

Multicultural Medicine

Confronting the Challenges in Primary Care

MODERATOR



Robert C. Like, MD, MS

Associate Professor and Director
Center for Healthy Families and Cultural Diversity
Department of Family Medicine
University of Medicine and Dentistry of
New Jersey–Robert Wood Johnson Medical School
New Brunswick, New Jersey

PANELISTS



Joseph R. Betancourt, MD, MPH
Senior Scientist
Institute for Health Policy;
Director for Multicultural Education
Multicultural Affairs Office
Massachusetts General Hospital
Boston, Massachusetts



David S. Kountz, MD
Associate Professor of Medicine
Chief, Division of Primary Care
University of Medicine and Dentistry of
New Jersey–Robert Wood Johnson Medical School
New Brunswick, New Jersey



Francis G. Lu, MD
Professor of Clinical Psychiatry
Department of Psychiatry
University of California–San Francisco
San Francisco, California



Elena Rios, MD, MSPH
President
The National Hispanic Medical Association
Washington, DC

From presidential initiatives¹ to national guidelines for health care organizations² to a campaign to create a nationwide awareness month,³ large-scale efforts are under way to promote minority health and eliminate disparities in care among disadvantaged and underserved communities. The focus is only fitting, considering demographic trends suggesting that the proportion of “people of color”—African Americans, Asian Americans, Hispanic Americans, Native Americans, Alaskan natives, Hawaiian natives, and Pacific Islanders—will grow from the current 28% of the US population to 40% by 2030.⁴

But how are these broad-stroke initiatives playing out among primary-care practices? Do physicians have the skills—and the will—to provide culturally responsive and appropriate care to the increasingly diverse population of patients in the United States? Moderated by Robert C. Like, MD, MS, who is Associate Professor and Director of the Center for Healthy Families and Cultural Diversity in the Department of Family Medicine at the University of Medicine and Dentistry of New Jersey–Robert Wood Johnson Medical School in New Brunswick, a distinguished panel of national experts was gathered to address the many issues surrounding multicultural medicine in this *Medical Crossfire*.

In addition to America’s established diverse populations, began Dr. Like, there is a continuing influx of immigrant and refugee groups from various parts of the world—each with its own cultural identities and health care concerns. “Although there are certainly great individual variations within each of these groups related to age, gender, socioeconomic status, and geographic location—to name just a few factors—we also know that these communities as a whole experience poorer health status, have difficulties accessing needed primary and subspecialty care, underutilize some services and overutilize others, and have suboptimal quality of care and clinical outcomes,” he continued. “So I’d like to start this with a general

question: What are some of the general health and mental health disparities seen in different racial and ethnic populations that should concern primary-care physicians?”

Disparities in Health And Health Care

“As a primary-care physician, I see the common illnesses—diabetes, hypertension, cancer, and, of course, the most common cause of death for all of us, heart disease,” began David S. Kountz, MD, who is Associate Professor of Medicine and Chief of the Division of Primary Care at the University of Medicine and Dentistry of New Jersey–Robert Wood Johnson Medical School. Hypertension



occurs in approximately 26% of the African American population, compared with 20% of Caucasians. The risk of end-stage renal disease is four times greater in African Americans than Caucasians, and the prevalence of hypertensive renal disease is more than 17 times higher in African Americans. Finally, the rate of death from stroke is approximately 66% higher in African Americans than Caucasians. Because even common diseases demonstrate disparities in presentation and prognosis, explained Dr. Kountz, “it is important for primary-care physicians to understand that these are not equal-opportunity diseases.”

Agreeing with Dr. Kountz, Joseph R. Betancourt, MD, MPH, pointed to the “very robust literature” that delineates the various disparities in health outcomes among different racial and ethnic groups. Particularly helpful in understanding these disparities, said Dr. Betancourt, who is Senior Scientist at the Institute for Health Policy; and Director of Multicultural Education in the Multicultural Affairs Office of Massachusetts General Hospital in Boston, is the Initiative to Eliminate Racial and Ethnic Disparities in Health.¹ Announced by President Bill Clinton in 1998, the initiative commits the nation to two goals: first, the meaningful improvement of the lives of minorities who suffer disproportionately the burden of disease; and second, the elimination of the disparities in health experienced by minority populations by 2010.

