Travesty of Trust:

A Critical Look at Racial and Ethnic Discrimination in the Healthcare Setting

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Abstract

The purpose of this thesis is to review the overarching purpose of healthcare, examine

race-related disparities in minority patient outcomes within specific fields of medical

practice, and discuss whether these disparities are the result of racial discrimination

within the clinical setting, or are due at least partially to genetic and environmental

factors, followed by an examination of how cross-cultural education for healthcare

professionals can be improved to equip medical personnel with the attitudes, knowledge,

and skills necessary to provide effective care to a culturally diverse patient populace. The

benefits of recruiting a culturally and linguistically diverse team of healthcare providers

are also discussed. Review of literature seems to indicate that poor patient outcomes for

minority groups are due at least in part to forms of discrimination in healthcare provision,

and therefore academic initiatives to implement for current and future medical

practitioners in order to address current racial disparities and discrimination in healthcare

and improve health outcomes for minority patients are also examined.

Travesty of Trust:

A Critical Look at Racial and Ethnic Discrimination in the Healthcare Setting

For thousands of years, physicians and others entering the practice of medicine have received a charge from their teachers and mentors to observe some form of the Hippocratic Oath: to commit to the ethical, honest practice of their art and promise to be ever mindful of their responsibility to practice medicine conscientiously while always acting with the ultimate best interest of the patient in mind (Miles, 2003). While vast increases in medical knowledge and tremendous changes in the development and availability of advanced medical technology have drastically altered the face of modern medicine during the past century alone, the basic principles of the Hippocratic Oath are still as relevant today as they were to the medical students of ancient Greece who solemnly pledged to observe it. Medical practitioners on all levels have a responsibility to their patients to treat each client with respect, compassion, competence, and fairness (Sarrafi & Pakpour, 2012).

However, each man or woman who serves as a member of the healthcare team enters the field of medicine already equipped with a unique, personalized set of values and presuppositions, some of which contribute to the effective practice of medicine, and some of which, unfortunately, hinder effective communication between client and caregiver, contribute to ineffective or unjust provision of care (or lack of provision of care), and lead to poor patient outcomes. A growing body of research indicates that negative ideologies and presuppositions regarding races and cultures, when held by physicians or other members of the healthcare provider team, have the potential to create far-reaching adverse effects in the process of disease treatment and prevention amongst

members of minority racial and ethnic groups (Andrulis, 2003). However, in order to

address the extensive impact of such ideology and prevent ethnically-driven hypocrisy in

the application of the Hippocratic Oath in modern medical practice, healthcare worker

awareness of racial biases and discriminatory thinking must be increased, while focused

educational efforts designed to improve understanding of the economic, societal, and

national health impacts of racial discrimination in healthcare provision should be

carefully implemented to supplement existing measures used within healthcare facilities,

along with the development and incorporation of nation-wide educational initiatives

designed to improve cross-cultural communication between medical personnel and

clients from racial or ethnic minority groups.

Healthcare: Its Purpose

In order to more accurately understand the gravity of the problem of race-related

inequity in the provision of healthcare and more fully grasp the underlying issues

involved in the identification and resolution of this problem, members of the medical

field should perhaps take a moment first to reflect upon both the nature and the

fundamental purpose of healthcare as a scientific practice. According to the World Health

Organization (WHO), as recorded in its first constitution from the early days of the

organization, health may be defined as "a state of complete physical, mental, and social

well-being and not merely the absence of disease or infirmity" (WHO, 1947, p. 1).

Healthcare, therefore, is a system dedicated to preserving, protecting, and furthering the

art and science of preventing and treating disease while simultaneously promoting health

and prolonging life through education, preventive care, and organized provision of

medical treatment and care for those in states of compromised health (Winslow, 1920).

According to the National Health Council (NHC), provision of quality healthcare is based on a partnership relationship between a coordinated, efficient team of healthcare professionals and patients and families who are informed and respected (Frampton, Gilpin, & Charmel, 2003). Effective health care is patient-centered, and involves seven key dimensions: 1) respect for the values, expressed needs, and preferences of the patient, demonstrated by a willingness to empathically view the situation thru the patient's eyes; 2) integrated and coordinated care utilizing a team approach to medicine to give patients needed support within a variety of different care settings and address both prevention and treatment; 3) education, effective communication, and information designed to support both the patient and the provider; 4) consideration for physical comfort, with attention to system and institutional design and a focus on factors such as pain management protocols and hospital accessibility; 5) emotional support and empathic, holistic practice of evidence-based medicine; 6) appropriate involvement of friends and family; and 7) effective transitions between phases of care and well-designed delivery systems to provide continuity in care during hand-offs between providers of care (Bezold, 2005).

Healthcare Goals

Theoretically, the NHC definition of quality healthcare could seamlessly be integrated into current health practice nationwide. However, real-life practice of medicine sometimes involves complex factors which add to the difficulty of defining the specifics of effective medical practice in actual clinical situations. Clearly understood goals and institutional guidelines can help to improve the consistency of availability of excellent healthcare, however, and in order to aid medical personnel in all areas of practice, the

Institute of Medicine defined the following six general guidelines to consider when

providing care:

1. Appropriate healthcare should be safe; medical professionals have an ethical,
   moral, and legal obligation to avoid inflicting unnecessary injury upon patients
   through care that is intended to help.

2. Appropriate healthcare should be effective; medical interventions should be based
   on a scientific knowledge of which patients would be likely to benefit from
   certain interventions, and which patients would most likely not reap any benefit
   from the same procedure.

3. Appropriate healthcare should be patient-centered; medical personnel have a
   responsibility to provide care that respects the individuality, autonomy,
   preferences, values, and needs of the patient, and clinical decisions should be
   guided by the patient's values.

4. Appropriate healthcare should be timely; delays and lengthy wait times can cause
   harm to those receiving care.

5. Appropriate healthcare should be efficient; waste of resources—whether energy,
   supplies, ideas, or equipment—must be avoided wherever possible.

6. Appropriate healthcare should be equitable; every patient has the right to
   approach his medical provider without wondering whether he will receive lower
   quality care because of his gender, socioeconomic status, ethnicity, geographic
   location, or other personal characteristics (National Academy of Sciences, 2000).

