

PROVIDER CURRICULUM SUPPLEMENT

A TRAINING GUIDE TO THE PHYSICIAN TOOLKIT ON CROSS-CULTURAL CLINICAL PRACTICE GUIDELINES FOR MEDICAID PROVIDERS



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USING THE PROVIDER EDUCATION CURRICULUM

What is the Purpose of the Provider Education Curriculum?

The purpose of the Provider Education Curriculum is to orient practitioners on practical application of the Cross-Cultural Clinical Practice Guidelines (CPG) and the contents of the Provider Toolkit.

For Whom is the Curriculum Designed?

The curriculum was designed to guide the user through content specifically aimed at addressing the Cross-Cultural CPG template and each section of the Provider Toolkit. It is also designed to factor in flexibility that will allow tailoring and/or expanding the content to use in practice settings as needed. This design feature, therefore, limits its use as a stand-alone product and it should not be used without the Cross-Cultural CPG and Provider Toolkit.

What Does the Content of this Curriculum Contain?

The curriculum content closely parallels the topics contained in the Provider Toolkit but also expands upon the information. Each module provides a framework to guide practice settings in identifying the basic session goals, learning objectives and topic focus areas most relevant to implementing the Cross-Cultural CPG. The modules are formatted to address an introductory overview, an outline that orients the trainer to the topics in the Toolkit, resources and an Appendix that contains various learning tools to facilitate discussion.

What Does This Curriculum Not Cover?

This curriculum is not intended to serve as a comprehensive learning device but rather offers suggestions for minimum areas of knowledge and competency-building activities recommended by experts in the field. It is strongly recommended that users access additional information during the various planning and implementation aspects of training to complement and tailor contents to meet their staff's experience and the populations being served by their practice.

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MODULE 1: CROSS-CULTURAL CLINICAL PRACTICE GUIDELINES

<u>Session Goal:</u>	<u>Learning Objectives:</u>	<u>Topic Areas:</u>
Introduce Cross-Cultural Clinical Practice Guidelines (CPG)	<ul style="list-style-type: none"> • Introduce CPG Statements • Introduce Toolkit Sections I & II 	<ul style="list-style-type: none"> • CPG Goal, Objectives and Statements • Changing Demographics • Health Disparities by Race and Ethnicity • Factors Contributing to Disparities

Overview

Changing demographics point to an increased demand for medical care delivery that is responsive to multicultural populations. Census data predicts that by the year 2030, approximately 40 percent of the American population will be comprised of racial and ethnic minority groups. Yet despite improved health outcomes among the overall population, ethnic minority populations continue to experience dramatically shorter life spans, higher morbidity rates and lack of access to quality health care (Lillie-Blanton & Correa, 1995; Waidmann & Ragins, 2000).

Problems with access and the delivery of health care for racial and ethnic minority populations have long been influenced by historical, sociocultural, political and institutional factors. Race and class have long contributed to the unequal distribution of health care, thereby further widening the gap in health disparities (Byrd & Clayton, 2000 & 2002). Numerous studies continue to point to health disparities among ethnic minority populations. For example, several studies have shown that minorities suffer heart disease, cancer, stroke and HIV/AIDS at disproportionately higher rates than whites (Cunningham et al, 2002; Collins et al, 2002; Keppel et al, 2002). Moreover, ethnic minorities are the least likely to have medical insurance, are disproportionately represented in the Medicaid population and are more likely to be underinsured, thereby limiting their access to medical care (Collins et al, 2002; Kaiser, 2003; Rosenbaum & Shin, 1998). Medicaid programs have historically served populations who have been disproportionately burdened by poverty, poor health status, disabilities and language barriers and who are likely to contend with problems that further affect their ability to access care, such as transportation, lack of child care, limited or no leave from work to keep medical appointments and language and literacy difficulties (Kaiser, 2003; Lonner, 2000; Rosenbaum & Shin, 1998).

According to the Census 2000 data, racial and ethnic minority groups make up approximately a third of the United States population. Yet ethnic minorities are more likely to have lower rates of employment-based insurance and rely more on Medicaid and other public insurance sources compared to Whites as shown in the table below.

Table 1.
Census Population and Medicaid Status

Race/Ethnicity	Census 2000	Medicaid Enrollees
African American	12.1 %	24.1%
American Indian/Alaska Native	0.7 %	2.2 %
Asian/Pacific Islander	3.7 %	3.9 %
Hispanic/Latino	12.5 %	22.5 %
Other	1.8 %	N/A
Whites	69.1 %	47.4 %
Totals	281.4 million	31 million

Source: Kaiser, 2003.

Table 1 also shows that over half of all Medicaid enrollees are represented by ethnic minorities, reflecting a disproportionate enrollment in public as opposed to private health insurance programs.

Consequently, the last decade has prompted numerous public, private, federal and state partnerships to establish targeted policies, standards and regulations that address multi-prong approaches to improving system structures, as well as process and outcomes-monitoring as a means towards reducing health disparities. One area that has not been given much attention, however, is the development of clear standards or clinical practice guidelines to support physician skill sets in delivering culturally and linguistically appropriate clinical care.

I. Guiding Principles for Cross-Cultural Practice

Part 1 of this session introduces the rationale for the cross-cultural clinical practice guidelines as a means to improve delivery of quality health care to diverse populations. The minimum topic areas for meeting this learning objective can address:

- a) **CPG Goal:** To provide guiding principles that improve patient-centered care as a means to reducing disparities in access, quality and health outcomes among diverse populations.
- b) **CPG Objectives:**
 - Improve skills for gathering information related to those factors that influence a patient’s health values, beliefs, behaviors and expectations for care.
 - Develop clinically effective treatment plans that are compatible with a patient’s values, preferences and needs.
 - Increase awareness of individual and institutional factors influencing clinical decision-making processes that affect outcomes of care.
 - Improve communication that promotes doctor-patient relationship based on mutual respect and trust.
- c) **CPG Guiding Principles:**
 - Review CPG statements (guiding principles).
 - Practice domains: statements focus on influencing behaviors to refine processes and practice in the area of:
 - Clinical assessment process.
 - Treatment planning and negotiating adherence.
 - Patient communication and education.
 - Organizational supports and system tools.

Resources to Facilitate Discussion

- ❑ Refer to Section I of the Provider Toolkit.
- ❑ Refer to Curriculum Appendix A: Module 1 Handout (CPG statements).
- ❑ Refer to Institute of Medicine Report on Unequal Treatment (2003).
- ❑ Refer to data sources on websites listed in Section II of the Toolkit.

II. Disparities in Outcomes of Care

Part 2 of this session aims to expand knowledge of health disparities, factors contributing to disparate outcomes and the link between quality and outcomes of care. The minimum topic areas for meeting this learning objective can address:

a) Changing Demographics:

- Demographics by race, ethnicity and immigrant influx for your state and service area.
- Health insurance status by race and ethnicity.
- Medicaid enrollment by race and ethnicity.
- Socio-demographic characteristics by race and ethnicity (education, SES, etc.).

b) Health Disparities by Race and Ethnicity:

- Healthy People 2010 indicators.
- Morbidity and mortality rates.
- Top chronic conditions affecting racial and ethnic minority populations.
- Minority experiences with accessing quality care.

c) Factors Contributing to Health Disparities:

- Patient level factors.
- Physician level factors.
- Institutional level factors.

Resources to Facilitate Discussion

- ❑ Refer to Section II of the Provider Toolkit.
- ❑ Refer to websites listed in Section II of the Toolkit to address Topics 1a and 1b above.
- ❑ Refer to the Institute of Medicine Report on Unequal Treatment (2003) and websites to address Topic 1c above.

MODULE 2: BASIC CONCEPTS

<u>Session Goal:</u>	<u>Learning Objectives:</u>	<u>Topic Areas:</u>
Examine Cultural Considerations in Health Care	<ul style="list-style-type: none"> • Introduce Core Cultural Concepts • Introduce Toolkit Section III 	<ul style="list-style-type: none"> • Basic Concepts • Biomedical vs. Non-Biomedical Systems • Cultural Dynamics Affecting Clinical Encounters

Overview of Cultural Concepts

Culture represents an integrated system of information that includes shared values, beliefs, norms, customs, traditions, symbols, religion and language that informs the internalized pattern of human behaviors within a given environment. Culture shapes our world views, values and experiences about health beliefs, views of diagnosis and treatment practice and teaches us how to behave during illness, what to expect from caring processes and what is expected from experts in healing (physicians, healers, nurses, etc.) during times of illness.

Cultural factors are situations or behaviors grounded in information and experience that have potential for shaping and impacting physician-patient communication, interaction and the nature of the relationship. Failure to take these factors into account can compromise care management during the cross-cultural encounter. Clinicians can focus on learning to identify and deal with cultural occurrences, and understand how they impact patient behavior and interaction rather than attempting to learn all culture-specific nuances for each group (Carillo, et al, 1999).

Cultural competence is a developmental process involving a series of changes that include increasing awareness and knowledge, changes in attitudes and behaviors, and gaining skills to engage with culturally diverse groups in a manner that results in positive outcomes. Cultural competence is a multi-dimensional occurrence that is expressed and measured at various levels that include:

- **Individual level:** Focuses on the clinician's cultural frame of reference (e.g., one's own perceptions, attitudes, behaviors, etc.).
- **Institutional level:** Focuses on the ability of the system components (e.g., administrative, governance, clinical services, information systems, etc.) to work together towards creating a culturally responsive practice environment.