“This initiative focuses on six areas in particular, but the health disparities among minority populations are not limited to these,” stressed Dr. Betancourt. The six areas, selected for major emphasis because they are known to affect many racial and ethnic minority groups across all life stages, are infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and immunizations. “These are all areas in which significant disparities in health out-

comes, morbidity, and mortality based on race and ethnicity have been identified,” he noted.

In addition to the disparities seen among minority populations in disease presentation and outcome, there is also inequality in health care delivery to these communities, added Elena Rios, MD, MSPH, who is President of the National Hispanic Medical Association in Washington, DC. For example, many members of minority groups lack insurance and do not have access to needed facilities; those who do have these disadvantages often have difficulties navigating our complicated health care system. “Health care providers, and especially primary-care physicians, need to understand the importance of culture and language in the communities they serve,” she declared. “Whether you are a private physician, an academic physician, or a member of a managed care plan, you will have to do your best to make sure that your office is culturally responsive and able to connect with the health beliefs and issues with which the patient comes to your system.”

“We’ve been focusing on medical problems, but US Surgeon General David Satcher recently discussed disparities in mental health among minority populations,” pointed out Dr. Like. “Dr. Lu, would you care to comment on that area?”

“I was very fortunate to attend the unveiling of the Surgeon General’s report, ‘Mental Health: Culture, Race, and Ethnicity,’ at the annual convention of the American Psychological Association,” responded Francis G. Lu, who is Professor of Clinical Psychiatry in the Department of Psychiatry at the University of California–San Francisco. “It was an inspirational event.” The report, a supplement to a 1999 document, “Mental Health: A Report of the Surgeon General,” highlights the role that culture and society play in mental health, mental illness, and access to related services.⁵ “Dr. Satcher made the point that



there are striking disparities in mental health care for racial and ethnic minorities,” explained Dr. Lu. “He listed among these disparities, specifically, less access to and availability of mental health services; poorer quality of mental health care; and underrepresentation of minority patients in mental health research. His second major point was that these disparities impose a greater disability burden on minorities. His final bottom-line message: culture counts.”

Behind the Disparities

“Why do health disparities exist in contemporary America?” challenged Dr. Like.

“First, it is important, as Dr. Rios mentioned earlier, to understand the difference between disparities in health outcomes and disparities in health care,” replied Dr. Betancourt. “There is a strong body of literature that demonstrates that social determinants—issues such as access to care, socioeconomic status, housing, occupation, education levels—all of these factors contribute significantly to health outcomes. But in seeking to eliminate health disparities, we need to understand that we must focus not only on these areas but also on disparities in the delivery of health care. And again, the literature points to significant disparities within the health care system as it relates to quality of care.”

“I think it is important to realize that the health care system does not do justice to all levels of people. We have a multitiered health care system in which ‘you get what you pay for,’” offered Dr. Rios. “The reality is that there is discrimination in the health care system, just like there is in other institutions in our society. There are quality-of-care issues, there are patient safety issues, there are medical fraud issues. If we are going to have a health care system with quality for everyone, that means creating

quality for the cultures and the languages of our Hispanic and minority patients.”

“So far, the reasons identified for these disparities are broad social and systemic issues,” observed Dr. Like. “Are you all saying that there is no bias or discrimination or even racism within clinical encounters at the level of the doctor–patient relationship?”

“The first problem is our discomfort with the topic,” suggested Dr. Kountz. “Much of our education and our societal focus has been on the lesson that we are all the same, that we are the American melting pot. So it’s a bit of a hurdle for many providers to accept that patients need to be treated differently based on race, ethnicity, or culture. We need to get over that hurdle by first acknowledging that this concept makes some physicians uncomfortable.”

“Perhaps for general health, but specifically for mental health, I do think the issues of racism and discrimination play a role in the communication issues, especially around mental health symptoms,” offered Dr. Lu. “Unintended biases and stereotypes on the provider’s part can influence the diagnosis and treatment plan.” He added that in certain minority communities, the stigmatization of mental illness is greater, leading members to shun needed mental health services. In fact, according to the Surgeon General, only one in three persons who needs mental health care receives it.⁵

“I think that physicians do have their own biases and prejudices,” commented Dr. Rios. She pointed out that these mind-sets are not restricted to providers from the dominant culture, noting that “about one third of the Hispanic physicians practicing in the United States are actually from foreign countries. They arrive with the biases of their own cultures.”

