upon the nation of origin. The highest rate is among the Hmong population, where 18% of the population are chronic hepatitis B carriers. The lowest is in the Japanese-Americans, with 1.9%. Other groups are as follows: Chinese 11%, Vietnamese 7.6%, Korean 6%, and Filipino 4%. The most common cause of hepatitis infection in Asian-Americans is perinatal transmission.

The long-term health consequence of hepatitis B is a higher rate of liver cancer as well as sclerosis. In Vietnamese-Americans, liver cancer is the second most common type of cancer. Vietnamese-American men have a 13 times increased risk of liver cancer compared to non-Asian-American men. Korean-American men have an 8 times greater risk, while Chinese-American men have a 6 times greater risk.

As a health care professional, you should first recommend testing, and second, recommend vaccination. Third, recommend screening for liver cancer with an alpha fetoprotein test. Treatment is available for chronic hepatitis B carriers, and you should refer these patients to a hepatologist.

**Response to Medications**

Asian Americans can often have a markedly different response to medications compared to Caucasians. Asian-Americans are often poor metabolizers of benzodiazepines. Therefore, the dosage must be individualized and the lowest effective dose should be prescribed. Another common class of medications that orthopaedic surgeons prescribe is analgesics:

- **Acetaminophen**: Asian-American patients often have higher clearance rates of acetaminophen than Caucasians. On the other hand, high doses of acetaminophen, which are hepatotoxic, can have an additive effect in a patient suffering from sclerosis secondary to hepatitis B.
- **Codeine**: People of Asian and Caucasian descent transform codeine into morphine similarly. However, those of Asian descent often experience significantly weaker analgesic effects from the drug. It is not uncommon for them to suffer from the negative side effects, such as nausea, vomiting, and constipation, without getting much analgesic effect from codeine. Codeine is typically metabolized by the CYP2D6 enzyme in Caucasians. However, in Asian men, other enzymes may be at work to clear the analgesic, making it less efficacious.

You should therefore take into account genetic factors when deciding on dosages, as well as toxicity and therapeutic considerations. Always keep in mind that intraracial as well as interracial differences exist. Again, each individual patient must be treated as just that—an individual. You must gauge your patient’s responses on an individual basis and alter medications accordingly.
RELIGION AND SPIRITUALITY

Many different religions are represented within the Asian-American population, including Buddhist, Taoist, Shintoist, Hindu, Sikh, Muslim, Christian, and other beliefs. When necessary, you may need to become familiar with some of the tenets of your patient’s faith in order to gain his or her confidence. Some patients will expect to be able to practice their religious beliefs, whatever their cultural background.

Yin and Yang

Many Asian-Americans tend to view health as a balance between opposites. Health is considered to be a balance between hot (yang) and cold (yin). They believe that “hot” conditions should be treated with cold therapies, and vice versa. For example, a rash (hot condition) may be treated with ice. The common cold may be treated with heat.

Specific symptoms may be associated with specific organs: anger with the liver, joy and depression with the heart. The traditional view of life and death may preclude use of extended life support. Views regarding organ donation may also be varied. In general, Asians are more reluctant to donate their bodies to science, and organ donation is far rarer in Asian countries than in the United States.

Asian-American patients may perceive surgical procedures as unnatural and disharmonious. You should fully discuss surgical issues with your patients and their families, allowing patients to come to terms within their family, cultural, religious, and social structure.

ALTERNATIVE MEDICINE

Many Asian-Americans may seek out acupuncture or other non-Western treatments, but these are not likely to negatively impact surgical treatment as much as herbal medications that could affect bleeding or organ function. It is prudent to inquire what kinds of alternative treatments your patient may be using, just as you would ask about over-the-counter medications.

Herbal Medication

Many Asian-Americans, especially older ones, are on herbal medications. With the popularity of alternative medicine permeating the general population, it has been estimated that up to 20% to 30% of the general U.S. population is on one herbal medication or another. In the Asian-American population, this figure may be as high as 30% to 60%.

Herbal medications are not innocuous. They are sold as food supplements, and therefore are not regulated by the U.S. Food and Drug Administration (FDA). As a result, different formulations of the drugs can have varying amounts of the active substance, as well as unintended contaminants. Be aware that the patient may not be willing to divulge that they are on some of these drugs unless specifically asked.

For patients about to undergo surgery, some of these alternative medicines can result in increased bleeding risk. You should notify your patients about the serious consequences that can result from taking such drugs prior to surgery. Information should be available from complementary (alternative) medicine clinics. Herbal medications that can affect coagulation include:

- Chondroitin. Affects coagulation. Chondroitin sulfate is structurally similar to heparin but there is no evidence that therapeutic doses cause increased bleeding.
- Garlic. Increases clotting time and fibrinolytic activity.
- Ginger. Can decrease platelet aggregation or may interact with coumadin, but there are no documented reports of bleeding problems with any of these.
- Gingko. Can decrease platelet aggregation or may interact with coumadin, but there are no documented reports of bleeding problems with any of these.
- Ginseng. Can decrease platelet aggregation or may interact with coumadin, but there are no documented reports of bleeding problems with any of these.
- Danshen, also known as Chinese sage, huang ken, radix salvia, red sage, salvia root, Salvia miltiorrhiza, ten shen. Used for cardiac conditions and stroke. Affects platelets and fibrin productions.
- Feverfew, also known as altamisa, Chrysanthemum parthenium, featherfew, fliritwort, Pyrethrum parthenium, Tanacetum parthenium, wild chamomile, wild quinine. Used to treat fever, migraines. Affects platelets.
- Quillinggao, also known as beimu (Fritillaria), chishao (Paeonie rubra, Chinese peony), jinyinfua (Lonicera japonica), and jisbi (Poncirus trifoliata). These have antiplatelet effects and can potentiate the risks associated with coumadin therapy.

CASE EXAMPLES FROM THE CULTURAL COMPETENCY CHALLENGE

Case 4: L.L.

1. When the doctor enters the examination room, an elderly Asian-American woman, who is accompanied by her husband and adult son, stands up and bows. The
doctor can acknowledge her with a slight bow or nod, for example. Many Asian-American women don’t shake hands, especially older women. Ignoring her bow would be impolite.

2. As you take her history, you should be aware that women of an Asian-American background generally are family or group oriented. In this case, the patient will make decisions about treatment together with her husband and son.

3. There are linear or circular bruises on her lower extremities. This may be the result of a common practice in Asian cultures of coining, the rubbing of coins (or bones) over a painful area, or cupping (creating suction) over a painful area. You need to find out whether your patient is using alternative health methods before investigating other possibilities suggested by the bruising.

4. She is indeed using coining as a health measure. Coining is not considered harmful, and even though there’s little evidence to prove its benefits, it may have psychosomatic benefits for patients.

5. She has degenerative joint disease of the knee. As the doctor explains this problem to her, she looks down and does not make eye contact. This is most likely because, in her culture, eye contact shows disrespect. It should be ascertained whether she understands what has been said by asking questions and using comprehension checks.

**Case 10: J.Y.**

1. A middle-aged Asian-American male sustained an isolated femur fracture in a fall from a ladder. His elderly parents accompany him. When the doctor starts talking about a possible surgical procedure for him, he wants his parents to leave the room. He wants to protect them from bad news or anything that may have a bad outcome. In many Asian cultures, such things are not openly discussed among family or friends.

2. J.Y.’s primary language is not English and there may be a problem communicating with him. A professional interpreter is preferred. In some cases, the patient may not want someone in his family hearing intimate details, and using a family member to translate is not a good option.

3. When he is in the preop holding area, the surgeon, with the translator’s help, should ask him which side is injured. Using red ink to write on the injured site is not a good idea for this patient, because some Asian-Americans might consider red the color of death and a bad omen.

4. Another bad omen is the number 4. Asian cultures associate bad luck and death with the number 4, much as Americans do with the number 13. To avoid unnecessary anxiety, the staff should not take an Asian-American patient to a room using that number.

5. Many Asian-Americans view the showing of pain or emotion as signs of weakness and would disdain the use of the Faces pain scale. In this case, it’s best to assess the pain level by checking pulse and blood pressure.

**BIBLIOGRAPHY**


Wong MD, Asch SM, Andersen RM, Hays RD, Shapiro MF: Racial and ethnic differences in patients’ preferences for initial care by specialists. *Am J Med* 2004;116:613-620. This study shows that African Americans and Asian Americans are less likely than Caucasians to prefer initial care by a specialist.
The American Indian (or Native American) population is approaching 2% of the US population, and in recent years, the birth rate has been increasing. At the same time, Native Americans make up only 0.3% of medical students, a rate lower than other groups.