In addition to these six aims, health care professionals should also be striving to think

of ways to incorporate preventive health measures into their practice in order to…

Racial Attitudes and Discrimination in the United States

Unfortunately, a growing body of research indicates that for patients from minority ethnic and racial backgrounds, the fear of discrimination from members of the medical community due to phenotypic appearance, cultural background, and socioeconomic status, is a well-grounded concern (Andrulis, 2003). Such discrimination in healthcare is arguably a form of racism. Racism refers to a social system of thinking in which population groups are categorized into races and then ranked preferentially by race, with groups who are viewed as superior receiving a higher percentage of societal resources and goods (Bonilla-Silva, 1996). The concept of *cultural* racism is fundamental to the existence and perpetuation of racism as a belief system, because cultural racism embraces the idea that certain racial groups are inherently or *culturally* superior, which gives rise to social institutions and social norms which support and implement such ideology (Jones, 1997). Within the societal context, racist ideology usually leads to the formation of individually-held negative beliefs and attitudes directed toward racial outsider groups (prejudice), and discrimination occurs when inferior treatment is directed towards members of these outsider groups—both by societal institutions and by individuals within society— as a result of prejudiced ideology. Significantly, due to the fact that racism as an ideology becomes deeply embedded within the institutions and culture of a society, discriminatory behavior often persists thru institutional policies and structures even if individual levels of racial discrimination and prejudice are declining within a society (Williams, 2009).

Terminology

When negative racial stereotypes have become rooted deeply within mainstream culture, this can lead to discriminatory behavior, even from individuals who do not personally embrace racial prejudice. Discrimination, for the purposes of this thesis, refers to differences in level or quality of care resulting from prejudices, stereotypes, and biases in decision-making and clinical communication. Disparities in healthcare refer to differences in the quality of healthcare which cannot be accounted for by differences in access to health or clinical needs or the preferences of the patient. Scientific evidence points to a statistically significant level of racial and ethnic discrimination within multiple contexts of society in the United States, including criminal justice, education, housing, health care, and labor markets (Blank, Dabady, & Citro, 2004; Fix & Struyk, 1993).

While the individuals perpetuating this type of institutional racial bias may be largely unaware of the existence of inequity, those targeted are often times aware of at least a portion of the discriminatory behavior which is directed towards them, and these individualized perceptions of injustice and unfair treatment causes stress (Clark, Anderson, Clark, & Williams, 1999). The role that stress plays in determining health and the role that chronic or acute stress plays when considering social disparities in health amongst various racial and ethnic minority groups are subjects still being studied; more attention will be directed towards this topic at a later point in this paper. For the purpose of this paper, the term racial discrimination includes racial, cultural, and ethnic discrimination. According to the *Encyclopedia of World Poverty*, racial discrimination is "the practice of limiting people's rights and privileges based on their phenotypic appearance," but arguably, cultural differences and ethnic norms, in addition to

phenotypic appearance, cause individuals to become the recipient of discriminatory

behavior as well (Miller, 2006).

Examples from History

In the history of the United States, there are several notable instances of

discriminatory behavior by members of the medical or pharmaceutical community, and

these have contributed to a significant widespread distrust towards the U.S. healthcare

system amongst members of many minority racial groupings. One of the most publicized

and perhaps the most obnoxious examples of racial discrimination in healthcare is the

infamous Tuskegee syphilis study: from 1932 to 1972, U.S. Public Health Service (PHS)

carried out an experiment using 399 African American men who were in the last stages of

syphilis, deliberately allowing the patients to die of the disease so that information could

be gathered about the disease process and its effects on the body. Some of the desired

information would be gathered through autopsy. The men were not informed of the

nature of the study, the specifics of their illness, or the fact that a cure had already been

found for the disease from which they were suffering (Scheidegger, 2009).

Recent research indicates that the Tuskegee syphilis studies have resulted in a rift

in the trust between black patients and white doctors, which continues to negatively

impact patient care, even in the present day (Poythress, Epstein, Stiles, & Edens, 2011).

Patients in the Tuskegee study were deliberately led to believe they were receiving

treatment for their illness, when in fact medical personnel were deliberately withholding

both treatment and information as they gathered data and recorded observations. When

embarrassing details about the study leaked to the press in 1972, 40 years after the study

began, the study was quickly terminated, but not before numerous victims of the study

had died of the disease, while multiple women had needlessly been allowed to contract

syphilis and several children had been born with congenital syphilis, all of which could

have been prevented if penicillin had been administered to male members of the

community at the time the study began (Andrulis, 2003).

　　　　While the healthcare community is still suffering the effects of the damage done

to the credibility of the medical community by the Tuskegee study, the study served to

highlight a need for regulation and establishment of a more well-defined ethical code by

which to practice medicine, and the 1979 Belmont Report, which outlined ethical

guidelines and principles to protect human subjects being used in biomedical or

behavioral research, as well as the establishment of the Office for Human Research

Protections occurred in response to widespread recognition of the problem posed by

previous lack of ethical regulation (Katz et al., 2006).

　　　　Despite implementation of these measures, more recent cases have given black

Americans no less reason to doubt the ethical standards and racial discriminatory

tendencies of those within the healthcare field. Although informed consent is now

required in all studies which use human subjects within the U.S., regulation of studies

performed internationally by U.S. healthcare personnel is not subject to the same degree

of scrutiny.

　　　　In 1996, Pfizer, an American-based pharmaceutical company, sent three doctors

to Kano, Nigeria, to treat children suffering from meningitis with Trovafloxacin

(Trovan), an experimental drug which had never been tested with children and which

caused severe hepatotoxicity and degenerative bone and joint diseases in animals tested

with the drug. After enrolling 200 children in their experiment, the doctors administered

sub-therapeutic doses of Ceftriaxone, a well-established antibiotic treatment for

meningitis, to the children in the control group in order to inflate the relative

effectiveness of Trovafloxacin. After two weeks, the doctors left Nigeria, and the

experiment was ended without follow-up treatment. Ultimately, 11 Nigerian children died

and many others were significantly debilitated by the treatment with Trovan, a fact which

the Pfizer doctors did not report until the parents of the children who had died during the

experiment sued Pfizer in 2002 on the grounds that the experiment had been conducted in

violation of international law, since informed consent was never obtained from the

parents or the children treated (Patterson, 2010).

