

PHYSICIAN TOOLKIT AND CURRICULUM

*Resources to Implement
Cross-Cultural Clinical Practice Guidelines
For Medicaid Practitioners*



Prepared by:
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USING THE TOOLKIT

What is the Purpose of this Toolkit?

The objective of this toolkit is to aid providers in practical application of the Cross-Cultural Clinical Practice Guidelines. It introduces the basic fundamentals of cross-cultural practice and offers steps and processes essential to delivering quality care to culturally diverse populations.

Who is the Toolkit Designed for?

This toolkit is tailored for physicians or clinicians who:

- Work in primary-care practice settings that serve culturally diverse Medicaid populations.
- Have participated in some basic cross-cultural training workshop or program.
- Seek to enhance delivery of quality of care across all populations served by their practice.

The Cross-Cultural Clinical Practice Guidelines offer guiding principles that serve as standards for improving the patient-physician interaction during the clinical encounter. The information contained is intended to be adapted over time.

What Does the Content of the Toolkit Contain?

This resource is organized into sections that address information relevant to implementing the clinical guidelines as follows:

- Section I introduces the rationale and the guiding principles underlying cross-cultural practice.
- Section II presents an overview of health disparities, and the link between quality and the clinical encounter.
- Section III presents an overview of cultural dynamics influencing the cross-cultural encounter.
- Section IV offers information for applying methods to enhance clinical assessment processes.
- Section V offers information for applying methods to enhance treatment planning and adherence.
- Section VI offers information for applying methods to enhance patient communication.
- Section VII offers information on factors that can affect decision-making during the cross-cultural encounter.
- Section VIII offers information for improving organizational supports and system tools in practice settings.

Sections I-III provide overview information, Sections IV-VII includes basic action steps that offer specific examples of techniques to select from or build upon over the course of the physician-patient relationship. Each section also provides references to access other materials (in the form of bibliographic reference and web-based resources) that support content that providers are encouraged to explore. The Toolkit is accompanied by a Provider Curriculum that identifies basic session goals, learning objectives and topic focus areas relevant to each section of the Toolkit.

What Does this Toolkit Not Cover?

The toolkit is not intended to be a comprehensive reference on cross-cultural medical practice. It does not cover in-depth discussion of cultural competence or diversity issues. Providers are encouraged to seek additional resources to complement the contents of the Toolkit and Curriculum.

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SECTION I: INTRODUCTION AND RATIONALE

While the United States continues to become a more culturally diverse society, so too, has the demand increased for medical care delivery that is responsive to multicultural populations. It is expected that by the year 2030, approximately 40 percent of the American population will be comprised of racial and ethnic minority groups. Despite significant medical advances made over the past century to improve health outcomes among the overall population, ethnic minority populations have not benefited from such improvements, as evidenced by their dramatically shorter life spans, higher morbidity rates and continued lack of access to quality care.

Cross-Cultural Clinical Guidelines: The Quality Imperative

The Institute of Medicine (IOM) report “*Crossing the Quality Chasm*” identifies patient-centered and equitable care as two of the six core dimensions of quality. These two dimensions emphasize providing care that is respectful of, and responsive to, individual patient values/preferences, and does not vary in quality based on ethnicity, socioeconomic status or geographic location. A more recent IOM report “*Unequal Treatment*,” however, highlights that minorities receive lower quality of care even when controlling for insurance, co-morbidity, education and socioeconomic status. This report notes that the nature of disparities are complex and involve several levels including health system processes, health care professionals and patients.

Current trends point to the use of clinical practice guidelines as one means to improve the quality of patient-care delivery and health outcomes. Yet many guidelines have not focused on issues of patient-centeredness and equity. Consequently, the cross-cultural clinical practice guidelines were developed to assist practitioners in improving the quality of care they deliver to diverse populations.

A key goal of the cross-cultural clinical practice guidelines is to provide guiding principles for improving patient-centered care as a means of reducing disparities in access and health outcomes among diverse populations. The primary objectives are to:

- 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 a doctor-patient relationship based on mutual respect and trust.