The Native American population consists of people from many different recognized tribes. They live in all areas of the country, but most live in the Western states. Only a minority of Native Americans—estimated to be as few as 30%—actually live on reservations. Native groups flourished in North, Central, and South America long before European settlers arrived, of course, but were decimated in the United States by America’s western expansion, which left a legacy of forced migration, broken treaties, disease, and betrayal.

Many Americans erroneously believe that the problems confronted by Native Americans have been eliminated by the growth of casinos on native lands. In actuality, less than 10% of all Native Americans have benefited from casino monies. In spite of the huge financial successes of a few tribal casinos, many continue to suffer from high rates of poverty and unemployment. In addition, health crises such as alcoholism and diabetes have destroyed individuals and families, while medical resources are urgently needed to “address the persistent crisis in American Indian health care,” as native physician Yvette Roubideaux has said.

How can you learn about Native American cultures in order to deliver better care? The Navajo concept of a cleansing ritual to remove impurities and barriers is shared by most native cultures in one form or another and is a useful metaphor for beginning the task of improving care for native patients. First, do not prejudge or oversimplify. Be attentive. Be aware that regions and tribes are different from each other. The diversity of this ethnic classification is huge, as for all humans—young and old, urban and rural, educated and not, rich and poor. To become “culturally competent” is to be willing to open the heart and mind to other voices and other rooms, to paraphrase Truman Capote.

Impact of Acculturation
One of the most salient issues is the conflict of traditional values versus nontraditional behavior. The generation of Native Americans born prior to World War II typically were much less acculturated than those born after the war. And the generation that followed, in turn, are even less apt to speak a native language or practice traditional religions than their parents. In fact, the traditional lifestyle is tied to the use of a native language, which is increasingly rare today.

In the view of the elders, many Native Americans who call themselves traditional are not truly connected to native traditions. This phenomenon of substituting imitative behavior for a traditional lifestyle engenders much conflict and angst. It leads to self-destructive actions that commonly bring patients to orthopaedic care, such as alcohol abuse and its associated vehicular accident and domestic violence trauma. Various tribes handle these issues in different ways. The Hopi, for example, have made the conscious decision to take their culture back to the Underworld (the place of origin in Hopi legend) from which it came. A New York group, however, is actively recruiting members who have been unconnected to tribal tradition for a long time.

Paying for Health Care
Economic issues are also critical. The casino industry is bringing major changes to native lands, with the infusion of cash from gambling literally changing groups and tribes overnight. For some, this means vast wealth, but not for others who may live far from cities.

Many Native Americans live in poverty or near-poverty. Where health care is concerned, the American Indian population may be the most underserved of all US minorities. Many depend on the Indian Health Service, a federal program under the Department of Health and Human Services, for primary care and public health services on or near Indian reservations, but the Indian Health Service is underfunded and serves a minority of Indians. Per capita expenditures for the 1.8 million patients it serves rank far below other per capita government health care payments. Some are also ben-
eficiaries of Medicaid and Medicare. On the other hand, the number of privately insured Indians is increasing, mainly because of casino earnings.

Given the economic upheaval in American health care, with falling reimbursements for specialty care from both private and governmental sources, there is an economic prejudice against the native patient, who commonly is not personally responsible to the provider for the cost of care. In Arizona, it’s increasingly challenging to find tertiary care for the native patient, even if privately insured, presumably because of care providers’ prior experience of lost revenue when caring for this population. These issues are very familiar to the orthopaedist. Often the university medical center is the depository of last resort, burdening an already overloaded public facility with potentially uncompensated care. This scenario is not universal, however. In Oklahoma, coverage for the native patient is much more streamlined. In any case, the biggest prejudicial factor in obtaining care may not be language or skin color, but rather the payor source for the patient.

**Bridging the Gaps**

Overall, the American Indian patient may be the most “American” of all the ethnic groups you encounter in your practice. When you are sensitive to the particular preferences individual patients and families express, you should find it possible to bridge the potential gaps that might otherwise derail treatment plans. You have to be willing to accept that your patient will not always choose as you do, and you may have to bend your own values to match your patient’s goals.

Some physicians have felt frustration about patients’ noncompliance with medication. Often this arises from their patients’ misunderstanding or lack of information, alcohol or substance abuse, or other situational factors. Taking the time to talk with your patients about the importance of taking medications and about their living situations can help them be more compliant.
**TRUST ISSUES**

Because of the many stories of the poor treatment of American Indians in history, some Indians may have little trust in mainstream medical personnel or institutions. Consider, for example, the often-told stories of abuses that may have led to disease among Indians—for example, the commonly held belief that early settlers deliberately infected blankets with smallpox to kill Indian tribespeople. By carefully explaining your diagnosis, procedures, treatment plan, and medical options, and by being sensitive and aware of your patient’s needs and wishes, you can help to bridge any gaps in trust your patient may have.

**GREETINGS**

Most Native Americans speak English and are acculturated. They are likely to refer to their tribal names, such as Navajo, Cherokee, or Sioux, if asked about their background. Some prefer the term American Indian to Native American. You may want to include an open-ended question in the intake questionnaire about what race or races they consider themselves to be.

Native Americans tend to reserve touching for friends and intimates. Many do use a handshake, but it is very light and fleeting. (It’s believed that too long or hard a handshake can impose energy the other person doesn’t want.) Don’t use direct, prolonged eye contact, especially with an elder. It’s considered invasive. The speaker and listener may direct their gaze across facial areas, rather than make direct eye contact.

Allow plenty of space between yourself and your patient. Some patients may find a face-to-face setting uncomfortable and prefer to sit beside you.

**COMMUNICATION**

The Native American communication style may seem indirect, to give others the chance to evade a subject they don’t want to discuss, or a question they consider too personal. Their style tends to be quiet, restrained, and unemotional, even when discussing extremely serious matters. Native Americans may respond with silence to questionable or untrue statements.

Taking time with conversation is important. Native Americans are likely to want one person to speak at a time, allow some silence, and then proceed to the next person. If someone speaks too quickly after another person, it’s considered inappropriate. Interrupting someone is considered extremely rude.

Avoid large or frequent gestures. Try to adopt a restrained approach overall.

When discussing the patient’s case and medical options, it may be especially helpful to use a model or a drawing to explain what may be wrong and what the remedy could be. Some Native Americans may have little or no experience with certain medical procedures. It would be helpful to them if you take the time to go over the process step by step, including the physical examination, the diagnosis, treatment options, and any subsequent steps that are required.

**FAMILY RELATIONSHIPS**

Don’t expect Native American families to follow a single, absolute pattern. You’ll find a wide variety of family structures: nuclear, extended, patriarchal, or matriarchal. In some families, the group may include grandparents, aunts, uncles, cousins, and even unrelated tribe members. Some patients
may want to use a family spokesperson, who doesn’t necessarily make the decisions.

**PHYSICAL EXAMINATION**

Be sensitive to issues of modesty when examining Native Americans. The patients should be given robes before any physical examination.

They may prefer not to share personal information and may resist discussing serious illnesses outside their family or giving consent for treatment procedures. You should be especially sensitive to the patient’s feelings about signing consent forms. It may be necessary to have family members go over the procedures and consent form alongside the patient. Take the time to explain or illustrate any procedures as clearly and carefully as possible.

**Health Issues**

Some diseases that American Indians/Native Americans tend to have at higher rates than other groups include alcoholism, diabetes, and tuberculosis. There is practically an epidemic of diabetes, with more than half of adults having it in some communities. Because of poor access to high-quality care, the lack of healthy food choices, and lack of money to buy proper shoes, many come to clinics with infections, strokes, or heart attacks. Alcohol-related death rates are 7.4 times as high among Native Americans as in the general US population, according to the Indian Health Service. Often alcoholism results in automobile accidents and domestic abuse, which lead to fractures and severe bruises.

**RELIGION AND SPIRITUALITY**

Until 1978, with passage of the American Indian Religious Freedom Act, Indians were not guaranteed religious freedom by the American government. Traditional religious practices were outlawed or disdained by non-Indians in the past. Environmental and other movements have sparked interest in native spirituality because of its message of honoring the sacred in the natural world.

Traditionally, different tribes had different beliefs and customs. There was never one specific native religion, but rather many. It should also be remembered that many Indians practice Christianity, estimated at one point to be about 40% of the population, or a combination of Christian and tradition beliefs. In native tradition, wellness is considered a state of harmony—of body, mind, spirit, and the Earth. There is usually a belief in a Creator and a strong bond or relationship with nature or the Earth.

**ALTERNATIVE MEDICINE**

Most American Indians use the mainstream health care system. Some traditional Indians may use other methods of treatment. Traditional healing practices vary among tribes. Find out what you can about any alternative treatment. It would be helpful to ask about any herb-taking or other treatment that might conflict with medication you prescribe.