Another problem, she contended, is that medical education promotes the physician and the culture of medicine as the ultimate decision-making authority. “This attitude



leads to physician–patient encounter problems. Fortunately, I think there is now more awareness of the importance of having a team effort between the physician and patient, of creating dialogue, exchange, and the sharing of information,” she said.

Raising the issue of stereotyping, Dr. Betancourt noted that “this is actually a natural process, something we all do to categorize information.” Interestingly, social-cognitive theory proposes that people stereotype most often when they are under time constraints, are multitasking, or are stressed—circumstances, observed Dr. Betancourt, “that really define the daily practice of a physician.”

Dr. Betancourt believes that, to combat this natural tendency, medical students and residents might benefit from practical, patient-based cross-cultural curricula that teach how to avoid cultural generalizations and how to improve interactions with patients of diverse backgrounds.⁶ “Many physicians are quite unaware of the literature on health care disparities,” he suggested. “They believe that medicine is, in fact, colorblind. They are very surprised to realize how they apply stereotypes, consciously and unconsciously, that contribute to these disparities.”

The Case for Cultural Competence

“One of the new buzz phrases is ‘cultural competence,’ a concept that has been proposed as a potential strategy for helping to reduce these disparities,” observed Dr. Like. In a landmark 1989 report, researchers at Georgetown University defined cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable them to work effectively in cross-cultural situations.”⁷ Dr. Like asked the panelists, “How would you define cultural competence?”

Cultural competence, offered Dr. Rios, is the ability “to respect and to understand some of the nuances in the belief systems of diverse peoples, especially about—but not limited to—illness and disease. Physicians also need to respect and to understand how different patients handle decision-making within their own contexts, their own families, their own traditions.” She added that patients from many cultures seek forms of health care in addition to western medicine, for example, folk healing, folk medications, or herbs; physicians need to query their patients about this possibility. She stressed that physicians also need to find out “if patients need information in a language other than English or interpreter services to be able to feel respected and keep them coming back to the doctor.”

“Cultural competence is a movement that is improving our ability to deliver quality care to diverse patient populations,” suggested Dr. Betancourt. “It is an issue that shouldn’t be marginalized because cultural competence can improve all facets of health care, both as a science and an art. We hope that within 10 years there is no longer a need to talk about cultural competence, but to instead have a health care system that is responsive to all Americans.”

Offering a slightly different perspective, Dr. Kountz stated that cultural competence gives physicians permission to evaluate patients on the basis of race, class, ethnicity, and other factors, a practice that was once believed to be biased. “We can now address patients as individuals and assess their health within the context of their culture,” he said. “I no longer need to say, ‘a 60-year-old male;’ I can say, ‘a 60-year-old Latino male’ or a ‘60-year-old Jewish male.’ These factors are relevant to the differential diagnosis and to the treatment of disease. I can now be more confident in treating the patient’s illness in a manner appropriate to its typical presentation and course in that population.”

“So there is also a certain amount of self-awareness that the physician must bring to the doctor–patient relationship?” queried Dr. Like.

“That’s a very good point,” agreed Dr. Lu. “Self-reflection and self-awareness of one’s own cultural identity is absolutely critical to controlling our biases and prejudices. We must constantly be working toward understanding these issues.”

Dr. Like offered the panelists a challenge: “I’m a busy practitioner, and I’m trying to run an office under a great deal of pressure. I’m under clinical productivity demands from managed care; I have to come into compliance with new HIPAA regulations. Why should I be interested in providing culturally competent care?”

“Quite simply, to do our jobs better,” replied Dr. Kountz. “The bottom line is, culturally competent care is better care.”

“We are talking about the root of professionalism,” agreed Dr. Betancourt. “The professionalism of the entire health care system and of the individual physician rests on the responsibility to deliver the highest-quality care to everyone.” Beyond professionalism, however, lie other, more practical reasons to embrace cultural competence. Among them, Dr. Betancourt highlighted moral and ethical tenets, business imperatives to improve market share, public health benefits, and risk management.