   While it could be argued that Pfizer's actions have little bearing upon racial

discriminatory tendencies within the U.S. because the subjects of the experiment were not

U.S. citizens, it should be pointed out that those responsible for designing and carrying

out the study were in fact citizens of the United States, and the manner in which Pfizer

chose to carry out their study reflected many of the same gross breaches of medical ethics

reflected in the Tuskegee syphilis study, since study participants were deprived of both

accurate information and appropriate treatment, factors which would have rendered the

study design unethical and therefore impracticable if Pfizer had attempted to carry out

their research within the United States. The message being sent to minority racial groups,

therefore, is that racial discrimination is only unacceptable if the subject has a means of

fighting back or bringing unwanted negative publicity to those responsible for exploiting

minority racial groups in the name of scientific research. Understandably, this is hardly a

reassuring notion to members of minority groups when approaching healthcare

professionals in the United States to seek care, and lack of trust between minority groups

and members of the healthcare team continues to be a significant problem in addressing

the issue of disparities in patient health and treatment outcomes for patients from

minority ethnic categories (Andrulis, 2003).

Racial and Ethnic Disparities: Relationship to Health Status and Healthcare

According to a study done by the National Research Council (NRC), the gap in

health between non-minority and minority Americans has persisted and even increased in

recent years (NRC, 2003). For example, the average life expectancy for African

American men in 1960 was 61 years, while white males at that time were expected to live

67 years; in 1996, the average life expectancy for white males had increased to 74 years,

while African-American males can expect to survive an average of 66 years, and

American-Indian males have a life expectancy of only 55 years (Collins, Hall, &

Neuhaus, 1999).

Potential Confounding Variables

Reasons for the disparities in health between different minority groups and whites

are complex, however, because members of racial and ethnic minority groups often have

an increased number of individual risk factors which increase their likelihood of

developing certain illnesses or conditions. Giving careful consideration to these risk

factors when conducting studies is often confounded by the fact that a disproportionately

high percentage of minority groups are found in the lowest socioeconomic tiers (NRC,

2003). Additionally, socioeconomic position alone has been found to be correlated to

health status, regardless of other individual risk factors: individuals on each tier of the

upward socioeconomic ladder tend to experience better health than those on the tier

behind them, even after health risk factors on the individual levels have already been

accounted for (Kaplan, Everson, & Lynch, 2000).

Additionally, health risks related to environmental factors, such as air, soil, and

water pollution or other physical hazards to health, tend to be more prevalent in

communities that are low-income or house a large number of ethnic minorities.

Therefore, racial and ethnic disparities in health, healthcare, and health outcomes post-

discharge sometimes reflect discrepancies in socioeconomic, behavioral, and social risk

factors or differences in living condition environment rather than some form of racial

discrimination in health care (House & William, 2000). Healthcare reform, therefore, is a

necessary part of addressing ethnic and racial disparities in health, but it is incapable, as

an independent factor, to explain or redress all of the differences in health status which

exist between minority and non-minority groups (Williams, 1999). In order to address

discrepancies in health status more fully, factors such as socioeconomic inequity, poverty

in communities of racial and ethnic minorities, and discrimination in housing and

educational options, as well as behavioral risk factors on the individual level and

differences in access to healthcare and use of services would all have to be thoroughly

explored and addressed (Williams, 1999).

Why do Racial and Ethnic Disparities in Healthcare Matter?

As stated above, it would be incorrect to assume that all disparities in healthcare

status between non-minority and minority patients result directly from racial

discrimination in healthcare. Such is not the case. However, it would likewise be

incorrect to assume that none of the differences in health outcomes for minority vs. non-

minority patients are correlated to racial discrimination in the practice of healthcare. In

truth, medical personnel have been placed in an awkward position between two goals,

which sometimes appear to be in conflict: on one hand they face the societal expectation

to follow strict ethical standards in providing service and to provide care with

compassion and fairness. On the other hand, medical staff also face the responsibility of

managing a limited supply of vital healthcare resources, and at times, decisions made in

treatment of patients may result in certain individuals receiving a larger portion of those

resources than others, which has the potential to cause healthcare to be unequally

distributed across various ethnic groups (NRC, 2003).

     All of this occurs within the larger modern context of increasing bureaucratic and

financial pressure on the healthcare profession as a whole, which could serve to worsen

the problem of racial discrimination in allocation of healthcare resources (NRC, 2003).

However, public confidence in health professionals could be irreparably damaged if the

healthcare industry begins to engage, even unintentionally, in social triaging—

determining eligibility for care based upon one's ethnic background. Trust is already a

fragile commodity between the healthcare community and many racial and ethnic

minority groups, although history would indicate that this is not without reason, as stated

above. This lack of trust becomes a significant issue, however, for the fact that it

decreases minority patients' willingness to seek medical attention or adhere to treatment

plans following discharge, which leads to increased rates of complications and higher

national medical costs for readmission of non-compliant patients who experience relapse

or worsening of their condition (Andrulis, 2003).

     When considered from a public health standpoint, racial and ethnic discrimination

in healthcare often gives rise to significant levels of mistrust and fear of medical

personnel for members of minority groups, which decreases patient compliance with

prescribed treatment regimens and impedes progress towards national health goals (NRC,

2003). The United States is increasingly composed of an ethnically diverse group of

individuals—a trend which is expected to increase exponentially by the year 2050—and

therefore the issue of providing effective healthcare to minority patients is one which the

healthcare field cannot afford to ignore or refuse to address (U.S. Bureau of the Census,

2010). As noted earlier, ethnic minority groups tend to experience poorer health overall,

with decreased access to care as compared to white Americans, and as a result, the

burden of infection and chronic illness experienced by members of minority ethnic

groups is disproportionately high. However, this has serious implications for all

inhabitants of the United States, since a less healthy nation results in higher national costs

for health care and rehabilitation efforts. In light of this reality, the federal *Healthy*

People 2020 initiative implemented an overarching goal of achieving health equity while

eliminating health disparities between racial groups and improving the health of people

from every ethnicity (U.S. Department of Health and Human Services, 2012).

Evidence of Healthcare Disparities

The following literature review summarizes several articles taken from peer-

reviewed journals published during the past 25 years. When selecting articles for review,

studies were selected based on whether or not they were designed to measure ethnic and

racial variation in provision of healthcare while also controlling for confounding

variables such as access to care (by studying patients with the same insurance status or

adjusting for differences in socioeconomic and insurance status). Studies included were

not limited to those with positive indications of ethnic and racial biases in care, and

studies conducted to assess differences in care according to the patient's geographic

region and socioeconomic status were included if racial or ethnic disparities in care were

assessed and access-related factors were controlled for. Review focused most heavily on

articles which attempted to control for potential confounding variables such as stage of

illness at time of treatment, patient preferences regarding procedure or treatment types,

setting in which care was received, procedure availability, intervention suitability, and

racial or ethnic variations in the severity of a disease.