A *culturally competent system of care* consists of a set of policies, attitudes and behaviors that come together at the individual, group or system level, enabling it to deliver medical care that addresses the cultural needs of diverse groups.

Western biomedicine is a term used often to describe the American health care system since it originated in -- and remains the dominant health-belief model of -- the United States and other European countries, whereas non-Western medicine is associated with non-European countries (Jackson, 1993).

Differences between Western and non-Western views on medical care models are frequently cited as a major factor influencing the cross-cultural clinical encounter. The predominant medical care models co-existing among many societies fall primarily into three categories: *Western Biomedicine*, *naturalistic* and *personalistic* models—each relying on distinct conceptual logics regarding origins of disease, approaches to diagnosis and treatment, types of practitioners used and practice among specific countries. These medical care models share distinct differences and similarities. While *Western biomedicine* emphasizes the origin of disease as a function of biochemical changes, *naturalistic* models explain illness based on the concept of maintaining equilibrium of physiological functions, and *personalistic* models explain illness as originating from purposeful intervention of supernatural forces. The fundamental differences among these models are

embedded within their etiology of disease/illness. While *Western biomedicine* emphasizes a reductionist approach in defining disease and treatment of illness based primarily on physical determinants, *naturalistic* and *personalistic* models incorporate physical, mental and spiritual components as well.

Certain cultures may share a conceptual ideology of health and illness that is rooted in a holistic approach to diagnosis and treatment. This is manifested by patients having different explanatory models (for causes and symptoms) of disease that intertwine *naturalistic* and *personalistic* models or even aspects of western medicine to address the multiple dimensions perceived to be affecting illness and treatment. Conceptual differences about the norms for use of medical care models can lead to problems with accurate diagnosis when medical providers are not aware of, or attentive to, variations in cultural expression, communication, meaning and interpretation of symptoms (Flores et al, 2000; Kleinman et al., 1978; Scott, 1997). The consequence of ignoring differences in health beliefs and practices will result in a patient not adhering to biomedical treatment plans and a delay seeking care at a chronic stage of a disease or illness.

Lastly, while acculturation to American cultural norms can occur over time and may influence behaviors towards utilizing Western biomedical systems, the reality is that cultural minority communities continue to access folk or traditional medicine as a primary source of care because of the low cost and easy accessibility. Practitioners must also exercise caution to not equate folk/traditional medicine to complementary alternative medicine (CAM) being adapted by *Western biomedicine* as the CAM's are primarily grounded in Eastern philosophies and marginally integrate views from Africa and the Caribbean, as well as from indigenous people's practices and those of people in other developing countries.

I. Introduce Core Cultural Concepts

This session aims to introduce core cultural concepts that influence the clinical encounter. The minimum topic areas for meeting this learning objective can address:

- a) **Basic Terminology:**
 - Review basic terms presented in the overview of this curriculum. Providers are encouraged to seek additional information and learn about other terminology pertinent to the cross-cultural clinical encounter.
- b) **Cultural Concepts Influencing the Medical Encounter:**
 - Health beliefs and practices.
 - Cultural values, norms and customs for interaction.
 - Communication styles.
 - Family dynamics.
- c) **Cultural Differences in Views of Diagnosis and Treatment:**
 - Views on origin of illness.
 - Views on diagnosis and treatment.
 - Practitioner types used.
 - Practicing countries.

Resources to Facilitate Discussion

- ❑ Refer to Office of Minority Health Website (www.ohmrc.gov) for resources to address Topic 1a above.
- ❑ Refer to Section III of the Toolkit and Appendix A: Module 1 for definitions on Topic 1b above.
- ❑ Refer to Curriculum Appendix B: Module 2 Handout (Cultural Dynamics Influencing the Clinical Encounter) to address Topic 1c above.
- ❑ Refer to the following websites to get information on health beliefs/practices across cultural groups:
 - ▷ Providers' Guide to Quality and Culture at <http://erc.msh.org/mainpage.cfm> provides links on cultural characteristics for select subgroups.
 - ▷ Understanding Health Culture of Recent Immigrants at <http://www.apha.org/ppp/red/Intro.htm> provides links to a maternal and child-health information catalog of health beliefs/practices.

MODULE 3: CLINICAL ASSESSMENT PROCESSES

<u>Session Goal:</u>	<u>Learning Objectives:</u>	<u>Topic Areas:</u>
Enhance Clinical Assessment Processes	<ul style="list-style-type: none"> • Introduce CPG Statements 1-3 • Introduce Toolkit Section IV 	<ul style="list-style-type: none"> • Eliciting Patient Views of Illness • Patient Cultural Assessment • Focus of Cultural Assessment

Overview

Consensus among medical professionals across a variety of disciplines points to the importance of assessing cultural, social, environmental and socioeconomic factors as part of diagnostic procedures, since these provide insight on how the patient understands, interprets and treats his or her illness.

The physician literature acknowledges and promotes the importance of adapting a modified form of cultural assessment that is compatible with the clinician's diagnostic activity (Flores, 2000; Kleinman et al., 1978; Pachter, 1994; Orr, 1996, Scott, 1997). Kleinman et al., (1978) were among the first to propose the concept of an explanatory model of disease/illness that provided a framework for eliciting patients' views on the etiology, onset of symptoms, cultural meaning of illness and treatment expectations grounded in the clinical diagnostic model. By eliciting the patient's views, the clinician is able to get information on the meaning of the disease/illness, meaning and severity of symptoms in relation to cultural norms and the patient's concept of the sick episode, as well as his or her expectations for treatment (American Psychiatric Association, 2000; Flores, 2000; Johnson, Hardt, Kleinman, 1995; Pachter, 1994; Scott, 1997).

Physicians who elicit information on the cultural health beliefs and practices are also in a better position to identify discrepancies among provider-patient views, generate a common language for anchoring physician-patient communication about illness and involve the patient in negotiation and decisions about treatment goals (Botelho, 1992; Buchwald et al., 1993; Carillo et al., 2002; Kleinman et al., 1978; Pachter, 1994; Scott, 1997; Vermeire, et al., 2001).

Betancourt et al., (1999) proposes an ESFT model to guide physicians on determining a patient's explanatory model, social risks, fears and concerns about medications, and understanding of the treatment regimen. This model serves as a patient-based tool that allows screening for barriers regarding compliance and identifying communication strategies to improve outcomes. Flores (2000) recommends that the physician-patient encounter utilize an assessment framework that incorporates an understanding of normative cultural values (i.e., *respeto*, *simpatia*, *familismo*, *fatalismo*), cultural beliefs, folk illnesses (culturally constructed diagnostic categories recognized among ethnic subgroups), language issues and provider practices. By understanding what cultural health beliefs and practices inform the patient's explanatory models of illness and treatment the physician can identify and accommodate those that improve the patient's condition and recommend alternatives for those practices that are harmful or that contraindicate biomedical therapies (Betancourt et al., 1999; Flores et al, 2000).

Moreover, the mental health literature has also moved toward formal methods to improve the collection of clinical information during the therapeutic encounter with ethnically and culturally diverse populations (American Psychiatric Association, 2000; American Psychological Association, 1993). The Diagnostic and Statistical Manual of Mental Disorders-4th Edition outlines a cultural formulation process to guide psychiatrists and other mental health professionals in a systematic assessment of the patient's cultural background, the role of culture in the expression of symptoms and the identification of culture-bound syndromes, as well as the effect culture may have on the clinician-patient relationship.

Cultural-assessment instruments are designed to collect information on cultural identity (cultural reference group, language preferences, etc.), explanatory models of illness (idioms of distress, culture-bound syndromes, preferences for professional and traditional sources of care), psychosocial stressors (social supports, role of religion, kin networks, etc.), differences

between patient-clinician cultural and social status and treatment modalities. Likewise, clinical guidelines for psychological services to culturally diverse populations focus on conceptual frameworks that enable psychologists to accurately assess the role of cultural values, the effectiveness of therapeutic styles, and the impact of the counseling process on utilization outcomes (American Psychological Association, 1993). Their guidelines encourage documenting not only the cultural, but also the socio-political (number of years in country, generation, English fluency, etc.), impact of environmental factors (discrimination, bias, prejudice, etc.) and institutional practices affecting ethnic minority patient care and treatment goals

I. Improve Information Gathering

The aim of this session is to introduce frameworks and techniques useful for gathering information on cultural, social and environmental factors during the cross-cultural clinical encounter. The minimum topic areas for meeting this learning objective can address:

- a) **Cultural Differences in Diagnostic and Treatment Practices (Review):**
- Views on origin of disease.
 - Views on focus of diagnosis.
 - Views on focus of treatment.
- b) **Eliciting Patient Views of Illness:**
- The Explanatory Model (EM):
 - i. Framework for eliciting a patient's views on the etiology, onset of symptoms, cultural meaning of illness and treatment expectations grounded in the clinical diagnostic model.
 - ii. Used to identify a patient's prevalent subgroup beliefs by using basic questions.
 - Practicing the Use of the Explanatory Model:
 - iii. Mnemonic devices exist to guide clinicians in eliciting patient views that include:
 1. ETHNIC framework.
 2. LEARN framework.
 3. BATHE framework.
 4. ADHERE framework.
- c) **Patient Cultural Assessment:**
- Purpose of cultural assessment.
 - Process of cultural assessment.
 - Contents of cultural assessment:
 - Cultural context.
 - Social context.
 - Environmental context.