Dr. Rios expanded on Dr. Betancourt’s points. “Because of demographic trends, physicians must become more culturally competent merely to stay in business,” she said. In addition, she noted, important federal guidelines offering a new interpretation of Title VI of the Civil Rights Act of 1964 were issued by the Clinton administration in August 2000.⁸ The new guidelines mandate that federally funded medical services can not be denied based on factors related to national origin and other cultural characteristics—including

limited English proficiency, or LEP. “Therefore,” she explained, “any doctor taking care of Medicaid or Medicare patients, as well as clinics and hospitals receiving federal funding, must demonstrate that they are not being discriminatory.” Providers can prove compliance, she noted as an example, by implementing standards like the Culturally and Linguistically Appropriate Services (CLAS) recommendations promulgated by the Office of Minority Health of the US Department of Health and Human Services (HHS).²

Dr. Like added that the Liaison Committee on Medical Education and the Association of American Medical Colleges have approved a new accreditation requirement relating to cultural diversity in the medical education curricula. “So medical schools and residency programs around the country are now hustling to figure out how they can train future health care providers to provide more culturally competent care.”

Responding to Objections about Cultural Competence

Despite this governmental and institutional support and the increasing acceptance of greater numbers of individual practitioners, cultural competence still meets pockets of resistance among the health care community. In his work, said Dr. Like, he has repeatedly heard three objections from the unconvinced; he proposed that the panelists present their reactions. “The first comment is: ‘Culturally competent care is just political correctness run amuck. I treat all my patients the same.’ How do you respond?”

“I vigorously disagree with that statement,” declared Dr. Kountz. “If health outcomes were the same among all populations, then that statement would be true. But health outcomes are not the same.”

“I have definitely heard this sentiment in my travels,” affirmed Dr. Betancourt. “But I





would just ask my colleagues who clearly respond to evidence-based medicine to take a minute to look at the very significant literature on racial and ethnic disparities in health. A convincing body of evidence shows the impact of social and cultural factors on health beliefs and outcomes, and demonstrates the significant barriers to quality health care that exist for patients with limited English proficiency.” Echoing Dr. Kountz’s opinion, Dr. Betancourt suggested that “perhaps physicians want medicine to be colorblind, but if we weigh all the evidence, we see that health outcomes are clearly not in support of that wish.”

“Dr. Betancourt mentioned English proficiency, and that leads me to the next comment that I have heard,” said Dr. Like. “And that is: ‘People should learn to speak English if they live in America. Physicians should not be forced to rely on interpreters or translate materials into multiple languages.’”

“I think that is an incredibly naive statement,” responded Dr. Rios. She noted that immigrant populations in this country have kept their languages and traditions alive for generations. Because of continual immigration—for example, historically, among Hispanics—she pointed out, “the United States will continue to see generations go through assimilation transitions, and English will not be the only language spoken. For the health care system to be able to thrive and maintain its quality, there needs to be acceptance that the Spanish languages of your Hispanic customers must be part of the communication system.”

“This country has been built on the shoulders of immigrants,” declared Dr. Betancourt. As has happened in the past, immigrants will learn English at their own pace and eventually acculturate, he said, “but that is no excuse for us to now cast these populations aside, especially at a time in which our economy really depends on immigrants for certain aspects of our productivity.” He added that “we are in a

unique situation in which we could really help smooth this transition, especially in this era of improving technology and the desire to deliver high-quality care.”

Still, the provision of interpreters and other assistance for patients who do not speak English—mandated by the Clinton-era adjustments to Title VI⁷ and upheld in court—continue to rankle many health care providers, who believe it is unfair that they must foot the bills for such services. In fact, trustees of the American Medical Association are currently reviewing two resolutions proposed at their annual meeting. One explores the possibility of shifting responsibility for interpreters from the physician to the patient; the other examines the implications of engaging bilingual staff and patients’ family members as informal interpreters.⁹ Dr. Kountz, however, advised his colleagues: “We are a nation of immigrants. The sooner we learn to deal with different cultures and different languages, the sooner we will be able to deliver improved health outcomes to our patients.”