Some traditional Indians may seek out a healer, or medicine man, who is believed to have the spiritual knowledge to identify the cause and cure of disease through such methods as prayer, chanting, music, the use of herbs, burning sage, counseling, hallucinogens, or medicine bundles, which may contain feathers, charms, and other objects. You should never dismiss the idea of consulting a healer. In many cases, when you pay attention to your patient’s need for a healer, you can help the patient cope more successfully with his/her injury or ailment.

**CASE EXAMPLES FROM THE CULTURAL COMPETENCY CHALLENGE**

**Case 17: Ashkii**

1. The public health service asks a physician to see Ashkii, an 11-year-old Navajo boy whose spine appears abnormal. He and his family live in rural Arizona and are unlikely to see a specialist. They will have problems traveling to an appropriate doctor and, although radiographs would be useful, facilities and experts to produce them are not available. The physician arranges to see Ashkii at the next rural clinic in his area. Physicians will have to be proactive in order to help some people living in remote areas.
2. The diagnosis is congenital scoliosis with a unilateral bar and the curve has progressed. After counseling the family about the history of scoliosis and care options, the physician recommends spinal arthrodesis.
3. They agree to the surgery, but leave a message to cancel surgery a few days before it. They live in a remote area and do not have phone service. Although difficult, a way should be found to get in contact with the family.
4. When they are reached, the family says their medicine man felt the moon wasn’t appropriate for doing the surgery on that date. The doctor respects their beliefs and asks them to find out if the medicine man can recommend another date better suited to the surgery.

5. The doctor accepts the medicine man’s counsel—medicine men rarely are at serious odds with physicians’ recommendations—and changes the surgery date accordingly. By complying with the family’s wishes, the doctor gains their trust and they proceed with the treatment plan more willingly.

Case 9: D.B.

1. An obese 65-year-old woman sees a physician about pain in her right knee. She says her knee has ached for years and has affected daily activities. She says that she has consulted a healer and has been using herbal rubs and over-the-counter nonsteroidal inflammatory drugs (NSAIDs). Taking a cue from her use of a healer, the physician asks about her background and learns she is an American Indian.

2. A large number of American Indians—whether from reservations, rural, or urban areas—continue to use traditional healers. They often prefer using standard medical care for acute problems, but frequently use both traditional and standard Western approaches to disease.

3. Traditional healing methods are sought for both physical and psychiatric problems. The use of traditional methods seems to depend on the individual’s beliefs, availability, and cost, and varies by tribe and location. Both traditional healing and standard medicine are often combined in treating a problem.

4. There seems to be more usage of traditional healing methods by older people, men, and people with lower education levels, although studies have been inconclusive. In the case of D.B.’s examination, her knee radiographs confirm a diagnosis of osteoarthritis. The physician recommends that she lose weight and increase the dosage of NSAIDs. Native Americans are not aggressive about using pain medications for chronic pain, instead using meditation, visualization, or activities to distract themselves.

BIBLIOGRAPHY


Sequist TD: Paving the way: Providing opportunities for Native American students. *N Engl J Med* 2005;353:1884-1886. This description of Harvard Medical School’s Four Directions Summer Research Program, which recruits Native American students for medical training, discusses the ways in which Native American health care lags behind other groups and the gap in information about their health needs.


The Hispanic/Latino population is the most rapidly growing group in the United States. Already the largest minority, it now represents almost 14% of the population, and is expected to rise to 24% by 2050, according to the US Census Bureau. Along with their growing population, the geographical spread of Latinos throughout the United States has been astounding. In addition to the Southwest, significant numbers now live in the Southeast and Midwest, as well as in New York, New Jersey, Colorado, Washington, and Oregon.

The number of Hispanic/Latino physicians, however, has not risen proportionally. Presently, only 2.4% of orthopaedists are Latino. Therefore, non-Latino physicians across the country will increasingly encounter patients who stem from a culture markedly different than their own.

The majority of Latinos emigrate from Mexico (65%); Puerto Rico, the Dominican Republic, Cuba, and Central and South America account for most of the rest. They come to the United States primarily to seek work and opportunity.

The terms Hispanic and Latino are not synonymous. Historically, Hispanic refers to Spain, its people and culture. It has also come to include the Spanish-speaking nations of the Americas, and, outside the United States, usually refers to people of Spanish ancestry. In the United States, the term has taken on a broader meaning, in part because of the US Census Bureau’s use of the term. Latino is short for “Latinoamericanos,” and usually refers to people of Latin America, regardless of ancestry. Some regard the term Latino as self-chosen and prefer it, because it refers to people of Latin America, and not Spain.

As used in the United States, both terms cover a wide-ranging variety of individuals who come from different regions, countries, and socioeconomic, ethnic, and racial backgrounds. Some may in fact object to being called Hispanic or Latino. It may be practical to ask patients in the intake questionnaire what term they would use or prefer to describe their own ethnic background.

Latinos’ historical traditions and cultures stem from the Aztec, Mayan, and Incan civilizations, as well as the Spanish, and are firmly rooted in the earth, which helps to explain Hispanics/Latinos’ belief in and attachment to alternative forms of medicines and caregivers. Traditionally, they are used to a patriarchal attitude from their physicians. Consequently, they regard their physicians with respectful distance and admire them for the knowledge that they represent. They may expect a physician to direct their care and may act dependent upon a care provider’s actions.

Ideally, to improve their practice and to better serve these patients, physicians and care providers need to familiarize themselves with Hispanic/Latino culture. By learning more about the culture and sensitively responding to it, and by practicing compassion and communication, non-Latinos can go a long way toward improving patient-centered care. This should result in a win-win situation for all.
Hispanic/Latino Patients

Trust Issues

Hispanics/Latinos have historically been the objects of stereotyping and prejudice by those who exercise privilege and power. As a result, Latinos may have an inherent, underlying mistrust of “the system.” Second- and third-generation offspring generally do not carry this mistrust to the same degree, and those with educations have learned to be assertive and expect quality health care.

To better understand the issue of patient trust, imagine being in a hospital in a strange country surrounded by people speaking a language that you don’t understand. Think of the difference a caring, concerned physician would make, and how using the tools of cultural competence—sensitivity, awareness, and compassion—could bridge the barrier of mistrust and misunderstanding.

Latino patients may have deep-rooted fears and attitudes about physical ailments and medical procedures. Try to be aware of what may concern your patients regarding:

- injury
- disability
- death
- laboratory tests
- MRI and CT scans
- medications
- surgery

All of these fears can be alleviated by communicating with the patient and carefully explaining medical procedures.

Greetings and Introductions

Many Latinos/Hispanics may prefer to be referred to by their country of origin: They are “Cubans,” “Salvadorans,” “Mexicans,” and so on. It is culturally courteous to address them as such. Asking them about their country of origin is a good icebreaker. It may also give you insight into how acculturated they might be. After a few more repeat visits and new patients from the same country, you will develop a common point of familiarity. If you take an interest and are open to learning more about them and their background, your patients will admire and appreciate your sincere efforts.

Don’t act rushed. It’s important to be inclusive of all the family and/or friends that may accompany the patient by acknowledging and greeting all of them, even the children. They will immediately accept you as warm and compassionate.

Be friendly, but not overly familiar. Latinos frown upon familiarity, especially on the initial office visit. The Spanish language differentiates between the formal and the familiar salutations—“usted” vs. “tu.”

Be direct and greet them with a handshake, while looking them in the eye. A warm smile and a “Buenos dias!” will go a long way. If your patients are Spanish-speaking, then say, “Yo soy, Doctor _______”! Don’t ask “How are you?” or “Como esta usted?” because this is considered part of a salutation and not a formal question. A better question or introductory statement is “How may I help you?” or “Como puedo servirle?”

Recent immigrants who speak mainly Spanish should be addressed as “Señor” or “Señora.” A younger woman should be addressed as “Señorita,” perhaps with a question, if you are not sure if she is married or a mother.

Communication

Verbal

It is the recent immigrant who has the most difficulty with the English language and who will likely need the facilitation of a Spanish-speaking interpreter. Generally, first-generation Hispanics, especially if they had some education in American schools, feel comfortable conversing in English. In a workers’ compensation or medical-legal case, the use of an interpreter may be required or advantageous. For the most part, second- and third-generation Latinos are acculturated and have some education and therefore speak English well.
If an interpreter is required, establish your protocol from the outset. Inform the interpreter that you will be speaking directly to the patient and that you expect the patient to look at you when speaking. The interpreter should function as a translator and facilitator and not as a barrier or intermediary.

**Nonverbal**

It is well known that communication is made up of both verbal and nonverbal components. This is especially important when trying to communicate with someone who does not speak your language, because in such cases, actions really can speak louder than words.