Resources to Facilitate Discussion

- ❑ Refer to Curriculum Appendix A: Module 1 Handout (CPG statements 1 - 3).
- ❑ Refer to Section III and IV of the Toolkit to address Topic areas 1a above.
- ❑ Refer to Curriculum Appendix D: Module 3 Handout (Mnemonics) to cover Topic 1b above.
- ❑ Refer to Toolkit Appendix A (Sample Patient Cultural Assessment Tool) to address Topic 1c above.
- ❑ Review Summary Action Points in Section IV of the Toolkit.
- ❑ Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.

MODULE 4: TREATMENT PLANNING AND ADHERENCE

<u>Session Goal:</u>	<u>Learning Objectives:</u>	<u>Topic Areas:</u>
Improve Treatment Planning and Patient Adherence	<ul style="list-style-type: none"> • Introduce CPG Statements 4 – 6 • Introduce Toolkit Section V 	<ul style="list-style-type: none"> • Considerations in Treatment Planning • Negotiating Treatment Plans • Monitoring Treatment

Overview

A variety of factors are said to influence patient treatment adherence, including patient health beliefs/views about medications, cultural and social factors, constraints of a patient's everyday life, the clinician's ability to provide appropriate information and elicit respect, and the clinician's attitude toward patients and an openness to negotiating differences (Barnard, 1985; Betancourt et al., 1999; Botelho, 1992; Kleinman et al., 1978; Lazare, et al., 1995; Vermeire et al., 2001). The current literature reveals a consensus on the importance of adopting treatment goals compatible with the patient's beliefs/practices and negotiation skills to enhance clinician-patient interaction and relationship during the cross-cultural encounter. Kleinman et al (1978) first proposed the concept of creating a cultural construction of clinical reality using the explanatory model of illness as the basis for revealing discrepancies among cultural belief systems and conflicts in treatment expectations. Botelho (1992) suggests that negotiation is a multifaceted process that examines the context of a patient's disease experience, deals with physician-patient explanations of illness and examines the personal and relationship levels between physician-patient, as well as problem solving on treatment goals, management and completing the clinician-patient relationship.

Considerations in Treatment Planning

Growing support points to the importance of using the patient's explanatory model as a basis for initiating discussion grounded on the concepts, words and metaphors familiar to the patient about treatment goals and expectations (American Psychiatric Association, 2000; Flores, 2000; Johnson et al., 1995; Orr, 1996; Scott, 1997). Clinicians are encouraged to elicit specific information about treatments used for symptoms presented under common folk illnesses, types of folk medicines and healers used to treat illness and, whenever possible, to integrate folk medicine and biomedical therapies as part of treatment planning (Flores, 2000; Pachter, 1994; Putsch, 1985; Yamey, 2000). Clarifying and discussing important ethical disagreements related to particular religious or cultural practices, as well as a willingness to compromise about treatment goals when possible, are equally important during the negotiation process.

Both Betancourt et al., (1999) and Flores (2000) propose models that illustrate the importance of physicians becoming knowledgeable about differences in views of treatment, culturally based treatment practices, and cultural norms relevant to interpersonal dynamics, to assure accurate communication between the physician-patient when negotiating treatment plans. When developing treatment plans, physicians can also determine if patients are utilizing particular folk medicines and suggest alternatives to harmful remedies when necessary. Moreover, the mental health practice guidelines parallels physician literature views on the importance of addressing treatment planning and negotiation processes that are culturally relevant.

The American Psychiatric Association (2000) guidelines suggest incorporating comprehensive approaches that include the medical, religious, psychiatric, community and traditional folk practices to get a broad view regarding specific factors that may affect treatment goals. Similarly, the American Psychological Association (1993) guidelines recommend that clinicians consider the impact of socio-political and environmental factors in designing treatment, and respect the role of the patient's family and culture by including specific religious beliefs and practices as part of treatment planning.

Lastly, a growing body of literature points to the importance of monitoring drug metabolism and response as a feature of treatment planning that may impact treatment outcomes. Studies related to ethno-pharmacy have uncovered significant differences in drug metabolism, dosing adjustment requirements, medication response and side effects among racial and ethnic groups (Kudzma, 1999; Salerno, 1995). Although the topic of ethno-pharmacology remains controversial, clinicians must be attentive to drug metabolism responses, as it can provide some insight on other factors than may be influencing adherence behaviors among racial and ethnic minority populations.

I. Factors Affecting Treatment Planning

The aim of this session is to identify factors affecting treatment planning and strategies to improve negotiation skills during the cross-cultural encounter. The minimum topic areas for meeting this learning objective can address:

a) Considerations in Treatment Planning:

- Cultural health beliefs.
- Role of family.
- Socioeconomic factors.
- Environmental factors.

b) Negotiating Treatment Plans:

- Cultural context.
- Identifying cultural discrepancies on treatment modalities.
- Resolving different views on treatment.
- Managing the relationship.
- Process of negotiation involves:
 - Relationship building.
 - Problem clarification.
 - Agenda setting.
 - Assessment.
 - Follow-up care management.

c) Factors Affecting Patient Adherence:

- Components of adherence.
- Culture.
- Socioeconomic status.
- Environment.
- Physiological - medication response.

Resources to Facilitate Discussion

- ❑ Refer to Appendix A: Module 1 Handout (CPG Statements 4 - 6)
- ❑ Refer to Section V of the Toolkit to address Topic 1a above.
- ❑ Refer to Summary Action Points in Section V of the Toolkit.
- ❑ Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.

MODULE 5: PATIENT COMMUNICATION AND EDUCATION

<u>Session Goal:</u>	<u>Learning Objectives:</u>	<u>Topic Areas:</u>
Enhance Patient Communication and Education	<ul style="list-style-type: none"> • Introduce CPG Statements 7 – 8 • Introduce Toolkit Section VI 	<ul style="list-style-type: none"> • Factors Affecting Communication • Cultural Factors Affecting Interaction • Working With Language Barriers • Patient Education Strategies

Factors Affecting Communication

Effective patient communication and education are also considered key to physician functions during the clinical encounter. Several factors are said to thwart effective communication during this interaction, including the physician’s awareness of the patient’s expectations, devaluing patient and family views on diagnosis or treatment goals, the patient feeling rushed, cultural norms/customs for interpersonal communication, language barriers, socioeconomic status, noncompliance, difficult or sensitive topics and physician biases (Collins et al., 2002; IOM, 2003; Rivadeneyra et al., 2000; Stewart et al., 1999). Successful communication, however, requires an awareness of the cultural (norms, values, language, etc.) or environmental (education level, literacy, etc.) factors that may be influencing physician-patient interpersonal communication styles or preempting learning, as well as the development of approaches and skills that can enhance clinician efforts.

Several authors point to the importance of recognizing differences in the cultural norms, values and customs that dictate verbal and non-verbal communication styles for developing relationships among various cultural minority subgroups (Buchwald et al., 1993; Flores, 2000; Giger & Davidhizer, 1999; Hardt, 1995; Johnson et al., 1995; Orr, 1996; Poss & Rangel, 1995). Physicians need to become aware and understand the norms for verbal greeting among people with different hierarchical status such as authority figures, elder members, or strangers and maintain respect, as these directly influence the quality and maintenance of interpersonal relationships. Current guidelines recommend applying basic principles for verbal communication such as avoiding medical jargon or elaborate explanations about the patient’s illness, speaking slowly, avoiding ambiguous statements or idioms not relevant to the patient’s conceptual orientation or vocabulary and using clear and specific language (Buchwald et al., 1993; Hardt, 1995). Clinicians should also be aware and understand the norms and role of non-verbal communication such as body language, eye contact, hand gestures, time orientation and personal space, as these also affect interpersonal communication. Many ethnic minority groups share cultural norms in which direct eye contact is considered disrespectful and close personal space is valued for enhancing relationships.

The use of interpreters adds another level of complexity to physician-patient verbal/non-verbal communication. Medical interpreters trained in cross-cultural communication can also be a source of important information in assessing and learning about verbal/non-verbal behaviors characteristic of different linguistic subgroups. Current guidelines also recommend that clinicians consider various factors during interpreter dependent visits such as: arranging patients and interpreters in a position that allows maximum observation of non-verbal cues, addressing patients directly and not the interpreter, learning basic words/phrases in the patient’s predominant language to make him or her feel more comfortable, observing patient-interpreter verbal/non-verbal interaction patterns, asking interpreters for the literal translation of what patients are saying and meeting with interpreters prior to patient encounters to discuss goals for visits.

Patient Education During the Medical Encounter

Patient education encompasses giving information, instruction and counseling that help patients understand and manage their illnesses or conditions (Grueininger et al., 1995; Lazare, et al., 1995). One of the most important roles of patient

education is to change risky behaviors that may be detrimental to the patient’s health, well-being and recovery during illness. Several factors are said to impede effective patient education, including the patient’s education level, literacy in his or her primary language, language barriers and familiarity with medical care concepts, as well as perceptions about the physician’s role and behaviors (Betancourt et al., 1999; Buchwald et al., 1993; Flores, 2000; Grueininger et al., 1995).

Experts point to the importance of considering patient education strategies that apply conceptual cultural equivalence and language differences, and consider literacy and education level when communicating and developing patient materials. Cultural equivalence was echoed as a major theme across the functions discussed in previous sections about the importance of communicating and developing patient materials that use idioms, expressions and semantic terms that are meaningful to the patient’s conceptual orientation. Physicians must also be able to adopt patient education methods that are sensitive to their patients’ reading, comprehension and literacy levels, and consider using alternatives such as visual aids when possible, simplifying messages and avoiding medical jargon in both verbal and written education strategies.