Dr. Like offered one final comment for the panel’s response: “‘Given the enormous diversity that exists in America, how can physicians be expected to learn about all the different ethnic groups and cultures from which our patients come?’ Your thoughts?”

“That comment is rather absurd in that of course it is unrealistic for any physician to know all of these various cultures,” replied Dr. Lu. “But there are certain basic principles and approaches, certain basic attitudes, and certain ways of adapting services of which every physician should be aware.” Pointing out that obtaining a consultation is a routine aspect of the health care provider’s responsibilities, Dr. Lu suggested that colleagues should become comfortable “with the importance of cultural consultations as a means of caring for patients from multiple cultures.”

Dr. Kountz echoed Dr. Lu’s perspective and provided a helpful metaphor. “As a pri-



mary-care physician, I know 50 diseases well and lots of diseases not so well. When I am faced with one of the diseases I know not so well, I better call for help,” he said. He recommended that health care providers should make efforts to identify the predominant populations in their community and thoroughly educate themselves about their beliefs, values, culture, and language. “And when the physician encounters a patient from a very different population, there are sources to which the doctor can turn for help.” Many medical and academic institutions have centers offering diversity services; Dr. Kountz used the Center for Healthy Families and Cultural Diversity at his own institution as an example.

Cultural Competence and the Clinical Encounter

“I would now like to ask you to share some practical approaches or strategies that the busy practicing primary-care physician can implement in caring for patients from diverse backgrounds,” suggested Dr. Like. “Are there some tools or techniques you use? Can you share some instructive clinical case examples?”

In response, Dr. Betancourt offered two examples from his own work. The first is a patient-based, cross-cultural curriculum that teaches a framework for analysis of the individual patient’s social context and cultural health beliefs and behaviors.⁶ The second is a communications model that allows physicians to screen minority patients for socioeconomic, individual, familial, and cultural factors that may present barriers to compliance with antihypertensive treatment.¹⁰ The model, called ESFT [Explanatory model; Social risk; Fears and concerns; and Therapeutic contracting.], is currently being tested. “It allows practitioners to assess patients for their understanding of the condition, the likelihood that they have the social skills and tools to adhere to the diagnostic or treat-

ment plan, their fears or concerns about the diagnostic or treatment plan, and, finally, their comprehension of the plan and what they need to do to fulfill it,” explained Dr. Betancourt. “There is literature and research to support every one of these components, and we think that it is helpful, not only for patients from diverse cultures, but for any patient who enters the clinic door with a different set of beliefs, behaviors, and perspectives about health, illness, and treatment.”

“In my own practice and in my work with medical students and residents, we have developed similar mnemonics, in particular, ETHNIC [Explanation of illness; Treatment tried or expected by patient; Healers seen, including non-physicians; Negotiate options that are mutually acceptable; Interventions that may include medications, alternative treatments, and/or psychosocial support; and Collaboration with the patient, family members, and other healers.], and BATHE [Background—patient’s history or current life circumstances; Affect—the feeling state; Trouble—the most troubling aspect of the illness or situation; Handling—assessment of patient’s functioning or coping skills; and Empathy—providing psychological support]. These can help the physician determine whether a patient can adhere to recommendations,” added Dr. Like. “These tools are very helpful and can readily be incorporated into the 10- or 15-minute visit with the patient.”

A similar cultural formulation for use in mental health practice is available through the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*,¹¹ volunteered Dr. Lu. “This tool is very useful, and I was glad to see that it was mentioned in the Surgeon General’s recent report.”⁵ The tool allows the practitioner to assess four cultural components that may affect the differential diagnosis and treatment plan: cultural identity; cultural explanations of illness; cultural stres-



sors and supports; and the cultural elements of the clinician–patient relationship. With the knowledge and insights gleaned from the assessment, he continued, practitioners can determine “how to respond differently to this individual patient and adapt services accordingly.” Another helpful resource, offered Dr. Lu, is a new book by Pamela A. Hays, PhD, titled *Addressing Cultural Complexities in Practice*.¹² Combining discussion and case reports, the book offers a framework for clinicians and counselors to recognize and work with the multidimensional cultural influences of their patients.