When you enter the room, smile and greet each family member. A smile will go a long way in initiating a relationship. Hispanics/Latinos are warm and compassionate people who appreciate friendliness, warmth, and courtesy. They are respectful of doctors, and they expect you to dress and act as a professional. Allow them to maintain a courteous and appropriate space. As in many cultures, staring is demeaning and makes them uncomfortable. It is a good idea to sit down so that you are at eye level or lower than them.

**FAMILY**

Latinos come from a patriarchal society. The husband (father) takes on the role of provider, authority figure, and decision-maker. The wife (mother) is the child-bearer and caretaker of the children. Siblings have a rank order. The eldest son becomes the head of the family and the decision-maker when the father dies or is feeble.

Although the Latino male aims to be macho (stoic and courageous), this is counterbalanced by his innate fear of physical incapacitation and death. You must be extra careful to educate him regarding any proposed surgery. On the other hand, be aware that the woman may not consent to any significant treatment without the specific permission of her husband.

The family relationships may be very relevant, particularly if you are seeking informed consent for an operative procedure. Strong family ties may be helpful when they support the patient in making a good medical decision.

**PHYSICAL EXAMINATION**

Practice a normal degree of modesty during the physical examination, particularly with female children and adolescents, who are usually chaperoned. It is not unusual for a father to accompany his daughter to the appointment.

Ask permission before you begin to examine your patient. If you are a male physician, it is imperative that you not examine a female patient alone without another person, preferably a female medical assistant, being present in the exam room. Sometimes the patient will be accompanied by a female chaperone (friend or family member).

**Health Issues**

High blood pressure, heart disease, and diabetes are major health risks for Latinos and appear more often in them than in Caucasians. Mexicans and Puerto Ricans, in particular, have a high incidence of diabetes. One reason that diabetes is such a concern is because it often leads to amputations. Obesity is also prevalent and can lead to degenerative joint disease. Often, foreign-born Latinos are actually healthier than those born in the United States, who tend to consume less fiber and more fast foods and use more alcohol and tobacco.

**RELIGION AND SPIRITUALITY**

Historically, attending church and observing religious practices have been extremely important to Latinos. Religious faith is considered an integral part of everyday life and is held in deep reverence. Fatalismo—the belief that most things are “out of their control” or preordained—may play an important role in the Latino’s attitudes toward the disease process, surgery, disability, and death. You may need to work at convincing your patients that they are in charge of their own health and educate them about steps they can take to improve it.

**ALTERNATIVE MEDICINE**

In addition to prayer, many Hispanics/Latinos use alternative forms of medicine for treatment. They believe they have their roots in the “earth,” so it is only natural that they have based their healing rituals and “medicines” on plants from the earth. In their native countries, they go to botanicas, which are stores that sell herbs and roots to cure almost every diagnosis, much like our pharmacies. Although not as common in the United States, there are also botanicas here, and patients often secure their initial treatments from them. Always ask patients if they are using such “medicines.” These methods and healers are especially popular with older patients and recent immigrants.
The following are other Spanish terms for alternative treatments:

- Curanderos are healers who use herbs in healing rituals.
- A huesero or huesera (female) is a healer who deals with bone and joint maladies.
- Masejeros or sobadores treat musculoskeletal problems by massaging the affected extremity. They can also dispense and use herbs and other medicants to treat patients, along with prayer and incantations.

**CASE EXAMPLES FROM THE CULTURAL COMPETENCY CHALLENGE**

**Case 1: Maria Salcedo**

1. A 28-year-old woman with a broken ankle is brought to the emergency room, and an orthopaedic consultant is called in. The patient and her husband recently emigrated to America from Mexico. She should be addressed as Señora and not Señorita, which refers to a girl or unmarried woman. Using American titles such as “Mrs.” or calling her Maria would be insensitive and disrespectful.

2. The doctor asks her if she wants to consult with her husband. In a Mexican family, a wife will tend not to consent to something as serious as surgery without her husband’s agreement. The doctor explains the pros and cons of surgery to both, using comprehension checks.

3. The couple talk about options other than surgery, mentioning curanderos and sobadores. Curanderos are traditional healers. Sobadores use massage to work the nerves, bones and other tissues into their proper position, and are similar to chiropractors and therapists. The doctor should recognize the roles they could play in treatment.

4. The role of the Hispanic/Latino mother in the care of her children is so strong that she may be unable to follow a recommendation to avoid weight bearing. A cast brace or cast may be necessary to protect the patient and the fracture, while allowing her to fulfill her role as caretaker for her children.

5. Although she is prescribed an analgesic for pain, she tells the doctor that she’ll get something from a botanica, a store that sells supplements, herbs, and other remedies. The doctor explains that she’ll probably respond better with the analgesic and needs to be aware of possible drug interactions.

**Case 6: Ramon Fernandez**

1. Ramon has ulcers of the toe and heel. He exemplifies the problem of smoking, diabetes, and cultural barriers affecting health care in Hispanics. This group is prone to complications of diabetes with infection and neuropathy. The doctor recommends that he should have treatment.

2. Out of fear of amputation, Ramon avoids proper treatment. Instead he turns to someone who performs a lesser and ineffective procedure, which leads to pain and infection.

3. When Ramon returns, the doctor needs to acknowledge the cultural barriers and gain the support of his family. He/she should treat the infection and diabetes aggressively.

4. The doctor asks the family for their help in getting Ramon’s consent to surgical treatment. The doctor explains the options and rationale for the surgery.

5. The patient consents to surgery and recovers well. He is still at risk for uncontrolled diabetes because of his dietary preferences.

**BIBLIOGRAPHY**


Irvine R, McPhee J, Kerridge IH: The challenge of cultural and ethical pluralism to medical practice. Med J Aust 2002;176:174-175. “The Western view of autonomy stresses the primacy of the individual in decision-making. On the other hand, people belonging to cultures in which there is a tradition of community and family support may often wish to include others in decision-making.”


Gender and gender-identified roles can have an impact on the physician/patient relationship and on patient compliance and outcome. A woman who sees a male physician likely would have concerns different than a man has; a man who sees a female physician brings his own set of concerns into the examination. Currently, an overwhelming number of orthopaedic surgeons are men, and there are potential issues they should be aware of when treating their female patients.

A woman’s interaction with her physician is influenced as much by her gender as by her race/ethnicity, socio-economic status, region of residence, and other traits. In addition, her physician’s attitudes and interaction with her also have a bearing on how she, in turn, responds.

Various cultural factors can affect how and what a woman communicates to a care provider and whether she will follow recommendations—her culture’s general attitudes and beliefs, its view of medicine, and its expectations of her behavior and responsibilities as a woman. Of course, any generalizations about an ethnic group/culture may not be appropriate for a given member of that group. In general, the more traditional a woman and her family are, the more likely it is that her culture’s views regarding Western medicine and the woman’s role in the family will take precedence during any medical decision-making process. An individual patient’s own experience with Western medicine and Western culture also influences her interaction with the health care system.

**Impact of the Caretaker Role**

A wide variety of cultures, including Hispanic, Asian, and Muslim groups, view women as the primary caretakers for their families, especially if they have children. The term “caretaker” here is a much deeper, broader concept of the woman’s role than the American image of the model wife and mother. In this context, the term reflects the woman’s role of taking care of everything and everyone in the house, including housework, food preparation, all childcare, and caring for ill family members. This view of a woman’s role is usually reinforced by other members of the family, as well as members of that culture’s community at large.

Because most women view their primary role as their family and their culture define it, these cultural expectations will take priority over any recommendation made by health care professionals. Depending on the degree to which a patient and her family are acculturated to the United States, a woman’s decisions about treatment may hinge on how medical recommendations could affect her role as caretaker. If a treatment option limits a woman’s ability to fulfill her role, she will most likely not readily accept it—unless care providers can make accommodations.

For example, a Muslim woman would consider herself responsible for staying with a child who is hospitalized, even if she herself needs medical attention. A Latino mother might be expected to carry her toddler or do strenuous chores despite being treated for a fracture. An African-American grandmother might feel too guilty to ask her grandchild to drive her to a clinic for treatments and stay home instead. In these cases, the care provider could discuss options with these women and their families and friends to help alleviate their situations.

**Other Gender-Related Concerns**

The topic of domestic violence is difficult for most women to talk about, whatever their culture. But for women from certain cultures, especially those in which women are in a more subservient position, discussing domestic abuse becomes the unthinkable. The health care community should be alert to the major health problem of domestic violence and sensitive to the dilemmas faced by victims of abuse.