Cardiac Care

Strong evidence of ethnic and racial disparities in provision of healthcare is most

consistently discovered in studies which document cardiovascular care to ethnic minority

groups. In a review carried out in 2000 by the Institute of Medicine's Committee on

Quality Care, 100 studies done on cardiovascular care to minority patients were

examined, and it was discovered that the bulk of the studies demonstrated statistically

significant disparities in provision of cardiovascular care to racial and ethnic minorities,

even after potentially confounding variables such as access to care, disease severity,

geographic location of care, type of care setting, comorbidities, rates of refusal, and

disease prevalence had been adjusted for (NAS, 2000). Two other major review articles

reached the same conclusion in their own review of literature (Kressin & Petersen, 2001;

Mayberry, Mili, & Ofili, 2000). Studies under review frequently did not specify factors

such as disease severity, existence of co-morbid conditions, or illness stage at detection,

and many also failed to document whether the patient had refused clinical procedures

recommended by physicians; this lack of information serves as a limitation when

interpreting the results of the data reviewed. However, trends in findings became apparent.

For example, in a study performed in 1989 on 4 million patients admitted for myocardial infarction, black men and women were found to undergo coronary artery bypass graft surgery (CABG) much less frequently than white patients, while studies done by McBean et al. and Gornick et al. on Medicare patients found that black individuals were only half as likely to receive cardiovascular procedures as white individuals (Ford et al., 1989; McBean et al., 1994; Gornick et al., 1996). Meanwhile, Allison et al. analyzed data from 4,052 Alabama patients in the acute care setting who were discharged with a diagnosis of anterior myocardial infarction (AMI), and after adjusting for differences in gender, age, illness severity, clinical factors, and characteristics of the hospital, results indicated that thrombolytics were 50% more likely to be administered to white patients than black patients (Allison et al., 1996).

Studies conducted in Veterans Administration (VA) hospitals resulted in mixed findings: Mickelson, Blum, and Geraci (1997) reported no significant discrepancies between minority Hispanic patients and white patients when analyzing rates of administration of cardiovascular procedures after AMI, but several other studies found that black patients at VA hospitals received cardiovascular procedures less frequently, or were offered to white VA patients more frequently than black patients (Peterson et al, 1994; Whittle et al., 1993; Sedlis et al., 1997).

Breast Cancer

Racial disparities or discrimination in the administration of breast cancer treatment cannot be as easily tracked, partially due to the fact that amongst cancer

patients, variations in the degree of disease progression are seldom controlled for and co-morbid factors are less frequently taken into consideration than with cardiac patients. Also, research indicates breast cancer has usually reached more advanced stages prior to diagnosis in minority patients, which further complicates attempts to evaluate differences in the quality of treatment provided to minority and non-minority patients (NRC, 2003).

However, in a 1989 study of 7,781 breast cancer patients receiving treatment in 107 different hospitals, evidence indicated that black women received prognostic testing in the form of progesterone receptor assays less frequently than white patients, did not receive radiation therapy as often following performance of a radical or modified mastectomy, and were significantly less likely to be given supportive rehabilitation following breast removal (Diehr et al., 1989). A second study assessing race-related differences in breast cancer survival rates among 246 white and non-white women who had been treated for breast cancer at three health maintenance organizations showed that black women did not survive as long on average after treatment and white women were more likely to survive than blacks—30% of the black patients died vs. 18% of white patients, while white women averaged 2.77 years of life after treatment, compared to 1.63 years for black women (Howard, Penchansky, & Brown, 1998). However, the same study found no significant racial discrepancies in disease stage at diagnosis, health services used prior to breast cancer diagnosis, or giving of breast examinations.

Asthma

Statistically, African American individuals have higher morbidity and mortality from asthma than white people, although whether this is due to genetic predisposition and biological factors or environmental risks related to living in urban communities with

higher levels of air pollution is not entirely clear (NRC, 2003). Cultural, as well as

socioeconomic factors, play into the management of asthma as a disease process. Studies

show that black patients typically have more emergency room visits related to asthma

exacerbations than their white counterparts, and they are more likely to treat asthma with

inhaled bronchodilators rather than inhaled corticosteroids for long-term maintenance,

indicating that asthma management for the African American population is focused more

on controlling acute symptom flare-ups rather than attempting to manage chronic

inflammation of the airway through use of corticosteroids (Zoratti et al., 1998).

Black asthma patients were also more likely to be hospitalized with greater

frequency for asthma exacerbations and were less likely to seek treatment from an asthma

specialist (Zoratti et al., 1998). Ineffective management of asthma by the African

American community may result partially from a lack of adequate patient understanding

of proper disease management and partially from inadequate monitoring by physicians.

Cultural differences in understanding and priorities may contribute to racial disparities in

asthma outcomes as well: a survey of black patients brought to the emergency department

for treatment of acute asthma exacerbations revealed that despite having reasonably good

access to health care (50% belonged to an HMO, while more than half lived within 10

minutes from a healthcare provider, and 70% reported that they had a regular personal

doctor who treated their asthma), most of the patients had asthma that was poorly

managed (Blixen et al., 1997). It is unclear, however, whether the historical mistrust of

members of the healthcare field by those within the African American community might

contribute to lower rates of asthma specialist utilization.

Diabetes

Mortality and burden of illness due to diabetes is 50-100% higher for Native Americans, Hispanics, and blacks than for white patients within the United States, but minority patients appear to do a poorer job of managing their illness, which may account for some of these differences (NRC, 2003). Results from a study of close to 1,400 diabetic Medicare patients indicated that, after accounting for age, education level, and gender, black patients were still more likely to forego glycosylated hemoglobin testing, ophthalmologic visits, lipid testing, and vaccines for influenza than were their white counterparts (Chin, Zhang, & Merrell, 1998). Similarly, the same study indicated that black patients were more likely to visit the emergency department with diabetes-related complications, and they typically had fewer visits to a regular physician for preventive and maintenance care. African Americans also more frequently suffer from the microvascular complications of diabetes, such as end-stage renal disease (ESRD) and amputation of the lower extremities secondary to circulatory insufficiency, although it is unclear whether the higher incidence of lower limb amputations is due to a greater genetic predisposition to diabetes, poor management of the disease process, cultural indifference to disease management at its earliest stages, or negligence or discrimination by the healthcare system itself (Lavery, van Houtum, Ashry, Armstrong, & Pugh, 1999). However, no significant ethnic or racial disparities existed when considering the number of visits to healthcare specialists with relation to diabetic complications, or concerning hypertension screening procedures, foot problems, or diabetic retinopathy (Cowie & Harris, 1997).