A key strategy for bringing cultural competence into physician’s offices is continuing medical education, suggested Dr. Kountz. He believes that programs on cultural diversity may soon be mandatory in continuing education for primary-care practitioners, much as training on HIV/AIDS and domestic violence is now mandatory in some states. “This is one way to put teeth into the recommendations to incorporate cultural competence in practice,” offered Dr. Kountz. He also believes that physicians should incorporate cultural information into case reports presented to their colleagues. “In presenting cases, we need to include data like ethnic, racial, and religious backgrounds of all patients. We should include this information regularly in our physician-to-physician communication so that it becomes part of our vernacular.”

Documenting Cultural Issues

“Let me ask a follow-up question relating to this area,” requested Dr. Like. “How do you document these cultural issues in your notes, not only so that the information will be relevant for clinical care but also pass muster with an external accreditation review?”

“Our office has encouraged providers to simply add into their initial medical history and also into their progress notes a

routine section on sociocultural assessment and intervention,” replied Dr. Betancourt. “In this section, providers can highlight information about a patient’s health beliefs or behaviors as well as descriptions of how cross-cultural tools and skills were used to address these circumstances and improve care.”

“Do you routinely document whether an interpreter is present?” asked Dr. Like.

“One of the first things that I document on every chart is the language of the patient,” confirmed Dr. Betancourt. “Then I document whether or not an interpreter was used as well as whether the interpreter was a professional, a staff member, or a family member.”

Ethnopharmacology

Dr. Like introduced the subject of ethnopharmacology, the scientific investigation of biologically active substances utilized by humans.¹³ “Are there any important direct impacts on prescribing practices that primary-care physicians should know about?”

“This is an evolving field, there is a great complexity to it, and we don’t want to fall into stereotypes again,” cautioned Dr. Lu. “But there has been a growing body of work supporting the concept of ethnopharmacology. The literature shows that there are a number of patients of Asian ethnic descent who can have their symptoms in psychosis, major depression, or mania treated effectively with lower doses of psychiatric medication. It is incorrect, however, to say that all Asian patients need lower medications; some Asian patients do require the usual dosages. Physicians need to be aware of this research and perhaps start their Asian patients at a lower dose and be cautious of side effects at the usual dosages.”¹⁴

Dr. Betancourt alluded to the current controversy over angiotensin-converting enzyme inhibitors and their efficacy in African Americans. “This field is, quite frankly, in its



nascency and there is a lot to learn,” he asserted. “The human genome project and related research will give us a better understanding of ethnopharmacology and the different ways our patients might metabolize and gain benefit from different medications.”

“I’ve seen a tremendous interest in the diversity of the patient population and the need to address that diversity on the part of the pharmaceutical industry,” observed Dr. Rios, adding that over the past two years she has taken part in several pharmaceutical advisory boards on Hispanic populations and “that has never happened before.” She also mentioned that the Pharmaceutical Manufacturers Association of America (PhRMA) has produced two handouts that review the current pharmaceutical clinical trials of medications for diseases that affect African American and Hispanic patients, respectively.

Confronting the Challenges

The national CLAS standards, previously mentioned by Dr. Rios, were adopted in December 2000 “to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.”² The 14 standards are organized into three themes: culturally competent care, language access services, and organizational supports for cultural competence. Of the 14 standards, four are mandates that must be adopted by any recipient of federal funds; nine are guidelines recommended for adoption as mandates by federal, state, and national accrediting agencies; and one is a recommendation suggested for voluntary adoption by health care organizations. Dr. Like asked the panelists to discuss these important standards. “What are the challenges in implementing these standards for the primary-care physician?”

Noting that the standards are meant primarily for health care organizations but that

most providers work within such organizations, Dr. Betancourt expressed that “it is important for providers to be aware of these standards and to incorporate them into their practices any way that they can.” His suggestions for implementation of the standards in primary-care practice include providing culturally competent care to patients; addressing workforce issues by hiring employees who reflect the community served; and providing appropriate education and training to both physicians and their staffs. “Not only are such steps helpful in fulfilling CLAS standards, they can only help physicians provide higher-quality care to their patients,” he concluded.