You should also be aware of a common characteristic that women demonstrate, which may surface during the medical interview. Many women are acculturated to avoid confrontations with authority, especially with male authority. They may seem more passive than men and not raise questions or doubts. They may say they agree to your recommendations but not carry them out. Again, by being aware, sensitive, and open to your patient, you will leave space for her to voice her feelings, misgivings and questions. Also, if she is provided with different options, she will have choices she may not have thought she had.
Gender issues also affect people whose situations have rarely been addressed by mainstream health care—the lesbian, gay, bisexual, and transgender population. Again, as for any other group, the chief concern should be for the well-being of the patient. Too often, patients’ sexual orientations have become an additional obstacle for them on the road to recovery, whenever a doctor or care provider treats them as second class or worse. Men and women in these groups may choose not to seek health care because of their concern about such bias in the medical community.

You can avoid bias by respecting your patient’s sexual orientation. Don’t automatically assume your patient is heterosexual. When treating your gay or lesbian patients, it is important to recognize that they will likely want their partners included in the decision-making process and acknowledged as “next of kin.” Be aware that anyone can be the victim of abuse—heterosexual men, gay men, and lesbian women. Ask all your female patients of childbearing age about potential pregnancy before doing radiographic studies or planning elective surgery, whatever their sexual orientation.

The same guidelines that apply to people of different ethnicities and cultures also apply here: By being sensitive, attentive, and open to learning more about your patient’s life situation, you can improve communication and outcome.
**TRUST ISSUES**

Studies have shown that people tend to prefer seeing a doctor of their own ethnicity. However, there are conflicting reports in the primary care literature regarding the impact of physician-patient gender concordance on patient satisfaction. There are no similar studies in the orthopaedic surgery literature.

Asian-American women who have emigrated to the United States may distrust Western medicine and/or have no experience with it or the American health care system. This, combined with limited English and the use of traditional Asian medical treatments, can hamper treatment. Generally, Asian Americans are less satisfied with their interactions with doctors than other population groups. On the other hand, immigrant Latino women come from a culture where doctors are autocratic and patriarchal, so they generally hold them in great respect for their knowledge and position.

**GREETINGS AND INTRODUCTIONS**

Address African-American women with titles such as Mrs. or Ms. and use their last names. Engage in friendly small talk before turning to the reason for the patient seeing you.

Asian women prefer being addressed formally. Shaking hands is usually acceptable, but they may greet you with a bow. Nodding in return is acceptable. Avoid touching unless you are examining the patient. Touching is considered rude. Some Asians will tend to avoid eye contact, out of courtesy and respect.

Hispanic women will prefer being addressed as Mrs. or Señora or Señorita. Be careful using these terms. Señora refers to an older married woman. Señorita refers to an unmarried woman, who has no children. If you’re uncertain, ask which it is. Shake hands. Eye contact is acceptable, but avoid prolonged eye contact. Engage in small talk before asking about her concerns.

In the case of a Muslim woman who is wearing traditional garb, it’s usually an indication that you are expected to greet the man or men accompanying her first. Male physicians should not attempt to shake hands with her unless she offers her hand first and female orthopaedic surgeons should not automatically offer to shake hands with male Muslim family members.

**COMMUNICATION**

**Verbal**

In general, be friendly and considerate. Avoid being overly friendly, however. Most people prefer a certain amount of formality, especially on their first visit.

African-Americans may feel uncomfortable with direct questions, which they may think invade their privacy. When you ask your African-American patients for information, tell them why you need it and provide detailed information about the risks and benefits of joint replacement.

An Asian-American woman will tend to protect her personal privacy and she may not answer questions directly. She may nod and smile, but this does not necessarily mean that she agrees with a statement. She may smile simply to avoid an uncomfortable situation and not want to say no or seem confrontational, even though she may be concerned about your recommendations. This could lead to nonadherence. Acknowledge her concern and give her options for handling her problem.

Because of the expectations of their role in the family, Hispanic women may wait before seeking medical attention. They may not ask questions or admit that they don’t understand something you’re saying. It’s important to clarify everything you discuss. Muslim women also may delay seeking care because of their family responsibilities.

**Nonverbal**

Most cultures consider smiling as friendly. It helps raise the comfort level. Don’t force or prolong eye contact.

Avoid gestures that could be interpreted as inappropriate or offensive in other cultures, such as the OK gesture, curled finger signals, or using the V for victory sign.

**FAMILY**

When you acknowledge and respect your patient’s family hierarchy, you can improve communication and your patient’s adherence to treatment. This means that you will
have to make an effort to learn about the different expectations that various cultures have about family.

A significant number of cultures are patriarchal. However, the role of men in these cultures can vary, from simply acting as the family spokesperson to being the one designated to receive all relevant health information and making and communicating health-related decisions for the women in the family. For example, traditional Greek and Japanese families expect the men in the family to communicate health-related decisions, but the female patients involved are part of the decision-making process.

On the other hand, recent female immigrants from either the Middle East, Pakistan, or India may expect the men in the family, primarily their husbands, to answer the physician's questions for them, to receive all health-related information, and to make and communicate decisions regarding their health care.

Physicians treating female patients from minority cultures should include the family in the conversations, and attempt to connect with husbands, fathers, brothers, and other, especially male, members of the family. Although interviewing techniques in Western medicine emphasize developing an empathic relationship with the patient, women who are members of some cultures may be uncomfortable discussing health issues with people, especially men, outside of their own family. In these situations, you should direct questions to the patient and the male members of the family accompanying her. Discussions regarding diagnosis and treatment options should include male members of the family.

Attention and awareness can improve communication with your minority patients.

**When treating Hispanic women:**
- respect the family hierarchy
- attempt to connect with husbands, fathers, and extended family members
- offer private discussion versus including family members
- recognize the role of a woman as caretaker in the family

**When treating Muslim women:**
- expect other family members to have input in decisions
- recognize that her primary responsibility is caretaker, especially of children

**Be aware that African-American women:**
- may rely on the support of others, including clergy and fellow church members

**Be aware that Native American women:**
- may have an extended family system
- will usually speak for themselves, but may want collective family decisions

**PHYSICAL EXAMINATION**

There may be a tendency among women in some population groups to put off seeing a doctor. You should be understanding, sensitive, and aware, and educate them about the importance of regular examinations. African-American women, for example, are less likely to have seen a physician in the past two years and have fewer physician referrals. There could be many reasons for hesitating to seek medical attention: personal, economic, lack of insurance, spiritual, and lack of information.

For women from some cultural groups, the physical examination itself—especially if conducted by a man—can be problematic. Some Muslim women may cover themselves with clothing and avoid physical contact with men. Some traditional women may require examinations from other women, because they are not permitted to disrobe before a male. Expose only the area to be examined, with male family members present.

Many Hispanic and Asian women regard modesty as very important and prefer to be examined by physicians of the same sex. A female staff member should be present during the examination; if this is not possible, be sensitive and respect your patient’s sense of modesty.

**Health Issues**

**Domestic violence (intimate partner violence)** is the single largest cause of injury to women between the ages of 15 and 44 in the United States—more than car accidents, rapes, and muggings combined. Between 2 and 4 million women are battered every year, and 2,000 die, according to the American College of Emergency Physicians. Domestic violence occurs among all ages, genders, races, educational backgrounds, and socioeconomic groups. Clearly, it’s an urgent health problem for women.

Orthopaedic surgeons may confront its consequences in their practice. All health care professionals should learn to recognize the signs of domestic violence. It’s important for all physicians to be aware of their own prejudices or misunderstandings about abuse and the victims of abuse. Bias can actually blind a doctor to the signs of abuse. You should...
familiarize yourself with the social and psychological issues causing women to feel helpless in the face of abuse.

You should always know your state and local laws regarding the reporting of suspected incidents. Information obtained in the course of treatment is usually regarded as strictly confidential. The law generally presumes that a person who has reached the age of majority can make his or her own decisions, although most states have legislation requiring physicians to report suspected cases of child abuse. In a few states, physicians may be required or permitted to report suspected cases of elder abuse and other cases involving disabled adults.

When dealing with suspected abuse, consider and discuss options with your patient for placement in a shelter. Returning to the abusive environment can put the victim at greater risk of injury or death. ED physicians and others can play a role in helping abuse victims by telling them that it’s a problem that must be solved, letting them know that they don’t deserve to be battered, and that help is available. Every ED and doctor’s office should have material with names and phone numbers of local shelters, advocacy groups, and legal assistance to give to patients if they feel it’s safe to take. Always tread carefully when handling such cases—your chief concern must be the safety and welfare of the victim, your patient.

Musculoskeletal conditions: Some conditions affect women more frequently than men or may have different presentations and treatment outcomes. Different physiology/anatomy and delayed presentation may be factors contributing to differing outcomes.

Osteoporosis: Approximately 44 million Americans have osteoporosis or low bone mass. Eighty percent of these patients are women. Although most women with osteoporosis are Caucasian, the condition is found in women of all races. Despite a significant number of older African-American women who sustain a fragility fracture, they are significantly less likely to be evaluated for osteoporosis, even after a fracture, compared to Caucasian women, and less likely to receive treatment.