The guidelines have been written for primary care practitioners serving racial, ethnic and linguistically diverse Medicaid populations through a variety of outpatient settings. The guidelines are comprised of a set of statements designed to enhance existing physician skill sets for meeting the above stated objectives. The statements were developed through extensive review of the medical literature and in consultation with a team of primary care physicians representing a variety of practice specialties and experienced in delivering care to diverse Medicaid populations. The guidelines place emphasis on directives aimed at influencing practitioner behavior to refine current processes that result in better patient outcomes.

Guiding Principles for Cross-Cultural Clinical Practice Guidelines

The clinical guidelines are comprised of 10 statements that highlight the processes and skill sets necessary for physicians to effectively obtain an adequate medical history, ensure an accurate diagnosis and develop a mutually agreeable treatment plan during the cross-cultural encounter.

The statements are intended to be used as a package to affect the entire spectrum of care including the individual, interpersonal and institutional aspects of patient care. They are as follows:

The 10 Guiding Principles

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 biomedical model 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 during 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 that support clinical practice aimed at delivering clinically appropriate and culturally responsive care.**

The guidelines emphasize promoting skill sets for establishing a doctor-patient relationship based on respect and empathy for cultural and racial diversity as the basis for exchange and engendering trust. In addition, they offer a framework to avoid the pitfalls of stereotyping and generalizing about subgroup beliefs, practices and behaviors. Practitioners must recognize that developing knowledge and skills to deliver patient-centered care to culturally diverse populations is an ongoing developmental process that requires gaining a certain level of awareness, reflecting on current practice and taking actions to continually modify care delivery processes.

The statements are intended to serve as standards to strive towards and are best adapted over time.

Practitioners may choose to customize the guidelines depending on the predominant cultural characteristics of patients served by their practice settings.

An important component of these guidelines require that practitioners have organizational and system supports consistent with national standards for Cultural and Linguistically Appropriate Services (CLAS) in health care settings. The successful adoption of Cross-Cultural Clinical Practice Guidelines not only depends on the knowledge, attitudes, behaviors and resources of the physicians within the organization, but also on creating a practice environment that is committed to reducing barriers to guideline use.

It is recommended that each practice setting provide training and establish interdisciplinary teams to share responsibility in adopting the use of the guidelines. Training can be tailored to the type of patient practice, level of knowledge and experience of physicians within a given setting. Strategies for practical application of these guidelines are addressed throughout the content of this Toolkit. A Provider Curriculum to orient practitioners in implementing these guidelines is included as a companion guide to this Toolkit.

REFERENCES

Department of Health and Human Services. *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in healthcare*. Final Report. Washington, DC: DHHS, Office of Minority Health; 2001.

Eddy D. Guidelines for policy statements: the explicit approach. *Journal American Medical Association* 1990; 263(16):2239-2241.

Evidence Based Health Care Work Group. *Implementing Evidence-Based Health Care*. Recommendations based on Community Health Centers Experiences; 2001. Available: www.qmnetwork.org. [2002].

Farquhar D. Recipes or roadmaps? *Canadian Medical Association Journal* 1997; 157(4):403-404.

Institute of Medicine. *Crossing the Quality Chasm. A New Health System for the 21st Century*. Committee on Healthcare in America; 2001; Washington, DC: National Academy Press.

Institute of Medicine. *Unequal Treatment. Confronting Racial and Ethnic Disparities in healthcare*. Committee on understanding and eliminating racial and ethnic disparities in health care. Washington, DC: National Academy Press.

Lillie-Blanton M, Correa A. *In the Nations Interest: Equity in Access to Health Care*. Summary Report. Washington, DC: Joint Center for Political and Economic Studies; 1995.

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.

SECTION II: OVERVIEW OF HEALTH DISPARITIES

Significant disparities in health status, delivery of health services and outcomes of care continue to persist among racial and ethnic minority populations despite scientific advances in medical technology, health promotion and disease prevention efforts. The nature of disparities is quite complex and has long been embedded in historical, social, political and institutional factors that have evolved over time. This section provides a brief overview of some factors that have bearing on health disparities.