Drug Therapy and Pain Management

Underuse of pain medication for minority patients has been documented both in the out-patient and the in-patient settings, as in the 1993 study by Todd, Samaroo, and Hoffman, which found that Hispanic patients admitted to the UCLA emergency department were only half as likely as their white counterparts to receive pain medication, even after other factors such as injury type and physician characteristics had been controlled for. A follow-up study conducted years later revealed that African American patients admitted to the emergency department with long-bone fractures were also less likely than their white counterparts to receive medication for pain (Todd, Deaton, D'Adamo, & Goe, 2000). More recent studies confirm this finding, as a literary meta-analysis conducted in 2012 indicated that blacks, as an ethnic minority group, continue to be routinely under-medicated when receiving analgesic therapy, as compared to their white counterparts (Meghani, Byun, & Gallagher, 2012). However, results are inconsistent when it comes to management of pain across ethnic and racial lines, because another study indicated that post-operatively, black patients received more narcotics for pain management than either Asians or Hispanic patients (Ng, Dimsdale, Rollnik, & Shapiro, 1996).

Additional research in the area of pharmacotherapy and ethnic variations indicates that differences in pharmacotherapy related to racial background exist across several drug classifications, however. In the treatment of dyslipidemia, black men and women were significantly less likely to receive lipid-lowering drugs, while African Americans were also significantly less likely to be prescribed a β-blocker for long-term management of hypertension (Hall-Lipsy & Chisholm-Burns, 2010). The same study indicated black

women with ovarian cancer often experienced a delay before the initiation of

chemotherapy treatments, as compared to their white counterparts—a delay which

increased overall mortality for black women by up to 13%.

Birth Outcomes

Racial discrimination within a society is a significant source of stress for those on

the recipient end. Studies have shown that stress accelerates the cellular aging process,

while chronic stress from multiple repeated environmental assaults causes wear and tear

to the human body which can eventually lead to dysregulation of its biological systems,

leading to chronic illness and premature mortality (Epel et al., 2006; Seeman et al.,

2004). Infant mortality rates for black babies in the Unites States within the first year of

life are double the infant mortality rates of white children—a statistic which has been

linked, at least in part, to the fact that African American women deliver premature, very

low birth weight babies three times more often than white women (Collins, David,

Handler, Wall, & Andes, 2004). While it is difficult to prove direct correlations, it has

been hypothesized that regular exposure to race-related stress and discrimination could

lead to experience of chronic stress, which can lead to development of hypertension, both

of which contribute to low birth weight babies and premature delivery, which in turn has

the potential to greatly increase infant mortality (Collins, David, Handler, Wall, & Andes,

2004).

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Assessing Potential Sources of Disparities in Care

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When approaching the concept of healthcare, optimal outcomes require the

successful integration of two separate points of view: each patient enters the healthcare

setting with a uniquely individualized, culturally determined and socially influenced set

of expectations, needs, and preferences, while care providers likewise bring an

individualized set of culturally defined expectations and beliefs, many of which have

been created or shaped by experience and professional training. The intervolving of these

two viewpoints, as the caretaker endeavors to understand the patient's unique

perspective, is necessary for the creation of a strong physician-client relationship within

which change can be facilitated (NRC, 2003).

Throughout the process of caring for each patient, however, the caretaker reserves

his right to exercise personal discretion in determining what kind of care each individual

needs and ought to receive, since multiple diagnostic and treatment options are typically

available. Lack of a generalized professional consensus regarding optimal treatments for

certain disease processes, variations in clinical practice, and the subjectivity of personal

judgment in the clinical setting are variables which lend themselves to possible racial

discrimination in healthcare, although these variables do not, in and of themselves,

produce disparities in care. However, multiple possible sources of disparity in healthcare

exist at the patient level as well as the physician level, since members of ethnic minority

groups may perceive and experience disease very differently than non-minority

individuals (NRC, 2003).

Possible Sources of Disparity at the Patient Level

For most patients, the type and level of care sought and received is shaped by the

values, expectations, hopes, and fears of the patient. In addition to differences in

perceptions of treatment goals, a significant percentage of minority patients also

experience doubt about the effectiveness of prescribed treatment and are therefore not as

willing to accept recommendations from their physician or other healthcare personnel

(NRC, 2003). This reluctance on the part of the patient to accept caregiver

recommendations may result in disparities in healthcare, but the ultimate cause for this

refusal in care may be rooted in the fact that many racial and ethnic minority groups have

a deep-seated mistrust of members of the medical community which springs from historic

examples of racial discrimination and personal experience of inferior care for minorities

(Byrd & Clayton, 2001).

  Patient preference vs. physician discrimination. Bloche (2001) points out that

the legacy of doubt regarding the trustworthiness of members of the healthcare

community springs from historical instances, such as the Tuskegee study, and continues

to cause racial disparities in healthcare today by serving as a deterrent that keeps black

Americans from seeking or agreeing to medical attention on a regular basis and thus

perpetuates the negative health impact of past racism. Additionally, minority patients

who have personally or vicariously had negative experiences with healthcare providers

that have demonstrated little empathy for minority patients during encounters in the

clinical setting are significantly less likely to prefer vigorous therapy or robust diagnostic

procedures, tending instead towards a minimalistic approach to healthcare (Bloche,

2001). While this may appear to be a difference in patient preferences, it is in fact a

noticeable response to a subtle form of racism exercised within the clinical setting (NRC,

2003).

  Mistrust and refusal of care. Health care behaviors and decisions are influenced

by multiple factors, such as culture, environment, resource availability, educational level,

and socioeconomic status; however, the decision regarding whether or not to seek health

care in the clinical setting has a large psychological component as well, because

utilization of health care is heavily determined by factors such as the individual's

interpretation of his symptoms, his beliefs about the severity or degree of his disease, and

the benefits of seeking treatment (Bogart, 2001). For example, according to the theory of

reasoned action, attitudes and perceived norms play a central role in determining health

seeking behavior (Ajzen & Fishbein, 1980), while the health belief model introduces the

idea that anticipated benefits and barriers often serve as the determining factor in

behavioral changes or continued maintenance of the status quo (Janz & Becker, 1984),

and self-efficacy theory emphasizes the importance of the patient's belief in his ability to

perform a given behavior (Bandura, 1997).