Osteoarthritis: Older women are also more likely than men in the same age group to have osteoarthritis. Although women receive more knee replacements (TKAs) than men, the rate of surgery does not reflect the incidence of this disease in women. Women also tend to have worse postoperative outcomes from TKA, most likely reflecting a delay in having surgery and worse preoperative functional status.

There are also differences in disease incidence among the races. For example, African-American women have two to three times the rate of osteoarthritis of the knee compared to Caucasian women and a higher rate than Hispanic women. However, they have fewer TKAs than Caucasians or Hispanics. Thus, an African-American woman with disabling osteoarthritis is less likely to know another African-American woman who has received a TKA. This may influence her decision to undergo such a procedure.

Female athlete triad: Orthopaedists frequently treat the sports injuries of female athletes. Beyond treating fractures and planning rehabilitation, you should recognize the importance of the female athlete triad: training regimen, menstrual cycle, and eating habits. Examining a training regimen may reveal possible problems that lead to injuries. By asking your patient direct questions about her eating habits and menstrual cycle, you can pinpoint a possible eating disorder. When you examine the whole patient and her life situation—not just a fracture—you increase the chances for successful treatment.

RELIGION AND SPIRITUALITY

Please refer to the chapter on Faith-Based Issues.

ALTERNATIVE MEDICINE

There is a tradition of using folk remedies, medicinal herbs, and healers in many cultures. Native American women, for example, may use native medicine, especially in group activities where women gather to support each other, a practice that offers many benefits. African-Americans may rely on folk remedies. Asian-Americans may use herbs. You should ask about such alternative medicines—without seeming dismissive or disrespectful—and be aware of any potential medical problems such remedies could cause, such as excessive bleeding.

CASE EXAMPLES FROM THE CULTURAL COMPETENCY CHALLENGE

Case 12: Hamidah Kanna

1. A 34-year-old Muslim woman who has covered herself with traditional clothing is accompanied by her husband, who begins by saying his wife fell down, has knee pain, and has difficulty walking. The doctor understands that the woman may defer to her husband and for the examination has a female nurse arrange the patient’s gown to uncover the knee. The husband’s presence in the room will help the patient feel at ease with the examination and recommendations.
2. The patient has medial joint line pain and a tear of the medial meniscus. If the doctor discusses arthroscopic treatment with her, her husband, and/or family and gains their approval, the patient may follow recommendations.

3. Accommodations should be made for keeping her disrobed only as much as necessary during the surgery, to reassure her and her husband.

4. Before the surgery, you need to have a discussion about her caretaking duties with her and her husband to make a better recovery possible. This may include adjusting her routine to control weight-bearing activities.

5. When she is returned to the recovery room, orders should be given to have the curtains drawn, and to give her as much privacy as possible. Dietary orders should be given that follow the dietary restrictions of Islam.

Case 5: Susan Robertson

1. An affluent-looking 40-year-old woman with an upper extremity fracture and periorbital ecchymosis needs urgent care. Her husband answers questions about the injury for her. Her type of injury, old bruises, and history of past ED visits suggest intimate partner violence (IPV), but there is not enough evidence to implicate her husband.

2. The exact cause of injury is unclear. Asking the husband to leave the room allows the woman an opportunity to discuss the cause of the injury.

3. Physicians have an obligation to protect the lives of patients. By discussing cases of IPV they’ve seen, they can gently ask the patient about domestic violence.

4. IPV can occur in every socioeconomic level, ethnic group, or sexual orientation. Multiple old fractures on radiographs often indicate IPV.

5. When a patient says she is the victim of IPV, it’s important to ask about her safety if she returns home and to offer to contact community resources.

BIBLIOGRAPHY


Ferguson WJ, Candib LM: Culture, language, and the doctor-patient relationship. Fam Med 2002;34:353-361. The authors state that minority patients are “less likely to engage empathic responses from physicians, less likely to establish rapport with physicians, less likely to receive sufficient information, and less likely to be encouraged to participate in medical decision making.” However, the participatory nature of the interaction is significantly greater in race-concordant versus race-discordant pairings for both Caucasian and African-American patients.


Religion is a major factor in the social structure of cultures, filtering across socioeconomic, regional, and ethnic differences. The question of how religion affects the physician-patient relationship is complex and often controversial. Religious and spiritual beliefs influence many patients’ decisions about health care, illness, and impending death. Doctors and care providers also bring their own religious perspectives to their encounters with patients. For many patients, religious belief can outweigh the doctor’s recommendations. How, then, can physicians and health care providers respond to their patients’ spiritual issues?

The first step is to recognize the influence of belief in patients’ lives and to learn about different faith systems. There are more religious groups in the U.S. than in any other country. Three-fourths of Americans say they are members of a Christian denomination. Catholics represent an estimated 25% of the US population and Baptists rank at an estimated 16%. Although the other Christian denominations are not as large, taken together, they comprise a substantial percentage of the population.

Jews make up almost 2% of the population, but they don’t all practice Judaism. The number of Muslims in the United States is difficult to ascertain, for various reasons. Estimates range from less than 2 million to 8 million. Of the US Muslim population, many are African American, and therefore confront an additional set of stereotypes. About 25% are of South Asian descent and about 12% are of Arab descent. Significantly, more Arab-Americans are Catholic than Muslim.

Estimates for Buddhist and Hindu groups in the United States are low, but as new immigrants arrive, their numbers are significantly increasing. With these populations growing, encounters between such patients and American hospitals and physicians are likely to increase. Knowing about the religious beliefs of your patients can help to improve communication and health care.

The role of religious and spiritual beliefs in the lives of patients can be an extremely ambiguous subject, and difficult to assess. Religion is not exclusive to one’s ethnicity or cultural background. Religion is not discernable by the clothing one wears. One should never assume that people observe a certain religion because they wear a turban, or beard, or garment of a certain kind. Religion may not play any part at all in most encounters between patient and physician. But there are times when your patient’s beliefs may have a major impact on your relationship with him or her. One example is the belief of Jehovah’s Witnesses that they should not receive blood transfusions. Give your patients the opportunity to tell you whether they might have any religious objections to possible treatment options, either in the intake questionnaire or directly when taking their personal history.

This is not intended to give an exhaustive account of the world religions. The guidelines speak to only some of the beliefs and practices that can affect the delivery of health care. More than anything, they are meant to bring to your attention certain significant factors that could play a part in your patients’ lives and possibly influence their attitudes toward medical care.
TRUST ISSUES

People who practice religious beliefs different than their doctor’s may not want to place trust in a doctor of a different faith or one who does not have a religious faith at all. They may want to place trust in their faith and fellow believers instead.

Care providers must not appear dismissive or demeaning toward patients’ beliefs, and should be prepared for handling situations in which patients ask them to pray for or with them.

When it comes to discussing religious and spiritual beliefs, patients are often as reluctant as their doctors and care providers to even broach the subject. Discussing religion in the health care setting automatically brings up the issue of privacy. However, asking about religious preferences and requirements could be important when getting your patient’s personal history, especially in a life-threatening emergency.

GREETINGS AND INTRODUCTIONS

Include direct, specific questions about religious or spiritual beliefs that might influence medical decisions in the routine patient history. How a patient answers can point to potential concerns, as in the cases of Jehovah’s Witnesses who may need a blood transfusion. It’s best to research and discuss possible conflicts with the ethics committee or hospital attorney before making major treatment decisions having to do with such cases. It may also be important to make accommodations for appropriate care related to your patient’s beliefs.

If your patient is a Muslim who observes traditional practices, and is accompanied by family, it is generally recommended that you acknowledge and speak to the husband or men of the family first. Learn to pick up on such signs as dress and demeanor when you meet Muslim women. Approach women who are wearing conservative, traditional dress with respect and without extending a handshake. Always allow the female to make this approach. Maintain a more formal demeanor and posture, make only brief eye contact, and always ask permission before touching. On the other hand, many less traditional Muslim woman do not dress by covering themselves, and exhibit a much different attitude; you can usually approach them as you would most of your other female patients.

Hasidic Jewish men (a sect of ultra-Orthodox Jews) will not shake hands with women, because they are not supposed to touch any woman other than their wife.

COMMUNICATION

Verbal
Because of possible language and cultural barriers, physicians must be careful in obtaining informed consent from patients of faith. You should always make sure that your patient and/or accompanying decision-makers (such as parents) understand and accept the risks associated with a major operation. Some people may believe that, with prayer, complications will not occur, while others may be more fatalistic and accepting of bad outcomes. For you, the important thing is to see to it that your patient understands the risks.