Moreover, patient education can be further confounded by language barriers even when trained interpreters are present. Current literature documents the perils of language barriers in diagnosis and treatment compliance. When trained medical interpreters are not available during the physician-patient education encounter, problems such as misdiagnoses and poor compliance may result, further eroding the physician-patient relationship (American Institutes for Research, 2002; DHHS, 2001; Flores et al., 2000). Other problems resulting from language barriers include lack of information on informed consent, which may result in malpractice or negligence claims against the physician, medical practice or hospital (Woloshin et al, 1995). Baker et al., (1998) found that the use of interpreters with Spanish-speaking patients tend to provide more positive response in terms of patient satisfaction regarding interpersonal aspects of care.

I. Improving Physician-Patient Communication

The aim of this session is to identify strategies to improve physician-patient communication and education during the clinical encounter. The minimum topic areas for meeting this learning objective can address:

a) Factors Affecting Physician-Patient Communication:

- Cultural norms/customs affecting interaction.
- Guidelines for addressing verbal communication.
- Tips for addressing non-verbal communication.
- Working with language barriers.
 - Tips for using a medical interpreter.

b) Factors Affecting Patient Education During the Medical Encounter:

- Conceptual equivalence of message.
- Education and literacy appropriateness.
- Language barriers.

Resources to Facilitate Discussion

- ❑ Refer to Curriculum Appendix A: Module 1 Handout (CPG Statements 7 - 8).
- ❑ Refer to Section VI of the Toolkit for content focus areas.
- ❑ Refer to Curriculum Appendix B (Cultural Dynamics) to address parts of Topic area 1a above.
- ❑ Refer to Summary Action Points in Section VI of the Toolkit to address Topics 1a and 1b above.
- ❑ Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.

MODULE 6: CONSIDERATIONS IN CLINICAL DECISION-MAKING

<u>Session Goal:</u>	<u>Learning Objectives:</u>	<u>Topic Areas:</u>
Increase Awareness of Clinical Decision-Making Processes	<ul style="list-style-type: none"> • Introduce CPG statement 9 • Introduce Toolkit Section VII 	<ul style="list-style-type: none"> • Personal Level Factors • Professional Level Factors • Institutional Level Factors

Factors Influencing the Clinical Decision-Making Process

Physicians are trained in a scientific rationality that emphasizes objectivity, numerical measurement of physicochemical data and the treatment of all human beings alike, while ignoring dissimilarities to find common features (Giorgianni, 1998; Helman, 1998). Physician practice centers on applying diagnostic and treatment procedures to all individuals in exactly the same manner. However, medical historians have pointed out the persistent inequities in application of procedures among ethnic minority populations (Byrd & Clayton, 2000; 2002). While the main functions of the medical encounter are to diagnose the problem, recommend treatment and provide patient education, the components that go into applying knowledge and arriving at decisions for treatment are fraught with uncertainty. Diagnostic methods depend on a breadth and depth of knowledge, but application of such knowledge is not always straightforward and is often affected by biases (Round, 2000). Studies suggest that health disparities among racial/ethnic minority groups may be attributed to aspects of clinical reasoning (Andrews & Elixhauser, 2000; IOM, 2003; Schulman et al., 1999).

The clinical reasoning process is used as a tool to analyze information and to generate hypotheses and test them if uncertainty exists among a diagnosis or regarding a treatment plan. The reasoning process aims to deduce information from particular facts, and recognize signs/symptoms from previous clinical experiences to make a decision and take a course of action (IOM, 2003; Quill, 1995; Round, 2000; Yamey, 2000). This process, however, must also integrate aspects of knowledge about the clinical condition (technical procedures), about the interaction between practitioner-patient and about the intersection between the patients and their conditions.

Several factors may influence the dynamics of how the physician applies her/his knowledge to derive a diagnosis, interacts with patients and makes decisions regarding treatment during the clinical encounter. These factors essentially fall into themes that address individual, professional and systemic level factors and are briefly discussed below.

a) Individual Level Factors. Physicians enter into the clinical encounter with a particular worldview and set of experiences that are also a product of continuous interaction among various cultural, social, economic and political determinants. This worldview directly informs structural and systematic ways of perceiving and interpreting various realities, views of hierarchical thinking and typecasting of patient populations (Barnard, 1985; IOM, 2003; Yamey, 2000; Saha et al, 1999). Physician bias and prejudice also influence subjective views that are informed by conscious and unconscious processes that are socially conditioned. Evidence in the literature suggests that bias and prejudice regarding perception of the patient's race, class, culture, age and gender may account for stereotypes and therefore contribute to disparities in care and treatment planning (Andrews & Elixhauser, 2000; Barnard, 1985, IOM, 2003; Round, 2000; Schulman et al., 1999). Likewise, physician-patient socioeconomic status (SES) [low SES as compared to middle SES] and explicit versus implicit communication about social status can influence clinical reasoning and decision-making processes. Barnard (1985) further suggests that sociolinguistic differences between physician-patient can result in viewing lower SES patients as being less linguistically competent and less able to communicate during the clinical encounter, thus influencing the physician's clinical reasoning processes (IOM, 2003).

b) Professional Level Factors. The clinician's professional experience, norms, behaviors and training specialty are also said to influence clinical reasoning and decision-making processes. Factors like the type of postgraduate

training completed, academic versus private practice experience, number of years in practice and experience in working with medically underserved and culturally diverse populations are some issues that may influence decision-making processes (Davis & Taylor, 1997; Silberman, 1995). Professional norms and behaviors also serve to inform the objective and subjective definition of the physician-patient relationship, social distancing from patients and views on biomedical versus holistic care models (Barnard, 1985; Byrd & Clayton, 2002; IOM, 2003). Aspects of medical training specialty can also influence the clinical decision-making process. For example, primary care clinicians focus on incorporating health-illness profiles, while specialty care physicians focus on specific diseases. Clinicians who are academic or research-based may focus on decisions that relate to improve training or publications, whereas community-based practice may be more pragmatic and less distant/formal in nature (Barnard, 1985; Round, 2000). The clinician’s exposure to cultural competence training is needed in order to understand differences among patient-provider worldviews, and social, economic and cultural factors influencing communication, trust and clinical decision-making, among other things (Betancourt et al., 1999; IOM, 2003; Like, Steiner, & Rubel, 1996).

c) Systemic Factors. System factors have also been identified as influencing the clinical reasoning and decision-making process (IOM, 2001a & 2003). Institutional policies represent those aspects of organizational administrative policies and procedures that may target rationing care to control costs, clinical productivity, quality improvement, workforce competence, the degree to which cultural and linguistic appropriate standards are adopted to support structure and processes and meeting compliance for regulations and laws (IOM, 2001a). Time constraints also influence clinical reasoning and decision-making processes in that it limits information gathering and fosters cognitive shortcuts or stereotyping, as well as a lack of attention to information relevant to patient cultural preferences/values and needs.

I. Increase Awareness of Factors Influencing Decision-Making

The aim of this session is to increase awareness of the various factors that influence clinical reasoning and the decision-making process. The minimum topic areas for meeting this learning objective can include:

- a. **Individual level factors.**
- b. **Professional level factors.**
- c. **Institutional level factors.**

Resources to Facilitate Discussion

- Refer to Appendix A: Module 1 Handout (CPG Statement 9).
- Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.
- Review Summary Action Steps.
- Refer to Section VII of the Toolkit for focused case study presentations.
- Refer to Curriculum Appendix E (Case Study Roster) to select a case for discussion.

MODULE 7: ORGANIZATIONAL SUPPORTS AND SYSTEM TOOLS

<u>Session Goal:</u>	<u>Learning Objectives:</u>	<u>Topic Areas:</u>
Improve Organizational Supports and System Tools	<ul style="list-style-type: none"> • Introduce CPG Statement 10 • Introduce Toolkit Section VIII 	<ul style="list-style-type: none"> • National CLAS Standards • Interpreter Service Arrangements • Quality Improvement Planning and Monitoring • Other Organizational Supports

Overview

While substantial literature focuses on the development of clinical practice guidelines, an area often neglected, yet of critical importance, is adoption of these guidelines into practice settings. Several factors are said to impede the adoption of clinical practice guidelines, including characteristics related to the system environment such as the habits, customs and beliefs of peers, provider background and medical training, legal or financial incentives, regulatory bodies and characteristics of the patient population served (Davis & Taylor-Vaisey, 1997; James, 1995; Weber, 2000). Davis and Taylor-Vaisey (1997) suggest that the creation of clinical practice guidelines without attention to how the system environment or practice setting is going to implement them is an exercise in futility. The successful adoption of clinical practice guidelines not only depends on the culture, knowledge, attitudes, behaviors and resources of the clinicians within the organization, but also requires multi-level strategies that aim to train physicians, change clinician behavior and create an organizational culture that is committed to reducing environmental barriers to guideline use (Davis & Taylor Vaisey, 1997; IOM, 2001a). Adopting cross-cultural clinical practice guidelines requires attention to enhancing system/office features that can support clinicians in modifying practice settings serving culturally diverse populations. The current literature points to specific recommendations in the area of physician training, workforce concordance, interpreter services, patient education materials, data collection and community networking.