The Link between Disparities and the Clinical Encounter

Ethnic minorities experience a higher incidence and prevalence of chronic health conditions, preventable hospitalizations, and morbidity and mortality rates compared to Whites. Although approaches to addressing disparities has been aimed at changing patient behaviors, emerging studies suggest that disparities may also be linked to physician and institutional behaviors.

- *Heart disease* is known to be higher among Black males than White males and 65% higher for Black females than White females; High blood pressure is nearly 40% higher in Blacks than in Whites. A patient's race and gender have been shown to influence a physician's decision to refer for cardiac catheterization after controlling for socioeconomic status, insurance and clinical symptoms (Schulman et al, 1999).
- *Diabetes* in Black, Hispanic and American Indian communities is 2 to 4 times greater than in White communities. Diabetic nephropathy, kidney failure and liver failure are 3-7 times higher among Blacks, Mexican Americans and American Indians than Whites. Yet Blacks are less likely to be referred for renal transplants and offered optimal treatment less frequently than Whites (Cummings et al, 1995).
- *Cancer* mortality rates are not only higher among Black, Hispanic and Vietnamese Americans but these groups have lower survival rates for specific types of cancers than Whites. Evidence-based studies suggest that differences in how physicians manage cancer based on a patient's race contributes to lapses in optimal cancer care that result in lower survival rates among Blacks (Bach et al, 1999; King and Brunetta, 1999).
- Hispanics are twice as likely as non-Hispanic Whites to receive no pain medication for long bone fractures. Studies suggest that differences in pain management and analgesic use relates to failure on the part of physicians to recognize presence of pain in patients who are culturally different from themselves (Todd et al, 1993).
- Black and Hispanic patients are less likely to receive major therapeutic hospital procedures for a number of conditions. Differential use of diagnostic and therapeutic hospital procedures for Blacks and Hispanics may be due to physician bias of patient race or gender (VanRyn and Burke, 2000).
- Physicians tend to perceive patients of other races more negatively than they perceive White patients. Physicians also tend to perceive patients of low socio-economic status (SES) more negatively than those of upper SES. These socio-demographic characteristics are associated with a physician's assessment of a patient's intelligence, likelihood of risk behaviors and ability to adhere to medical advice (VanRyn and Burke, 2000).
- Ethnic minorities are more likely to use emergency rooms (ER) as their regular or primary source of care. Approximately 6.6% of visits among Whites occurred in the ER compared to 7.8% for African American and 9.6% for Latinos (Harris, Andrews and Elixhauser, 1997).

While these disparities can be explained by various social, cultural, economic and environmental determinants, the IOM Report on “Unequal Treatment” highlights that delivery of quality care remains a product of the relationship between physician, institutional and health care system behaviors.

Patient Experiences with Clinical Encounter Medical Care System

According to national surveys, ethnic minority patients also face difficulties in accessing quality care and communicating with physicians, and report negative experiences with the medical care system (Kaiser Family Foundation, 1999; Collins et al, 2002).

- Blacks (16%) and Hispanics (18%) were most likely to feel they had *been treated with disrespect* (spoken to rudely, talked down to or ignored) during a health care visit and felt this was related to aspects of communication.
- Asians were least likely to feel that their doctor *understood their background and values* and were more likely to report that their doctor looked down on them because of their culture.
- Black, Hispanic and Asian patients reported having more *communication problems* during doctors visits compared to Whites such as not fully understanding their doctor, feeling that their doctor did not listen to them, or having questions but not asking them during the visit.
- One in three Blacks (30%) and 41% of Hispanics report that *complying with treatment plans* would cost too much compared to 24% of Whites and 27% of Asians. Among those who visited a doctor or hospital, 1 in 4 reported ignoring medical advice because they disagreed with the doctor.

As a result of these experiences, ethnic minority groups feel less involved in their health care decisions, report ignoring medical advice because they disagreed with their doctor and are less likely to comply with treatment plans.