Nonverbal
Avoid a facial expression or gesture that communicates dismissal of the patient’s beliefs. Even though physicians may not believe the same things, they should show respect toward the patient. Present yourself in a professional manner, and do not appear too informal in how you stand or sit, especially the first time you interview your patient.

FAMILY

A number of traditional cultures are patriarchal. For example, a traditional Muslim woman will consult her family prior to following a physician’s recommendations, and may end up not returning for follow-up surgery. Therefore, it’s helpful to gain a husband’s/family’s trust and support so
they are more likely to advise her to follow your instructions.

It’s also important to recognize that some Muslim women and some women of other faiths are considered the primary caretakers in the household. Talking to the female patient and her husband about her ability to fulfill this role while she undergoes treatment will help improve her chances for a better outcome.

**PHYSICAL EXAMINATION**

**Orthodox Jews**: Traditional Orthodox Jewish women prefer having their bodies and limbs covered. Care providers may need to accommodate these preferences in the clinical setting.

**Muslims**: In the cases of traditional Muslim women, the male physician should examine a female patient in the presence of another female. The husband’s presence during the examination may also help a female patient feel more comfortable with the examination. Physicians should take steps to expose only the exact limb or area needing examination. In addition, surgeons should take precautions during the procedure, including keeping her covered, except for the exact site of surgery; covering windows to ensure privacy; and limiting the number of people (especially men) in the operating room.

**Hindus**: Hindu women may prefer being treated by female medical staff. Some Hindus wear jewelry or “sacred threads” of religious significance, and should be asked for permission if the jewelry must be removed.

**RELIGION AND SPIRITUALITY**

People of different religions will often seek the support of their clergy and others who share their belief. For example, Christians may want to discuss their case with their pastors and fellow church members. Fasting and dietary restrictions and specific rules for the handling of the dead are observed by a number of different religious groups.

**Buddhists**

Buddhists revere Buddha as an example of a better way of life. They believe in reincarnation and karma (ie, good actions result in rewards and bad actions result in punishment). Buddhism emphasizes the attainment of a clear, calm mind and principles of compassion. Buddhists practice the religion according to their cultural or national origin. They have no specific theology, but seek individual enlightenment and tranquility.

Buddhists believe illness is an inevitable part of life. They believe that suffering is caused by desire and that illness and pain are punishment for wrongdoing. They may be fatalistic and passive in response to pain or illness, and wait a long time before seeking treatment. Buddhists will adhere to a treatment plan as long as it helps them attain enlightenment and a clear mind.

**Christians**

Belief in Jesus Christ as the son of God and savior of humanity is at the heart of Christianity. Christians believe the Bible to be God’s word and study the life and teachings of Jesus. Christianity has been the predominant religion in the United States. Generally, the tenets of the various denominations do not conflict with most standard medical practice. However, there are denominations in particular that should be discussed because of the potential impact certain of their beliefs could have on a patient’s care and treatment.

**Jehovah’s Witnesses**

This group believes in the Bible and one God, Jehovah. They believe that Jesus was the son of God and follow his example. They refrain from nationalism, war, and politics, believing that God’s kingdom is mankind’s only hope. They will discuss their beliefs with others, often going house to house. They believe in living a morally “clean” life, without adultery, excessive eating or drinking, smoking, or gambling.

They believe that the use of blood, blood products, and transfusions is forbidden because of Biblical teachings. Although Witnesses accept surgery, they do not accept the use of blood transfusions during it. Whole blood, packed red blood cells, plasma, platelets, and white blood cell administration are forbidden. Some Witnesses may accept the use of albumin, immune globulins, and hemophiliac preparations. Always ascertain their wishes and be specific in your history and documentation.

**Christian Scientists**

*(The Church of Christ, Scientist)*

Based on the life, teachings, and works (or miracles) of Jesus, this group studies the Bible and their founder’s text, *Science and Health with Key to the Scriptures*. They believe in the power of prayer to heal pain and illness. They also believe that prayer and the study of the teachings of Jesus will help people improve their lives generally by seeking harmony in all aspects of life.

Usually, Christian Scientists will use prayer alone for healing, although individuals are always free to choose any form of treatment they think will work best for them. They attend services, and often rely on the Church’s practitioners.
to help them with spiritual treatment for healing when they seek a cure through prayer alone. These practitioners are not considered healers, and are more like counselors or spiritual advisers.

They believe that faith and prayer can heal their physical problems. The Church does not restrict them, however, from seeking medical help if they feel they need it. Members have reported many cases of healing by prayer alone, but have also been criticized for not getting necessary medical treatment, especially in life-threatening circumstances. There were a series of court battles in the 1980s and 1990s involving Christian Science parents whose children had died because they didn’t seek medical treatment.

You can let such a patient know that you respect his or her faith in prayer, but at the same time offer your medical expertise and recommendations for treatment and include the possible complications that might occur without such treatment. A good way to do this is to point out other such cases and what their outcomes were with treatment.

In cases that involve operations on Jehovah’s Witnesses and Christian Scientists, especially of children, you may need to consult the hospital’s ethics/legal committee.

**Mormons (The Church of Jesus Christ of Latter-Day Saints)**

Colloquially known as Mormons, this group comprises about 2% of the US population. Most live in the West, but others live around the world. Mormons consider themselves Christian and believe their Book of Mormon to be another testament of Jesus Christ. They live by a health code that warns against the use of stimulants and substances, and they abstinence from tea, coffee, alcohol, and tobacco. There are no restrictions of any prescribed drugs, however.

The Mormon practice of administering to the sick may be requested by your hospitalized patients, who would prefer some privacy for the practice. It is given to anyone who requests it, is regarded as a source of comfort, and is not only for the terminally ill or dying. Typically two members of the church’s clergy visit. One places consecrated oil on the head and the second person places hands on the person’s head and offers a prayer on his/her behalf.

One other practice involves the wearing of sacred undergarments, which, in the event of an accident, ED staff should remove carefully and treat with respect. Latter-Day Saints who have participated in a special Temple ceremony wear these garments at all times, although they usually do not wear them if they must stay in the hospital.

**Hindus**

Hinduism is often thought to be the world’s oldest religion. It is actually a collection of many religions and is dominant in India. Hindus believe in an infinite force that is the ultimate reality and views gods and people as manifestations of this force. Although there are many ideas of what Hinduism is, the concept of reincarnation is central to it. Because Hindu practices vary so much across regions, it’s best to ask patients about specific requirements.

Ayurveda is a medical system based on Hindu ideas and is commonly used in India and Southeast Asia. Its aim is to balance mind, body, and spirit in order to prevent illness. It also provides guidance to treat specific health problems. Fasting is common among Hindus.

**Muslims**

Islam means “peace and submission to the will of God (Allah).” Muslims believe in one God (Allah) and the last messenger, Mohammed. They also believe in all the other prophets from Adam to Jesus, all the revealed books, the angels, and the last day. The Five Pillars of Islam are faith, prayer, fasting, charity, and Hajj (pilgrimage to Mecca).

Muslims receive illness and death with patience and prayers. They consider an illness as atonement for their sins. They consider death as a part of a journey to meet their God. However, they are strongly encouraged to seek treatment and care.

Maintaining modesty precautions during every interaction with the health care system is important. Privacy concerns are particularly important for females.

Use signs on patient doors that ask for hospital personnel and visitors to knock and wait for permission to enter in order to give female patients or family members time to cover themselves.

In addition, as with other religions, faiths, and cultures, traditional Muslims observe dietary laws. The holy book (the Qur’an), prohibits eating pork or pork products, meat of dead animals, blood, and all intoxicants, and it is inappropriate for these foods even to be delivered to the patient’s room.

Religious practice also includes daily cleansing, which requires running water, and a quiet space for a prayer mat facing Mecca. During Ramadan, Muslims fast from dawn to dusk daily for one month a year; this month rotates based on the lunar calendar.
Specifying these precautions to all who will care for the patient should be a priority.

Orthodox Jews
Judaism worships one God, follows the Ten Commandments, and teaches the importance of charity. The three categories of Judaism are Orthodox, Conservative, and Reform. Orthodox Jews observe traditional Jewish law, which places restrictions on food, clothing, observance of the Sabbath, and the handling of those who have died. Conservative and Reform Jews tend to be less strict about observing Jewish law. Among the Orthodox there is also a range, with some being extremely observant.

Except for not allowing autopsies, traditional Jewish law does not prohibit medical procedures. Kosher dietary laws prohibit pork, mixing dairy and meat in the same meal, and certain types of seafood. These laws also require separate sets of kitchen and eating utensils. Hospitals should consult with a rabbi or Jewish organizations, and inform food services departments of any special needs. Some hospitals with large Jewish patient populations already offer such options.

ALTERNATIVE MEDICINE
Fasting, meditation, and prayers may bring psychological benefits to some patients.