I. Improving Organizational Supports

The aim of this session is to identify system factors that can support cross-cultural practice. The minimum topic areas for meeting this learning objective can address:

a) Review of Standards and Policies Related to Reducing Disparities in Healthcare

- National CLAS Standards 1 – 14.
- Additional organizational supports relevant to physician practice (see Section VIII of the Toolkit).

b) Interpreter Service Arrangements

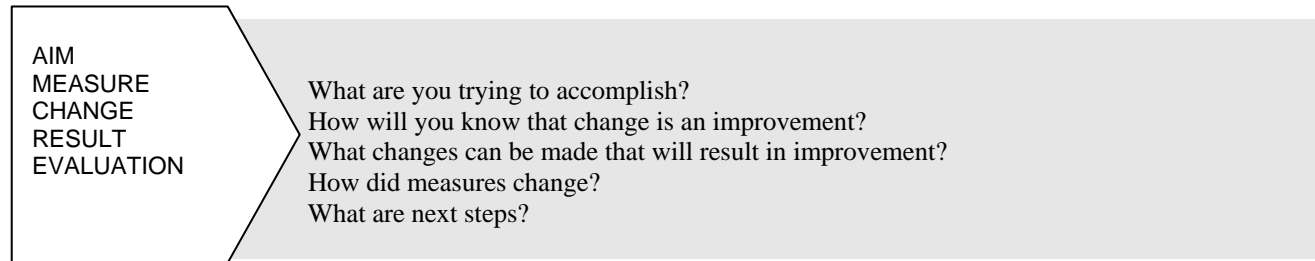
- Title VI Regulations.
- CLAS Standards 4 – 7.

c) Quality Improvement Planning

Quality is culturally defined and rooted in a value system that constitutes a set of cultural rules and expectations. Concepts of quality are first and foremost culturally bound constructs that depend on the rules that are valued within a particular group or society and what is considered quality or competence in one group is not applicable in another (Donabedian, 1988).

Quality improvement models are based on trial and learning approaches to systematically build knowledge and make decisions to improve the problem at hand (Nolan, 1998). They provide an opportunity to test an idea about a change and to

learn what actually leads to improving the systems performance in a process or outcome. Trial and learning approaches are best carried out through small-scale efforts in consecutive test cycles to determine whether they can be implemented on a larger scale or into day-to-day operations. Improvement models use a logical sequence of steps to guide participants through the “test and learn” process by using Plan-Do-Study-Act or PDSA cycles.



The PDSA logic presents the framework to guide the components and steps of the plan to inform that learning process as follows:

1) Project Aim: What are you trying to accomplish?
<ul style="list-style-type: none"> <input type="checkbox"/> Identify a goal relevant to improving an aspect of quality that contributes to reducing disparate outcomes of care in quantifiable terms. <input type="checkbox"/> State how this goal will move you towards improving outcomes of clinical care for a targeted subgroup population. <input type="checkbox"/> Specify what data sources were used to both identify and decide on this QIP goal as a priority.
2) Baseline Measures: How will you know that change is an improvement?
<ul style="list-style-type: none"> <input type="checkbox"/> Identify existing clinical data stratified by race, ethnicity and language (ex: diabetes, asthma, maternity process indicators, patient satisfaction, interpreter services, etc.) reported to Medicaid or other insurers. <input type="checkbox"/> Identify the baseline measures that will tell you that improvement is actually taking place. <input type="checkbox"/> Set numeric goals for improving that baseline measure as (or when) it becomes available.
3) Changes: What intervention can be made that will result in improvement?
<ul style="list-style-type: none"> <input type="checkbox"/> Identify root causes underlying the problem/area you are trying to improve. (Why is it a problem, what processes are involved, what systems underlie those processes?) <input type="checkbox"/> Describe proposed change you have chosen to test/implement. Clarify how this intervention will assist in meeting your goal.
4) Results: How did measures change?
<ul style="list-style-type: none"> <input type="checkbox"/> Describe what data and measures relevant to the aim will be analyzed. <input type="checkbox"/> How do you plan to communicate your findings (ex: in graphs, charts, tables, etc.)? <input type="checkbox"/> Describe data relevant to effects of intervention and measures, including intermediate steps influencing the overall measure and what factors prove how well the intervention works.
5) Evaluation: What next steps can be taken to improve on change made?
<ul style="list-style-type: none"> <input type="checkbox"/> Describe how end results will be used to improve goal attainment. <input type="checkbox"/> State how end results will be used to modify change in process. <input type="checkbox"/> Describe follow-up activities that will be planned for continued improvement (ex: number of test cycles, etc.).

Resources to Facilitate Discussion

- Refer to Curriculum Appendix A: Module 1 Handout (CPG Statement 10).
- Refer to Section VIII of the Toolkit.
- Refer to Appendix G of Toolkit to review CLAS Standards.
- Refer to Toolkit Appendix E for sample QIP plans.
- Refer to Curriculum Appendix E (Case Study Roster) and identify a system process intervention that can enhance clinical care processes for case selected.
- Refer to <http://www.usdoj.gov> to track Executive Order no. 13166, Improving Access to Services for Limited English Speaking Persons.

APPENDIX A: MODULE 1 HANDOUT**Cross-Cultural
Clinical Practice Guideline Statements**

1. Elicit the patient's views on illness and treatment practices to understand his or her health values, particular concerns and expectations for care.
2. Assess the cultural norms, values and customs that influence the patient's health-seeking behaviors, practices and expectations for the physician-patient relationship.
3. Assess the patient's environmental context to determine what social experiences and resources may be affecting illness, behaviors or health-seeking practices.
4. Identify a range of treatment goals for a given medical condition that can be mutually satisfactory and take into account the patient's cultural health beliefs, practices, norms, customs and traditions.
5. Identify the social and environmental factors that may potentially interfere with adherence to treatment goals.
6. Work collaboratively with the patient to negotiate treatment plans that incorporate aspects of the biomedicine while integrating cultural concepts for treating illness familiar and important to the patient.
7. Develop communication skills that are respectful of the patient's cultural norms, values and language to facilitate empathy in the clinical encounter.
8. Utilize patient-education strategies in the clinical encounter that take into consideration literacy, cultural appropriateness and language concordance.
9. Acknowledge that personal, professional and institutional factors can affect aspects of clinical decision-making which, in turn, may lead to disparities in care.
10. Take proactive steps to adapt institutional and system processes aimed at delivering clinically appropriate and culturally responsive care.



APPENDIX B: MODULE 2 HANDOUT

Cultural Dynamics Influencing the Clinical Encounter

American/Western Cultures	Concepts	Non-Western Cultures
<ul style="list-style-type: none"> •Health is the absence of disease. •Disease/illness results from exposure to pathogens, hematological or environmental factors. 	<p>Core Health Beliefs</p>	<ul style="list-style-type: none"> •Health is a state of harmony within body, mind, spirit, family, community & outside world. •Illness results from body imbalances (hot/cold; ying/yang). •Illness results from God’s will or supernatural forces (spirits, deity, etc.) that affect mental and physical function.
<ul style="list-style-type: none"> •Seek medical system to prevent disease & treat illness. •Use physicians, nurses, psychiatrists, surgeons, specialists and select bodyworkers (chiropractors, etc.). •Prevention is practiced to avoid future disease. •Foods used to ensure biological functioning. 	<p>Health- Seeking Practices</p>	<ul style="list-style-type: none"> •Seek medical system when in acute stage of illness. •Use herbalists, midwives, santiguadoras, curanderos, priests, shamans, espiritistas, voodoo priests, etc. •Prevention of disease is not practiced. •Foods used to restore imbalances (hot/cold; ying/yang).
<ul style="list-style-type: none"> •Values individualism: focus on self-reliance & autonomy. •Values independence and freedom. •Values youth over elderly status. •Personal control over environment & destiny. •Future oriented. •Efficiency: time is important; tardiness viewed as impolite. 	<p>Cultural Values, Norms, Customs</p>	<ul style="list-style-type: none"> •Values collectivism: reliance on other & group acceptance. •Values interdependence with family and community. •Values respect for authority and elderly status. •Fate controls environment & destiny. •Present oriented: here and now. •Efficiency: time is flexible; viewed as impolite/insulting.
<ul style="list-style-type: none"> •Greeting on first name basis denotes informality to build rapport. •Being direct avoids miscommunication. •Eye contact signifies respect and attentiveness. •Personal distance denotes professionalism & objectivity. •Gestures have universal meaning. 	<p>Communication Styles</p>	<ul style="list-style-type: none"> •Greeting on first-name basis denotes disrespect. •Being direct denotes conflict. •Eye contact is considered disrespectful. •Close personal space valued to building rapport. •Gestures have taboo meanings depending on cultural subgroups.
<ul style="list-style-type: none"> •Individual interests are valued and encouraged. •Individual is the focus of health care decision-making. •Reliance on nuclear & immediate family bonds. 	<p>Family Dynamics</p>	<ul style="list-style-type: none"> •Individual interests are subordinate to family needs. •Family is the focus of health care decision-making. •Reliance on extended family networks.

References: Harwood (1981), Buchwald (1993), Putsch (1985), Flores (2000) Spector (2000), Leininger and McFarland (2002).

NOTE: This table is an expanded version of the one in Section III of the Toolkit. Clinicians must use caution in learning and applying these categorical characteristics as these can potentially result in stereotypic behavior. Instead these should be viewed as a continuum where they represent the extreme end of the spectrum. They can be used as a basis for further exploration rather than making generalizations about certain cultures fitting to a set of specific unifying characteristics.