However, at its core, health seeking behavior, especially in the clinical setting,

reflects not only the patient's desire to benefit from seeking treatment, but also his

decision to engage in a social interaction with a member of the health care community

(Ditto & Hilton, 1990). One cannot examine other factors relating to healthcare provision

without also giving consideration to the potential impact this social component of the

physician-client relationship plays in determining health outcomes, because if a patient

believes his disease condition has reached a critical point, anticipates the benefits of

receiving treatment outweigh the benefits of continuing without it, but believes that

seeking help might subject him to the condescension of a physician who refuses to

sincerely endeavor to understand his problem or limits the patient's treatment options due

to his ethnic identity, then the patient may refuse to seek help until the disease has

reached a more critical stage, at which point the disease may have progressed to an

intractable level (Hobson, 2001).

Within the African American community in particular, prior research indicates that perceived racial favoritism or cultural myopia in the attitudes and communication styles of health care professionals leads to fewer visits to physicians as well as increased levels of patient dissatisfaction with health care (Blendon, Aiken, Freeman, & Cory, 1989; Gornick et al., 1996). Fewer physician visits and negative expectations concerning health care experiences or personal interactions with physicians and other medical personnel, however, often results in patients choosing to delay seeking health care until their condition becomes severe enough to impede function; once a disease has reached this point, treatment requires a substantially greater numbers of medical resources than would have been required if the patient had presented to the physician earlier in the disease process with a minor medical complaint. Additionally, negative expectation and apprehension regarding members of the health care community is not conducive to the development of an effective, therapeutic relationship between the patient and health care professional, and if therapeutic communication has not been established, patients are significantly less likely to implement recommended treatments, interventions, or behavioral changes. Outright refusal of treatment may also result if patients feel ignored, slighted, or disrespected due to their racial or cultural identity (Garcia & Duckett, 2009).

Language barrier. For members of many minority racial populations, obtaining medical care is further complicated by the existence of a language barrier. Within the United States, the Spanish-speaking population is one of the fastest-growing demographics, with trends predicting that Latinos will comprise 25% of the U.S. population by 2050 (Garcia & Duckett, 2009). Unfortunately, employee demographics within healthcare have not kept pace with national demographic trends, and many

healthcare facilities do not offer consistent access to Spanish-speaking healthcare workers

capable of facilitating in the provision of culturally-competent medical care (Garcia &

Duckett, 2009). Spanish-speaking clients who were interviewed about their own

experiences within the U.S. healthcare system following discharge reported that simple

aspects of accessing health care, such as scheduling appointments via telephone, speaking

with physicians or other medical personnel during office visits, or planning for discharge

and follow-up care were often difficult, frustrating, and overwhelming due to the

complexity of the health care system as a whole and the lack of medical personnel who

spoke Spanish and understood their culture (Garcia & Duckett, 2009). This frustration

frequently led to decreased compliance with physician recommendations, fewer follow-

up visits, and increased rates of complications secondary to treatment non-compliance

(Garcia & Duckett, 2009).

   Biological and genetic differences. Race-specific differences in response to

pharmacological treatment, possibly related to differences in genetic makeup, race-

related alterations in disease pathogenesis, or disparities in environmental factors, such as

exercise and dietary habits, may contraindicate implementation of the same therapeutic

interventions or drug therapies for minority vs. non-minority patients. For example, black

patients suffering from left ventricular dysfunction were significantly less likely to

experience beneficial results from enalapril, as compared to white patients treated with

the same angiotensin-converting-enzyme inhibitor in a study done in 2001; in this study,

white patients experienced a 44% decrease in heart-failure related hospitalizations

following treatment, while black patients experienced no notable risk reduction (Exner,

Dries, Domanski, & Cohn, 2001). While further research needs to be done in order to

determine racial differences when responding to pharmacologic treatments, it should also be noted that a great number of therapeutic courses have proved to be beneficial for minority patients as well as non-minority clients (NRC, 2003).

However, a higher percentage of disabling and chronic illnesses exist within certain minority groups statistically, perhaps as a result of genetic and environmental factors. Nationally, morbidity and mortality are highest amongst black Americans (roughly 1.6 times that of white patients), which mirrors the ratio from 1950 (William & Rucker, 2000). Mortality and morbidity statistics in part reflect the increased burden of disease that certain ethnic groups experience related to particular causes of mortality. African Americans, Alaskan natives, American Indians, and Hispanics are all disproportionately affected by diabetes; likewise, rates of rectal and colon cancers are highest in Alaskan natives of all ethnic groups within the United States, and Americans from Korean background experience stomach cancer at higher rates than any other ethnic group (Institute of Medicine, 1999).

Possible Sources of Disparity at the Clinical Encounter Level

Organization of the healthcare system. Certain aspects of the healthcare system are very complex, and at times, the manner in which the facility providing care is organized, with relation to financing and accessibility of services, makes it difficult for minority patients, who may face limited language proficiency or an inability to read English, to obtain care. In addition, the time pressure under which physicians routinely operate may hinder accurate client assessments and increase communication barriers already present due to cultural and language differences between physicians and minority patients (NRC, 2003).

While finances and accessing basic care can pose difficulties for minority patients, the situation becomes more complex when referrals are made to seek specialized medical attention. Access to specialty care in the medical field often involves a significant number of steps in order to maneuver through the different levels of bureaucracy commonly found in hospital administration, and, for many ethnic minority groups, this is an overwhelming challenge which they are unable to accomplish, choosing rather to forego specialized treatment (NRC, 2003).

Physician/patient racial concordance. Because health care is a holistic experience which integrates cultural background, societal norms, styles of communication, and social concepts of illness and health, many minority patients in recent studies have indicated their level of satisfaction with the care received in healthcare settings is higher when care is received from a physician or healthcare worker who shares their nationality and culture. For example, African American patients who received care from an African American healthcare professional more frequently rated their visit and their physician as having been excellent, and they were more likely to feel they had been treated with respect, that medical issues had been thoroughly explained, that concerns had been carefully heard, and that care was accessible to them (Saha, Komaromy, Koepsell, & Bindman, 1999). Hispanic patients were less likely to rate their Hispanic physicians as excellent, but satisfaction with overall care increased when patient-physician concordance was incorporated into care (Cooper-Patrick et al., 1999).