Factors Contributing to Disparate Outcomes

Several factors are viewed as contributing to these disparate outcome:

- 1) *Patient level factors* that include differences in cultural health beliefs and practices that may lead to lack of agreement in treatment or care regimens; language barriers; familiarity with U.S. medical system, education or literacy levels; lifestyle behaviors related to dieting, obesity, smoking, physical activity, alcohol intake; and lower socioeconomic status that impose constraints for adapting lifestyle changes, accessing preventive services and in turn seeking care at a chronic stage of disease.
- 2) *Physician level factors* may also include lack of training in cultural competency, stereotyping, prejudice and bias about patient groups that influence decision-making processes about diagnostic procedures or referrals that can affect access to optimal care or patient care management.
- 3) *Organizational systems* deficient in the tools and resources needed to support clinical care processes to diverse populations.

MODULE 7: ORGANIZATIONAL SUPPORTS AND SYSTEM TOOLS

Session Goal:

Improve Organizational Supports and System Tools

Learning Objectives:

Topic Areas:

- 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

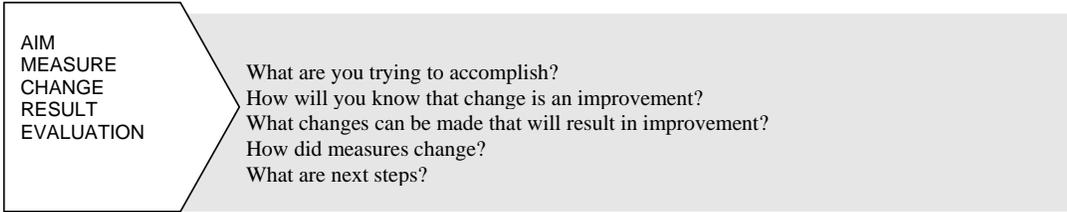
- Title VI Regulations.
- CLAS Standards 4 – 7.

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. 	Core Health Beliefs	<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. 	Health- Seeking Practices	<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. 	Cultural Values, Norms, Customs	<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 rapport. •Being direct avoids miscommunication. •Eye contact signifies respect and attentiveness. •Personal distance denotes professionalism & objectivity. •Gestures have universal meaning. 	Communication Styles	<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. 	Family Dynamics	<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

APPENDIX C

<p>ETHNIC</p> <p>E: Explanation T: Treatment H: Healers N: Negotiate I: Intervention C: Collaborate</p>	<p><u>ELICIT HEALTH VIEWS</u></p> <p>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.</p>	<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.
<p>LEARN</p> <p>L: Listen E: Explain A: Acknowledge R: Recommend N: Negotiate</p>	<p><u>ELICIT HEALTH VIEWS</u></p> <p>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.</p>	<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?
<p>BATHE</p> <p>B: Background A: Affect T: Trouble H: Handling E: Empathy</p>	<p><u>ELICIT PSYCHOSOCIAL CONTEXT</u></p> <p>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.</p>	<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.)
<p>ADHERE</p> <p>A: Acknowledge D: Discuss H: Handle E: Evaluate R: Recommend E: Empower patient</p>	<p><u>TREATMENT ADHERENCE</u></p> <p>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.</p>	<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

<i>Case Study Vignettes</i>	SOURCE
<p>Case Study #1: A 58-year-old Dominican women 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>Case Study #2: A 34-year-old Egyptian women 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>Case Study #3: 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>Case Study #4: 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>Case Study #5: A 57-year-old African American male who recently moved from Georgia has a history of HTN. He takes the doctors 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>Case Study #6: 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

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<p>Case Study #7: A 30-year-old Mexican woman 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>Case Study #8: A 42-year-old Ojibwa woman 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 cholelithiasis. 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>Case Study #9: 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>Case Study #10: 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>Case Study #11: 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>Case Study #12: 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 cavitary 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>Case Study #13: 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.

APPENDIX E

- 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, 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.

APPENDIX E

- 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.
- 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. *Archive 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].