Traditionally, Hindus are vegetarian, and find meat, especially from cows, undesirable. Their health practices often include using herbal remedies and adjusting their diets. They also are likely to use a system of “hot and cold foods” to remedy health problems. These designations have nothing to do with the food’s temperature or spices. Hindu patients may use various methods, such as yoga, breathing exercises, meditation, herbs, massage, special foods, and plant, metal, or mineral preparations for treatment. A few cases of contamination of these preparations have been reported.

You should ask your patients if they are using any herbs or special preparations for medicinal purposes and find out how such supplements and “medicines” may affect them. You can do this in the same way you would ask whether they are taking any over-the-counter medications. By being sensitive to their traditional practices while at the same time educating them on the benefits of your treatment plan, you can elicit their compliance.

CASE EXAMPLES FROM THE CULTURAL COMPETENCY CHALLENGE

Case 3: Mohamed
1. Muslim parents bring their 5-year-old boy with severe bowlegs to the doctor. They are from an Arabic country and speak little English. The mother is covered with a black gown and head covering and does not speak during the interview. The doctor extends a handshake to the mother and then the father, but the mother does not offer her hand.

2. The father is customarily the head of the household. In initial interviews with health care providers, he would be the person most likely to provide information. It is appropriate to address the father first, and then greet the mother.

3. In the greeting, offer a handshake to the male member of the family. Approach the woman with respect, and do not extend your hand—allow the woman to be the first to extend a handshake. Using your left hand to touch or contact someone may be considered offensive.

4. The boy has severe infantile tibia vara (Blount's disease). The doctor plans surgical realignment of the boy's legs and needs to make accommodations for his stay in the hospital. This includes dietary restrictions, providing an area for prayer, and accommodations for privacy and hygiene concerns.

5. The potential risks of the surgery should be reviewed again before surgery. The parents need to understand the possibility of an adverse outcome after surgery.

Case 16: Todd Pennington
1. A 27-year-old male Jehovah's Witness has been injured in a motor vehicle collision. He has a fracture and needs open reduction and internal fixation.

2. Jehovah's Witnesses are prohibited from receiving transfusions of blood or blood products. Patients should be asked direct and specific questions about their religious beliefs as part of the routine personal and social history-taking.

3. Religious beliefs should be taken into account when discussing and making decisions about treatment options, risks, and possible alternatives. Based on the relevant legal cases, review by clergy, and review of the medical literature, it is appropriate to respect a mentally competent adult patient’s religious conscience with regard to blood and blood products.

4. If the patient refuses to allow blood transfusions, the doctor should review alternatives and offer to transfer his care to another physician. The Jehovah's Witness
national website (www.watchtower.org) and/or local congregations should be consulted to review alternatives to blood transfusions. Hospital liaison committees of Jehovah’s Witnesses can help to find physicians experienced with these patients.

5. The Witnesses are prohibited from using whole blood, packed red blood cells, plasma, platelets, and white blood cell administration. Physicians and healthcare professionals can learn about different religious beliefs by discussing them with the patient, with other physicians who have experience caring for similar patients, with the patient’s clergy, local clergy of the same faith, or the hospital clergy. Various national organizations and information resource centers also can provide information.

6. If this patient has significant and substantial blood loss in a life-threatening emergency, the doctor should first consult with the patient, his family, and the hospital ethics committee, another physician more familiar with the care of Witnesses, or a Jehovah’s Witness liaison group to clarify the patient’s wishes and rights. In most cases, physicians do not increase the risk of liability when they comply with an adult patient’s wishes based on religious belief.
BIBLIOGRAPHY


Bash A: Spirituality: The emperor’s new clothes? J Clin Nurs 2004;13:11-16. The article questions whether spirituality can ever be defined, given that each person’s spirituality is individual to him or her, and questions whether tools can be developed that would help define a patient’s belief for health care providers.

Erde E, Pomerantz SC, Saccocci M, Kramer-Feely V, Cavalieri TA: Privacy and patient-clergy access: Perspectives of patients admitted to hospital. J Med Ethics 2006;32:398-402. In interviews, more than half the patients preferred not being listed by religion, but most welcomed visits from their own clergy, even though those visits were prompted by being on a hospital’s listing.


Hirsch S: Cultural competence, Arab-Muslim population. Presentation at AAOS Annual Meeting, Chicago, IL, 2006. This presentation provided an overview of the U.S. Arab-Muslim population.

http://www.adherents.com/rel_USA.html#religions. Accessed December 7, 2006. This site collects data on religions in America, including membership and religious statistics by geographic location for more than 4,200 religions, denominations, movements, etc. It includes information on religious groups and uses figures gathered in the National Survey of Religious Identification. This scientific nationwide survey of 113,000 Americans asked about religious preference, along with other questions. The site also includes data from the American Religious Identity Survey (ARIS) conducted in 2001, with a sample size of 50,000 Americans. Complete ARIS data is published online at: http://www.gc.cuny.edu/faulty/research_briefs/aris/aris_index.htm. Accessed December 7, 2006.

http://www.adherents.com/largecom/com_islam_usa.html. Accessed December 7, 2006. This link examines the question of the number of American Muslims, and includes a range of sources that debate how many Muslims live in the US.

http://religiousmovements.lib.virginia.edu/nrms/chrissci.html. Accessed December 7, 2006. This site provides the history and philosophy of Christian Science and a number of links, and references to books and articles, pro and con, on the subject of Christian Science and health care.


http://www.sdhl.nhs.uk/documents/cultural.html. Accessed December 7, 2006. This site contains the South Devon Healthcare NHS Trust’s Handbook on Cultural, Spiritual and Religious Beliefs, which presents information for UK health care professionals about the preferences of major religious groups, with an emphasis on health care, and can also be useful resource for American professionals.
RECOMMENDED RESOURCES AND ADDITIONAL READING


Culturally Competent Care Education Committee (CCCEC) of Harvard Medical School (HMS): Culturally Competent Care Education at Harvard Medical School: Background, History and Accomplishments—June 2006. The report, which details the cross-cultural medical education initiatives at HMS over the last five years, is also available online—along with an excellent DVD and tips on teaching cultural competence—at: www.hms.harvard.edu/cccec.

CCCM: A Family Physician’s Practical Guide to Culturally Competent Care. This program, from the US Department of Health and Human Services Office of Minority Health, contains a variety of self-assessment tools, case studies, video vignettes, learning points, CME posttests, and the opportunity to submit and receive feedback regarding specific cases and content. The Website (http://cccm.thinkculturalhealth.org) is free and serves not only as the portal to the CME program but also provides references on the latest issues in cultural and linguistic competency. The guide is actual-

ly a series of Cultural Competency Curriculum Modules (CCCMs) commissioned by HHS.


Elliott C, Adams RJ, Sockalingam S: Normative Communication Styles & Values for Cross-Cultural Collaboration. Office of Multicultural Health, Department of Human Resources, Oregon, 1999. This study examines the communication styles of people from a variety of cultures, including such factors as animation/emotional expression, gestures, range of pitch and volume, handshaking, touching, and much more.


Holmes L, Bernstein P, Rodriguez-Trias H, Ruzek SB: Enhancing Cultural


**Recommended Resources and Additional Reading**


Leininger MM (ed): *Culture Care Diversity and Universality: A Theory of Nursing.* Sudbury, MA, Jones and Bartlett, 2001, p 42. This book analyzes cultures from the perspective of nursing and offers suggestions on how to improve care for patients of diverse backgrounds.


National Center for Complementary and Alternative Medicine, National Institutes of Health. This is a comprehensive Website for information on alternative medicine. http://nccam.nih.gov/research/results/gait/qa.htm


Rundle A, Carvalho M, Robinson M (eds): *Cultural Competence in Health Care: A Practical Guide.* San Francisco, CA, Jossey-Bass, 2002. This guide was developed by doctors and nurses at Children's Hospital in Boston, who worked with diverse religious and cultural patients.

Section of General Internal Medicine, Boston City Hospital, in collaboration with the Department of Interpreter Services and the Boston Area Health Education Center: The Bilingual Medical Interview I (1987), and The Bilingual Medical Interview II: The Geriatric Interview. Film, available from BAHEC, 818 Harrison Ave, Boston, MA 02118 (617)534-5258.

Smedley B, Stith A, Nelson A: Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine, Washington, DC, National Academies Press, 2003. This report outlined many issues that contribute to health care disparities, and also examined the different perceptions of health care among different ethnicities. African-American patients were likely to perceive their physician interactions differently than Caucasian patients, with African Americans being four times more likely than Caucasians to believe racial discrimination is common in doctors’ offices and nearly three times as likely as Caucasians to believe African Americans receive a lower quality of health care than Caucasian patients.