APPENDIX C: MODULE 2 HANDOUT

Differences Among Biomedical and Non-Biomedical Techniques

BASIC CONCEPTS	BIOMEDICAL TECHNIQUES	NON-BIOMEDICAL TECHNIQUES	
		Naturalistic (Physical)	Personalistic (Spiritual/Mental)
Views on Origin of Disease	<ul style="list-style-type: none"> Disease is caused by pathogens, biochemical or hematologic changes due to environmental factors (e.g., stress, poor nutrition, injury, aging process). 	<ul style="list-style-type: none"> Illness is caused by impersonal forces (cold, heat, wind, dampness, etc.) or conditions creating imbalances in bodily humors, or disruption of physical function. Bodily imbalances originate from foods, medicines or changes in physical conditions (pregnancy, menses, childbirth), emotions (anger) or environment. 	<ul style="list-style-type: none"> Illness is caused by external agent that may be supernatural (God, deity, etc.), non-human (evil spirit, ancestor) or another human being (witch, sorcerer). The external agent causes disease via theft of soul, or invoking spells that affect mental or physical function.
Focus of Diagnosis	<ul style="list-style-type: none"> To identify pathogen or biochemical process responsible for abnormality. Diagnostic procedure relies on physical exam and laboratory tests. 	<ul style="list-style-type: none"> To identify forces contributing to bodily imbalances. Diagnostic procedure may use taking of pulse, examining tongue or eyes to determine state of internal organs, hot-cold/ying-yang imbalances. 	<ul style="list-style-type: none"> To identify agent behind the act and render it harmless. Diagnosis of physical symptoms is of secondary concern since condition will not improve without addressing primary belief for cause of disease.
Focus of Treatment	<ul style="list-style-type: none"> Destroy or remove entity causing disease or modify/control affected body functions. 	<ul style="list-style-type: none"> Restore equilibrium of physiological function. Treatment may include herbs, food combinations, dietary restrictions, enemas, massage, poultices, acupuncture, cupping, coining and stopping western medication treatments. Prevention includes avoiding mental, environmental and emotional factors that affect equilibrium and balance. 	<ul style="list-style-type: none"> Primary treatment involves a curing ritual to remove object of intrusion (lifting spell, reversing technique). Secondary treatment to address physical symptoms & implement cure done by herbalist. Prevention of illness involves making sure social networks with people, deity or ancestors are in good working order.
Practitioner Types Used	Physicians, nurses, psychiatrists, chemists, surgeons, specialists.	Herbalists, body workers, midwives, Santiguadora, Curanderos, etc.	Priests, Shamans, Espiritistas, sorcerers, voodoo priests, etc.
Practicing Countries	U.S. and European societies.	China (traditional), India (Ayurveda) Greece, Latin America, Caribbean, Phillipines, Pakistan, Malaysia, etc.	Indigenous groups of Americas, African tribes, Asian tribes, Latin American, Caribbean groups (Cuban, Puerto Rican, Haitian, etc.).

References: Loustaunau and Sobo (1997), Harwood (1981), Jackson (1993), Spector (2000).

NOTE: This table is an expanded version of the one in Section IV of the Toolkit. Clinicians must use caution in learning and applying these categorical characteristics as these can potentially result in stereotypic behavior. Instead these should be viewed as a continuum where they represent the extreme end of the spectrum. They can be used as a basis for further exploration rather than making generalizations about certain cultures fitting to a set of specific unifying characteristics.

APPENDIX D: MODULE 3 HANDOUT

Mnemonic Devices to Elicit Patient Views

MNEMONIC	FRAMEWORK	SAMPLE QUESTIONS
ETHNIC E: Explanation T: Treatment H: Healers N: Negotiate I: Intervention C: Collaborate	<u>ELICIT HEALTH VIEWS</u> E: Elicit patient's explanation of the problem. T: Elicit information on treatment practices. H: Elicit information about use of healers. N: Negotiate options. I: Determine Intervention. C: Collaborate with patient.	<ul style="list-style-type: none"> • What do you think may be the reason you have these symptoms? • What do friends, family, others say about these symptoms? • Do you know anyone else who has had this kind of problem? • Have you heard about/read/seen it on TV/radio/newspaper? What concerns you most about your symptoms? • What kinds of medicines, home remedies or other treatments have you tried for this illness or symptoms? • Is there anything you eat, drink, or do on a regular basis to stay healthy? Tell me about it. • What kinds of treatment are you seeking from me? • Have you sought any advice from traditional/folk healers, friends or other people for help with your problems? Tell me about it. • Negotiate options that will be mutually acceptable to you and your patient that do not contradict but incorporate patient's beliefs. • Ask what are the most important results your patient hopes to achieve from this intervention. • Determine an intervention with your patient. May include incorporation of alternative medical remedies, spirituality and healers as well as other cultural practices. • Collaborate with patient, family members and other health care team members, healers and community resources.
LEARN L: Listen E: Explain A: Acknowledge R: Recommend N: Negotiate	<u>ELICIT HEALTH VIEWS</u> L: Listen with sympathy and understanding to patient's perception of the problem. E: Explain your perceptions of the problem. A: Acknowledge and discuss differences and similarities. R: Recommend treatment. N: Negotiate treatment.	<ul style="list-style-type: none"> • Listen with sympathy and understanding to patient's perception of the problem. • What worries you the most? Are you afraid that you may have something serious? What do you think has caused this problem? Have you started any treatment on your own or gotten advice from someone else? • How can I be of the most help to you? • Assess potential circumstances and problems in a person's life that may have an impact on his or her health or health behaviors in the areas of a) control over life b) changes in life c) language and literacy d) support network. Ask: Do you have coverage for your medications? Are there times that are bad for you to come to appointments? Is transportation a problem for you? What brought you here to this city? How does medical care differ here? Do you have any trouble reading medicine bottles or appointment cards? Do you have family and friends that you can call on for help? • Recommend a plan of action with an explanation of your rationale, using language that patient is able to understand. To make sure we understand one another, can you tell me what I just told you? Is there any part you do not understand? Do you have any questions? • Negotiate a plan of action with your patient after you have made your recommendations. Now that we understand each other, let's develop a plan that works for you. What do you think the next steps should be?
BATHE B: Background A: Affect T: Trouble H: Handling E: Empathy	<u>ELICIT PSYCHOSOCIAL CONTEXT</u> B: Elicit information on context of patient's visit. A: Allow patient to report/label his or her current feeling/state/mood. T: Help physician and patient focus and bring out symbolic significance of illness or event. H: Get an assessment of functioning and provide direction for an intervention. E: Legitimize patient's feelings and provide psychological support.	<ul style="list-style-type: none"> • B: What is going on in your life? • A: How do you feel about what is going on? • T: What about the situation troubles you the most? • H: How are you handling that? • E: That must be very difficult for you. (Legitimize the patient's feelings and provide psychological support.)
ADHERE A: Acknowledge D: Discuss H: Handle E: Evaluate R: Recommend E: Empower patient	<u>TREATMENT ADHERENCE</u> A: Acknowledge the need for treatment. D: Discuss potential treatment strategies. H: Handle any questions or concerns. E: Evaluate patient's understanding. R: Recommend and review treatment regimen. E: Empower by engaging patient.	<ul style="list-style-type: none"> • A: Ask about previous treatments used and determine mutual goals. • D: Discuss potential treatment strategies as well as consequences of non-treatment with patient. Consider issues such as treatment effectiveness, prognosis, use of complementary medicines (brand name vs. generic, etc.). • H: Handle any questions or concerns the patient may have about treatment (e.g., side effects, fears or worries, costs, dosage, frequency, timing, sequence, duration of treatment, drug or food interactions, proper storage techniques, etc.). • E: Evaluate the patient's functional health literacy and understanding of treatment, and assess barriers and facilitators to adherence (e.g., environmental, economic, occupational, socio-cultural, family situation and supports). • R: Review and recommend the therapeutic treatment regimen with the patient. • E: Empower by eliciting the patient's commitment and willingness to follow through with treatment regimen.