Ratings of interpersonal care also varied according to patient-physician racial concordance. African American patients seen in primary care settings rated their visits with white physicians as much less participatory when compared to white patients after

other factors, such as gender and educational status, had been adjusted for, while black

patients who interacted with race-concordant physicians were likely to report

significantly greater levels of participation (Cooper-Patrick et al., 1999). Greater levels of

participation and higher rates of patient satisfaction were positively correlated with

increased patient compliance in following prescribed treatment regimens, with increased

participation and adherence in making treatment decisions, and higher utilization of

preventive care (NRC, 2003).

Need for Cross-Cultural Education

As the racial demographics of the United States population has changed, so also

has the need for educational initiatives which reflect these changes. In order for the

healthcare field to remain financially stable while still meeting the needs of its diverse

patient population in an ethical and effective manner, members of the health provider

community need to join with other sectors of society, many of whom are responding

proactively to shifts in racial demographics by seeking to improve their understanding of

minority cultures in order to improve communication and service to these groups and

form partnerships. The challenges posed by the necessity of dealing with an increasingly

diverse patient population will not simply resolve themselves or diminish in the future,

and in order to adapt, clinicians need to be equipped to understand and graciously work

with variations in the ways which certain minority groups recognize symptoms,

differences in the threshold at which they will seek care, disparities in level of ability to

communicate disease symptoms, variations in certain minority patients' ability to

comprehend the management strategy of healthcare facilities and the expectations of care,

and differences in sources of motivation for adherence to preventive and curative

measures prescribed by caregivers (Flores, 2000).

Lack of proper cultural understanding in provision of care contributes

significantly to racial and ethnic discrimination in healthcare, because differences in

social norms, cultural understanding, and societal expectations all differ significantly, and

each of these factors heavily impacts communication and influences decision-making in

the clinical setting. Additionally, communication between provider and client is a key

aspect of the healthcare exchange which largely determines patient satisfaction, which in

turn influences patient adherence to treatment regimens, which ultimately determines

health outcomes (Stewart et al., 1999). Therefore, cross-cultural education and

discovering effective ways in which to bridge the barriers currently posed by differences

in cultural understandings and perceptions of healthcare is perhaps one of the most

pressing needs within the healthcare field at this time, as a growing body of research

indicates that sociocultural differences, if unexplored, misunderstood, unappreciated, and

not communicated during clinical encounters, results in high rates of patient

dissatisfaction, which leads to poor adherence to treatment regimens, worse health

outcomes, and the continuation of ethnic and racial disparities in health care provision

(Flores, 2000). Both the culture of the patient and the culture of the provider must be

considered in order to avoid stereotyping, which can lead to discriminatory and biased

provision of care (Nunez, 2000).

Foundation of Cross-Cultural Education

The definition of culture is widely debated, but the word can conceptually be

defined as "an integrated pattern of learned beliefs and behaviors that can be shared

among groups and includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs" (NRC, 2003, p. 201). Sociocultural factors have a huge impact on every aspect of each encounter in the clinical setting, and yet educational curriculum for health professionals has only reflected the importance of cross-cultural understanding to a limited extent (Carrillo, Green, & Betancourt, 1999). In the past, the cross-cultural components of healthcare curricula were designed to increase understanding of ethnicity- and race-specific disease patterns, incorporate ethnopharmacology, and improve health outcomes while approaching each patient encounter with an enhanced awareness of the impact which sociocultural influences have on health behaviors and beliefs so that these factors could be managed within the clinical encounter (Carillo et al., 1999).

The need for cross-cultural education in medicine has been discussed in medical literature since the civil rights movement of the 1960s; however, the practice and implementation of cross-cultural methodologies in practice has only recently begun to gain significant attention (Chin, 2000). During the two decade period between 1980 and 2000, the focus of healthcare literature shifted from discussion of the need for culturally sensitive medical practice to the need for culturally competent care, which was a paradigm more focused on skills (Rios & Simpson, 1998). However, the current diverse state of the U.S. population demands that the question of revising old cross-cultural education approaches and implementing new ones in medical education be given immediate attention (NRC, 2003).

Approaches to Cross-Cultural Education

Cross-cultural medical training incorporates three conceptual models with separate focuses: knowledge, skills, and attitudes (NRC, 2003). All three are necessary in order to create a robust picture which addresses all aspects of the equation when considering the multifaceted issue of treating patients with minority status.

Attitudes—increasing sensitivity: a cultural awareness approach. Cross-cultural care, by its very nature, is heavily dependent on the attitudes and beliefs of the caregiver, and thus a professional approach to caring for minority patients demands cultural sensitivity and awareness of one's own beliefs as well as those of others; each patient interaction must be approached with curiosity, sensitivity, empathy, respect, humility, and an awareness of the influences acting upon that particular patient (Bobo, Womeodu, & Knox, 1991). Curricula which focus on the attitudes of healthcare providers incorporate exercises to encourage self-reflection, thorough understanding of personal culture, one's own biases and tendencies regarding stereotyping, and development of a deep appreciation for diversity in health behaviors, values, and beliefs (Culhane-Pera, Relf, Egil, Baker, & Kassekert, 1997). Training and clinical practice in how to ask open-ended questions, how to have open conversations about the types and effects of discrimination in healthcare, how to identify personal biases and how to appropriately compensate for those biases, as well as how to proactively foresee potential challenges in accessing healthcare for minority patients and making appropriate interventions to address those challenges (Berlin & Fowkes, 1998).

Changing current trends in medical practice involves willingness to work hard and persevere in laboring to change attitudes and modify the biases and racist tendencies

deeply ingrained in culture, and it is an emotionally-charged process which can seem

abstract and frustrating to medical professionals-in-training or for those already

practicing their art (Kai, Spencer, Wilkes, & Gill, 1999). However, the ability to engage a

patient in effective, participatory communication during clinical interactions without

communicating condemnation, disapproval, or disrespect is vitally important to

improving outcomes for patients from minority communities, which is integral to the

achievement of the ultimate goal of decreasing disease burden nationally (Cooper-Patrick

et al., 1999).

Knowledge—becoming culturally informed: a categorical approach.