APPENDIX E: CROSS-CULTURAL CASE STUDY ROSTER

Case Study Vignettes	SOURCE
<p><u>Case Study #1:</u> A 58-year-old Dominican woman has been diagnosed with hypertension. Despite being seen by several physicians who ordered multiple tests to rule out secondary causes, and having tried various medications over the years, her blood pressure has remained poorly controlled. After completing the medical interview, the physician surmises that the patient may not be complying with her regimen. The physician explores the patient's explanatory model. The patient communicates an episodic problem related to tension and stress that requires treatment only as needed.</p>	Carillo et al, 1999
<p><u>Case Study #2:</u> A 34-year-old Egyptian woman accompanied by her husband presents as a new patient to a male physician. A history of menstrual irregularity is elicited, but this problem has been denied and minimized previously. Her husband dominates the conversation by answering all medical history questions for her. When conversation is shifted back to the patient, he states she does not speak English very well. For the PE the husband leaves the room and it becomes clear that the patient is proficient in English. When the patient is asked to disrobe, she becomes noticeably uncomfortable in the presence of a male physician.</p>	Carillo et al, 1999
<p><u>Case Study #3:</u> A 53-year-old African American male from North Carolina presents with a severe cough that gradually worsened over the past year. He noticed some blood-streaked sputum four months ago. He came north with family five years ago and holds down two jobs. He cannot afford to take time off work because of illness as he is sole wage earner for his family and mother-in-law. He has avoided medical attention for fear of a secondary diagnosis that would prevent him from supporting his family in the future. He is also concerned about the possibility of the cost of medications, tests or operations.</p>	Carillo et al, 1999
<p><u>Case Study #4:</u> A 29-year-old Puerto Rican single mother brings her 12-year-old daughter to her (the mother's) first medical appointment. The physician was troubled by the child's interpreting ability and called in a female lab technician who is from Central America. This interpreter summarized the patient's wordy monologue in one brief sentence, saying that patient felt tired and fatigued during sexual intercourse. The physician ordered a complete blood count and thyroid studies and scheduled the patient to return in one month. The patient left the office unrelieved.</p>	Carillo et al, 1999
<p><u>Case Study #5:</u> A 57-year-old African American male who recently moved from Georgia has a history of HTN. He takes the doctor's anti-HTN medication when he gets symptoms (e.g., headaches, feels blood rise, etc.). When he is told his BP is high after the office visit, he experiences emotions (anger, anxiety). In addition, he eats lots of garlic and pickles, rubs his body with Epsom salts and avoids pork and salt. These activities are believed to decrease blood volume and lower blood away from the head so he will not have a stroke. He does this intermittently rather than continuously. He is a devout Christian who turns to faith healing when pressure/stress is extremely high. He is reluctant to tell the doctor of these activities for fear of ridicule. However, he is willing to tell a doctor who seems open to hearing about alternative ways.</p>	Kulhane-Pera, 1999
<p><u>Case Study #6:</u> A 19-year-old Hmong mother brings her 3-year-old son, who has been sick for two days and has a 103.6 fever. The child is quiet and subdued, but not listless. You examine the child and there appears to be no infection. You recommend a septic work-up, including LP and blood cultures. The parent refuses, wanting to take the child home for traditional Hmong treatment first. You then ask questions to elicit beliefs, concerns and desires. The mother thinks the fever may be caused by germs, so she came to the doctor. But the results indicate no infection apparent, so she thinks there could be other reasons (e.g., soul loss, fright, recent change in weather, spirits, etc.) as he had fallen last week. The mother does not want to have multiple blood tests and LP procedures on the child. She had a sister who died in a refugee camp after a lumbar puncture. She decides to take the child home to the grandparents to have them evaluate and treat him with traditional therapies. She believes there is something important that the grandparents can do for the child, although she is not sure what it is. She is willing to return if this approach does not work and the child does not get better.</p>	Kulhane-Pera, 1999

APPENDIX E

<p><u>Case Study #7:</u> A 30-year-old Mexican women who recently arrived from a rural village in Mexico brings in her 10-month-old girl, who has a fever, vomiting, diarrhea, decreased appetite, abdominal bloating and sunken fontanelle. The mother is concerned about the baby and has been using traditional remedies. She recently changed from breastfeeding to formula. Thinking the child is reacting to formula and has empacho, she tried to find a curandero to treat her but was not able to pay for the cost. As the diarrhea continued and the sunken fontanelle occurred, she tried traditional techniques like pushing up on the palate and turning the child upside down with her hair in water, with some success. Now she comes to the doctor and wants medicine. She is familiar with ORT but is reluctant to admit the baby to the hospital due to concerns with her undocumented status and the doctor’s motivations and language. She says she will go home to talk with her family members before consenting.</p>	<p>Kulhane-Pera, 1999</p>
<p><u>Case Study #8:</u> A 42-year-old Ojibwa women from a reservation comes to you presenting with symptoms of RUQ tenderness. You took a medical history and ordered RUQ- ULS and diagnosed cholecystitis and cholelithias. You recommend surgery. She is reluctant to go to hospital as she knows hospital won’t let her perform a traditional healing ritual before/after surgery (burning sage to purify room). She politely declines, avoiding direct eye contact with you and seems hesitant to explain her cultural practices for fear of not being taken seriously. She would like her family members to be present.</p>	<p>Kulhane-Pera, 1999</p>
<p><u>Case Study #9:</u> A 49-year-old African American male resides in the inner city with his extended family. He lives with his 5 children, 2 grandchildren, elderly mother and a sister-in-law. He completed 11th grade and is working more than 40 hours a week in a steel factory with an income that places him at poverty level and leaves him unable to buy health insurance. He was diagnosed with cancer one year ago, which has been making him tired and unable to eat. He is receiving spiritual healing from his pastor for this illness. He comes to your office presenting fatigue and abnormal lab tests.</p>	<p>Purnell, L., 2002</p>
<p><u>Case Study #10:</u> A 71-year-old elderly Black woman, Mrs. Washington, was in the recovery room after surgery. To assess her condition, the nurse spoke her name “Mary.” The patient slowly opened her eyes but made no further sign of acknowledgement. The nurse became concerned, because most patients responded readily and clearly at this point. Shortly afterwards, the nurse called the woman Mrs. Washington. The patient then became alert and cooperative.</p>	<p>Galanti, G., 1997</p>
<p><u>Case Study #11:</u> A female Filipino patient with limited English-speaking ability was explained the harmful effects of medication she needed to take prior to being discharged from the hospital. Her husband served as an interpreter in the process. Throughout the nurse’s explanation, the couple nodded in agreement of understanding and laughed nervously. When the nurse tested them verbally on the information, it was apparent that they understood very little. What had happened?</p>	<p>Galanti, G., 1997</p>
<p><u>Case Study #12:</u> A home health care visit to a 65-year-old Vietnamese LESP female refugee reveals she is living in a two-bedroom apt with 8 other members of her extended family. They had all arrived in the U.S. two years ago and still hold to strong traditional customs. The patient was recently discharged from an acute hospital suffering from lung cancer along with tubercular cavitory lesions in the lungs. She does not speak English and her teen granddaughter acts as an interpreter. The teen has to communicate via her 80-year-old uncle [also NESP], as he is the patriarch of the family and an important figure.</p>	<p>Galanti, G., 1997</p>
<p><u>Case Study #13:</u> A 47-year-old Hispanic male with Dm for two years who is on oral medications comes to the clinic with blurred vision, requesting eye drops. He is an undocumented laborer living with his brother. His wife and children are in Guatemala, caring for sick, aging parents. The patient drinks on weekends to relieve stress. He was hospitalized two years ago with sepsis and Dx with DM, and was given a glucometer and basic DM education. He goes to a local health center periodically to get free samples of Diabeta, but it is difficult for him to go routinely. He knows diabetes is a chronic disease as his mother and aunt also have it, and he is aware of the symptoms of blood sugars. He takes medications when he can, herbal medicines including cactus every morning and goes to church. He feels these treatments help make him feel better. He has had little success controlling his blood sugars and the doctor recommends insulin therapy. The patient is reluctant to try this, as he dislikes needles, is asymptomatic and knows insulin can cause serious problems such as blindness or infection leading to amputation. He refuses the doctor’s recommendations, wanting eye drops and more samples.</p>	<p>Kulhane-Pera, 1999</p>

RECOMMENDED READING (BIBLIOGRAPHY)

- American Institutes for Research. *Teaching cultural competence in health care: A review of current concepts, policies and practices*. Washington, DC: Office of Minority Health, US Department of Health and Human Services; 2002.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association; 2000.
- American Psychological Association. Guidelines for Providers of Psychological Services to Ethnic, Linguistic and Culturally Diverse Populations. *American Psychologist*, 1993;48(1):45-48.
- Andrews R, Elixhauser A. Use of major therapeutic procedures: Are Hispanics treated differently than non-Hispanic Whites? *Ethnicity and Disease* 2000;10:384-394.
- Baker D, Hayes R, Fortier J. Interpreter use and satisfaction with interpersonal aspects of care for Spanish speaking patients. *Medical Care* 1998;36(10):1461-1470.
- Barnard D. Unsung questions of Medical Ethics. *Social Science Medicine* 1985;21(3):243-249.
- Betancourt J, Green A, Carrillo E. Hypertension in multicultural and minority populations: Linking communication to compliance. *Current Hypertension Reports* 1999;1(482-488).
- Blackhall L, Murphy S, Frank G, Michel V, Azen S. Ethnicity and attitudes toward patient autonomy. *Journal of American Medical Association* 1995;274:820-825.
- Botelho RJ. A negotiation model for the doctor-patient relationship. *Family Practice* 1992; 9(2):210-218.
- Buchwald D, Caralis P, Gany F, Hardt E, Muecke M, Putsch R. The Medical interview across cultures. *Patient Care* 1993 (April 15, 1993):141-166.
- Bureau of Primary Care, Health Research Services Administration, US Department of Health and Human Services. (2000). *Evidence Based Health Care Guideline Implementation Study*. Available: www.qmnetwork.org [2000].
- Byrd W, Clayton L. *An American Dilemma, Volume One: A Medical History of African Americans and the Problem of Race: Beginnings to 1900*. New York: Routledge; 2000.
- Byrd W, Clayton L. *An American Dilemma, Volume Two: Race, Medicine and Health Care in the United States 1900-2000*. New York: Routledge; 2002.
- Carrillo E, Green A, Betancourt J. Cross-cultural primary care: A patient-based approach. *Annals of Internal Medicine* 1999;130(10):829-834.
- Collins K, Hughes D, Doty M, Ives B, Edwards J, Tenney K. *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans: Findings from the Commonwealth Fund 2001 Health Care Quality Survey*. The Commonwealth Fund; 2002. Available: www.cmf.org. [2002].
- Culhane-Pera K, Like R, Lebensohn-Chialvo P, Loewe R. Multicultural curricula in family practice residencies. *Family Medicine* 2000;32:167-173.
- Davis D, Taylor-Vaisey A. Translating guidelines into practice: A systematic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines. *Canadian Medical Association Journal* 1997; 57(4):408-416.
- Department of Health and Human Services. *National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report*. Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health. Washington, DC.;2001.
- Donabedian A. The Quality of Care: How can it be Assessed? *JAMA* 1988;240(12):1743-1748.
- Flores G. Culture and the patient-physician relationship: Achieving cultural competency in health care. *Journal of Pediatrics* 2000;136:14-23.
- Flores G, Abreu M, Schwartz I, Hill M. The importance of language and culture in pediatric care: Case studies from the Latino community. *The Journal of Pediatrics* 2000;137(6):842-848.
- Galanti G. *Caring for Patients from Different Cultures. Case Studies from American Hospitals*. 2nd ed. Philadelphia, PA: University of Pennsylvania Press; 1997.
- Giger J, Davidhizer R. Introduction to Transcultural Nursing, *Transcultural Nursing: Assessment and Intervention*, 3rd ed. St. Louis: Mosby, Inc.; 1999:3-19.
- Grueininger U, Duffy D, Goldstein M. Patient Education in the Medical Encounter: How to facilitate learning, behavior change and coping. In: Lipkin M,

BIBLIOGRAPHY

- Putnam S, Lazare A, eds. *The Medical Care Interview. Clinical Care, Education and Research*. New York: Springer-Verlag, 1995:122-133.
- Hardt E. The bilingual interview and medical interpretation. In Lipkin M, Putnam S, Lazare A, eds *The Medical Care Interview. Clinical Care, Education and Research*. New York: Springer-Verlag, 1995: 172-177.
- Harwood A. *Ethnicity and Medical Care*. Cambridge: Harvard University Press; 1981.
- Helman C. *Culture, Illness and Health*. 3rd ed. Boston: Butterworth-Heinemann; 1998.
- Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001a.
- Institute of Medicine. *Health and Behavior. The interplay of biological and societal influences. Committee on Health and Behavior: Research, Practice and Policy*. Board on Neuroscience and Behavioral Health. Washington, DC: National Academy Press; 2001b.
- Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Healthcare. Washington, DC: National Academies Press; 2003.
- Jackson L. Understanding, eliciting, and negotiating clients' multicultural health beliefs. *Nurse Practitioner* 1993;18(4):36-41.
- James B. Implementing Practice Guidelines through Quality Improvement. In Graham N, ed. *Quality in Healthcare: Theory, Application and Evolution*. Maryland: Aspen Publication; 1995.
- Johnson M, Hardt E, Kleinman A. Cultural factors in the medical interview. In Lipkin M, Putnam SM, Lazare A, eds. *The Medical Care Interview. Clinical Care, Education and Research*. New York: Springer-Verlag; 1995: 172-177.
- Kaiser Family Foundation. *Key Facts: Race, Ethnicity & Medical Care*. California: The Henry J. Kaiser Family Foundation; 2003.
- Kaiser Family Foundation. *National Survey of Physicians Part 1: Doctors on Disparities in Health Care*. The Henry J. Kaiser Family Foundation; 2002. Available: www.kff.org. [2002].
- Keppel K, Pearcy J, Wagener D. *Trends in Racial and Ethnic Specific Rates for health status indicators: United States 1990-98*. Healthy People Statistical Notes 2002:23.
- Kleinman A, Eisenberg L, Good B. Culture, illness, and care: Clinical lessons from Anthropologic and cross-cultural research. *Annals of Internal Medicine* 1978;88:215-258.
- Komaromy M, Grumbach K, Drake M, Vranzian K, Luries N, Keane D, Bindman A. The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations. *New England Journal of Medicine* 1996;334(20):1305-1310.
- Kudzma EC. Culturally competent drug administration. *American Journal of Nursing* 1999;99(8):46-51.
- Kulhane-Pera K. Cross-Cultural Medicine curriculum. Pilot Program Draft; 1999.
- Langer N. Culturally competent professionals in therapeutic alliances enhance patient compliance. *Journal of Health Care for the Poor and Underserved* 1999;10(1):19-21.
- Lazare A, Putnam S, Lipkin M. Three Functions of the Medical Interview. In: Lipkin M, Putnam SM, Lazare A, eds. *The Medical Care Interview. Clinical Care, Education and Research*. New York: Springer-Verlag; 1995:3-19.
- Leininger M, McFarland M. *Transcultural Nursing: Concepts, Theories, Research and Practice*. 3rd ed. New York: McGraw-Hill; 2002.
- Like R, Steiner P, Rubel A. Recommended core curriculum guidelines on culturally sensitive and competent health care. *Family Medicine* 1996;28(4):291-297.
- Lillie-Blanton M, Brodie M, Rowland D, Altman D. Race, Ethnicity, and the health care system: Public perceptions and Experiences. *Medical Research and Review* 2000;57(supplement 1):218-235.
- Lillie-Blanton M, Correa A. *In the Nation's Interest: Equity in Access to Health Care. Summary Report*. Washington, DC: Joint Center for Political and Economic Studies; 1995.
- Lonner T. *Constructing the Middle Ground: Cultural Competence in Medicaid Managed Care*. Seattle: The Cross Cultural Health Care Program; 2000.
- Loustaunau M, Sobo E. *The Cultural Context of Health, Illness, and Medicine*. Westport, CT: Bergin and Garvey; 1997.
- Morales L, Cunningham W, Brown J, Liu H, Hays R. Are Latinos less satisfied with communication by health care providers? *Journal of General Internal Medicine* 1999;14:409-417.
- Moy E, Bartman B. Physician Race and Care of Minority and Medically Indigent Patients. *Journal American Medical Association* 1995;273(19):1515-1520.
- Nolan T. Understanding Medical Systems, *Annals of Internal Medicine* 1998;128(4):293-298.

BIBLIOGRAPHY

- Orr R. Treating Patients from Other Cultures. *American Family Physician* 1996;53(6):2004-2006.
- Pachter LM. Culture and clinical care: Folk illness beliefs and behaviors and their implications for health care delivery. *Journal of the American Medical Association* 1994;271(9):690-694.
- Poss J, Rangel R. Working Effectively with interpreters in primary care setting. *Nurse Practitioner* 1995;20(12):43-47.
- Purnell L. The Purnell model for cultural competence. *Journal of Transcultural Nursing* 2002;13(3):193-196.
- Putsch R. Cross-cultural communication. The special case of interpreters in healthcare. *Journal of American Medical Association* 1985;254(23):3344-3348.
- Quill T. Barriers to Effective Communication. In: Lipkin M, Putnam S, Lazare A, eds. *The Medical Care Interview. Clinical Care, Education and Research*. New York: Springer-Verlag; 1995:110-121.
- Rivadeneira R, Elderkin-Thompson V, Silver R, Waitzen H. Patient centeredness in medical encounters requiring an interpreter. *The American Journal of Medicine* 2000;108:470-474.
- Rosenbaum S, Shin P. *Medicaid Managed Care: Opportunities and Challenges for Minority Americans*. Washington, DC: George Washington University Medical Center for Joint Center for Political and Economic Studies under Kaiser Family Foundation Grant; 1998.
- Round A. *Introduction to clinical reasoning* 2000;(8). Student BMJ. Available: www.studentbmj.com [2002].
- Saha S, Komaromy M, Koepsell T, Bindman A. Patient-Physician racial concordance and perceived quality and use of health care. *Archives of Internal Medicine* 1999;159(19):997-1004.
- Salerno E. Race, culture, and medications. *Journal of Emergency Nursing* 1995;21(6):560-562.
- Schulman K, Berlin J, Harless W, Ferner J, Sistrunk S, Gersh B, Phil D, Dube R, Taleghani C, Burke J, Williams S, Eisenberg J, Escace J. The effect of race and sex on physicians recommendations for cardiac catheterization. *New England Journal of Medicine* 1999;340(8):618-626.
- Scott C. Enhancing patient outcomes through an understanding of intercultural medicine: Guidelines for the practitioner. *Maryland Medical Journal* 1997;46(4):175-180.
- Shapiro J, Lenhan P. Family medicine in a culturally diverse world: A solution-oriented approach to common cross-cultural problems in medical encounters. *Family Medicine* 1996;28(4):250-255.
- Silberman C. Quality Improvement: A patient's perspective. In: Graham N, ed. *Quality in Healthcare: Theory, Application and Evolution*. Maryland: Aspen Publication; 1995: 315-333.
- Spector R. *Cultural Diversity in Health and Illness*. New Jersey: Prentice-Hall; 2000.
- Stewart M, Brown J, Boon H, Galajda J, Meredith L, Sangster M. Evidence on patient-doctor communication. *Cancer Prevention and Control* 1999;3(1):25-30.
- Vermeire EH, van Royen P, Denekens J. Patient adherence to treatment: Three decades of research: A comprehensive review. *Journal of Clinical Pharmacy Therapy* 2001;36(5):331-342.
- Waidmann T, Ragins S. Racial and Ethnic Disparities in Healthcare Access and Utilization: An examination of state variation. *Medical Care Research and Review* 2000;57(Supplement 1):55-84.
- Weber V, Joshi M. Effecting and leading change in health care organizations. *The Joint Commission Journal on Quality Improvement* 2000;26(7):388-399.
- Woloshin S, Bicknell N, Schwartz L, Gany F, Welch H. Language barriers in medicine in the United States. *Journal of American Medical Association* 1995;273(9):724-728.
- Yamey G. *Looking after patients who won't look after themselves* 2000;(8). Student BMJ. Available: www.studentbmj.com [2002].