Traditionally, within the academic setting and in the practice setting, the need for

cultural competence has focused on providing medical professionals with knowledge

regarding the values, beliefs, attitudes, and health behaviors seen within particular

minority ethnic groups (Paniagua, 1994). However, trying to simplify complex cultures

into a short list of health behaviors, beliefs, and things to do or to avoid in caring for a

particular ethnic subset of patients is almost insulting to the true complexity of culture

and the individuality of each patient, particularly since outside factors such as

socioeconomic status, new ideologies incorporated into old belief systems through

acculturation, and the dynamic nature of cultural norms in general makes it impossible

to categorize people into stereotypical boxes (Chin, 2000). In fact, research indicates

that teaching only knowledge of cultures without an emphasis on practical application of

that knowledge to attitude and clinical skillset can actually have a detrimental effect on

patient outcomes, because it may lead to stereotyping or increased discriminatory

behavior (Shapiro & Lenahan, 1996).

Increased knowledge of cultures and ethnic traditions is beneficial if properly applied, however. For example, in assessing communities and providing primary care, it is helpful for medical professionals to be informed about the ethnic demographics of the community which their clinical practice will service: knowing factors such as socioeconomic status, dietary habits, typical occupations, housing patterns, and traditional healing practices, as well as the prevalence and incidence of certain diseases, can help medical professionals be more accurate and targeted in their provision of care (Nora, Daugherty, Mattis-Peterson, Stevenson, & Goodman, 1994). Additionally, knowledge of disease prevalence within certain ethnic groups, ethnopharmacologic trends, and cultural perceptions of healthcare within a given ethnic minority group can help healthcare professionals personalize and tailor interactions within the clinical setting to meet the needs of a diverse clientele, but caregivers must be mindful of the dynamic nature of culture and be careful not to stereotype. However, the focus of increasing knowledge about particular patient populations should always be to improve delivery of care and enhance patient-caregiver communication on the individual level (Shapiro & Lenahan, 1996).

Skills—enhancing communication: a cross-cultural approach. Providers who implement the cross-cultural approach to medical treatment of ethnic minority patients are taught to approach communication through a framework of specific communication skills designed to increase the caregiver's awareness of key social issues and cultural and health beliefs, while also providing guidelines and methodologies regarding how to deal with and implement information in effective care plans once it has been obtained (Nunez, 2000). Curricula which adopt the cross-cultural approach focus on teaching healthcare

providers methods for obtaining accurate information from patients, discerning patient

wants, needs, expectations, and communication styles, as well as identifying decision-

making patterns and preferences, the role of the patient's family, and becoming aware of

existing issues such as mistrust in the patient-caregiver relationship (Carillo et al, 1999).

Cross-cultural education regarding patient care utilizes an inductive approach and

attempts to focus attention on the patient rather than on a broad theory that places the

patient in a particular category; the patient himself, therefore, is the starting point as well

as the teacher, and the practice style of the provider should be adapted to meet patient-

specific needs (Shapiro & Lenahan, 1996).

Other Interventions to Eliminate Racial and Ethnic Disparities in Healthcare

Patient/Physician Concordance

While increasing the effectiveness of cross-cultural education when preparing

medical professionals for entry into the healthcare field is an important step in the

improvement of healthcare within the United States, recent studies indicate that pairing

patients with a physician of their own race or ethnicity can also significantly impact

patient outcomes in a favorable way (Chen, Fryer, Phillips, Wilson, & Pathman, 2005).

Patients who shared a race-concordant relationship with their physician expressed greater

trust in their healthcare provider, were more likely to follow recommendations given, and

were more likely to feel that they understood their physician. For nearly a quarter of all

African American patients and one third of Latino patients, having a physician who

shared their race or ethnicity was strongly preferred (Chen, Fryer, Phillips, Wilson, &

Pathman, 2005). However, that still leaves a significant portion of minority patients who

do not want or need a physician from the same minority background, and part of

providing effective care for the increasingly-diverse patient population of the United

States in the future should potentially involve changing the admission survey at hospitals

and other healthcare settings to include questions regarding the patient's preference—or

lack thereof—regarding their physician's cultural and lingual background (Chen, Fryer,

Phillips, Wilson, & Pathman, 2005). Patient-physician concordance involves more than

simply ethnic background, because it encompasses factors such as common language,

shared social experiences, and mutual understanding of cultural beliefs, all of which can

significantly impact the perception and delivery of healthcare, although pairing minority

patients with physicians from the same minority grouping may not always be practical or

possible (Chen, Fryer, Phillips, Wilson, & Pathman, 2005).

Language

        In addition to the sizeable impact of shared culture on the interactions between

patient and healthcare provider within the medical setting, shared language also has a

significant impact (Garcia & Duckett, 2009). While translators are available at some

hospitals, there are still a significant percentage of minority patients who face formidable

linguistic and cultural barriers within the health care system due to lack of translator

availability when receiving care and services and a lack of access to personnel who

understand their cultural norms (Garcia & Duckett, 2009). With the upward surge in the

Spanish-speaking immigrant population within the U.S. in the past five decades,

healthcare clinics face a rapidly-increasing need for personnel who are fluent in both

English and Spanish, although the influx of other minority groups are increasing the need

for translators or bi-lingual personnel across the nation (Garcia & Duckett, 2009). While

incorporating new curriculum with an emphasis on culturally competent communication

will help to improve health care provision to a more culturally diverse patient population, the institutions responsible for preparing future medical personnel also need to begin actively recruiting a culturally diverse student body into the healthcare professions if the U.S. healthcare system is to accurately reflect the populations it serves, both through common language and shares beliefs, traditions, and culture (Garcia & Duckett, 2009). Recognition of the need for these types of personnel is the first step in implementing these system-level changes, which will probably be slow in coming (Garcia & Duckett, 2009).

Conclusion

Significant discrepancies in level and types of care provided to patients of differing ethnic and racial backgrounds exist in current medical practice today. These discrepancies in level of treatment are adding to the national burden of disease by contributing to the number of poor patient outcomes through lack of compliance to treatment measures and lack of adherence to preventive care regimens. In order to address the increasingly diverse healthcare needs of the U.S. population, a three-pronged educational approach is needed—one designed to modify deep-seated cultural stereotypes in health care professionals, provide a framework for the ethical practice of care to diverse ethnic groups, and increase effectiveness of patient-caregiver communication for patients from minority groups in order to improve adherence to treatment plans and increase patient willingness to take part in preventive care. A thoughtful combination of the cross-cultural framework, categorical approach, and cultural awareness model are needed both for physicians in current practice in the form of continuing education classes and for new health care professionals just entering the field of medicine, while

consideration should also be given to what measures healthcare institutions can take to

actively recruit a culturally and linguistically diverse staff in order to better reflect the

cultural and lingual needs of their patient populace.

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