“The first concern I have is that providers might react negatively to the fact that these standards are being handed down by the federal government,” said Dr. Lu. He urged colleagues, however, to adopt the perspective that no matter their source, the standards can help individual providers to deliver better care to patients by shaping and improving the cultural competence of the organizations in which they work. “Obviously, physicians themselves can only do a small portion of the work necessary to fulfill the standards,” he offered, but they will benefit from changes within their organizations.

One of the most useful of the 14 standards, continued Dr. Lu, is the guideline on creating collaborative relationships with patients and communities. “We spoke before about collaborative care at the clinical level of the doctor-patient relationship, but the same principle can apply in working with patients and communities. This is a very important perspective to nurture.”

Dr. Rios urged colleagues to view the community as a resource and not an obligation. “Find out what resources exist in the community that can help you help your patients,” she recommended. “Hospitals and clinics may offer the services that are difficult for individual physicians to provide. Community leaders,



civic groups, and local newspapers can help physicians share health care messages and convince the public of the importance of preventive medicine and regular check-ups. Doctors are very busy, but fostering these relationships can save time and improve care in the long run.”

Dr. Kountz concurred, suggesting that community doctoring could parallel the strategy of community policing. “As primary-care physicians, we live in these communities, we should know their health issues. Physicians need to get into the important community organizations—the churches, the barber shops, the social clubs—and really talk to individuals. The question we don’t ask enough is, ‘What are your community’s health issues?’ ”

Similar endeavors—for example, faith-based initiatives and awareness campaigns that create partnerships between health care providers, community organizations, local businesses, advocacy groups, and state and local governments—are demonstrating impressive successes, added Dr. Like, and have, in some cases, eliminated certain disparities in the community.

“I have one final question for the panelists,” he said. “Is culturally competent care, fundamentally, just the provision of good patient-centered care? Or is there more to it?”

“It’s very important for the practitioner to realize that one does not arrive at all the information one will ever need about cultural competence and then is finished with it. Cultural competence is an ongoing task,” replied Dr. Lu. He noted that Tervalon and Murray-Garcia, in a recent publication, introduced the concept of “cultural humility.”¹⁵ The traditional notion of competence in clinical training, they write, is “a detached mastery of a theoretically finite body of knowledge,” a concept that may not be appropriate for culturally sensitive physician education. They suggest, instead, the concept of cultural humility, which incorporates “a lifelong commitment to self-

evaluation and self-critique, to redressing the power imbalances in the patient–physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.”

“Cultural humility is an essential attitude to have,” declared Dr. Lu. “It is very important to break away from the stereotypes and the clichés and be open to an understanding of this particular patient and the complexity of his or her cultural identity. We need to strive for ongoing understanding rather than premature closure. That’s my understanding of cultural humility.”

“Patient-centered care is a fantastic principle that seeks to involve the patient in decision-making and to assure that within the medical encounter, at a minimum, there is full understanding between patient and physician. But I believe that, to date, patient-centered care has not incorporated the challenging social and cultural issues we have discussed,” observed Dr. Betancourt. “One of the basic tenets of cross-cultural care is patient-centered care, but I hope for an expansion within the field of patient-centered care so that we within the medical community are able to explore other areas that have previously not been highlighted.”

“The point I hear you all making is that this is really an ongoing journey, and the desire to always learn more may be the most important aspect of cultural competence,” summarized Dr. Like.

Final Thoughts

In presenting their final thoughts on multicultural medicine, each of the panelists stressed the essential role of the individual primary-care physician in supporting the promise of broad-based societal and governmental initiatives. “Many racial and ethnic minority consumers and families prefer to

receive general and mental health services through their primary-care physician,” noted Dr. Lu. He pointed out that the federal government, in collaboration with the private sector, is working on initiatives and pilot projects to further explore and develop this very important interface. “I hope that primary-care physicians will understand the significance of this recognition, especially for ethnic minority patients,” he concluded.

“I would just like to offer a word of encouragement to primary-care doctors,” offered Dr. Rios. “They are so important to our communities of color, both as first-line care givers and as facilitators into the rest of the health care system. Primary-care physicians can really set an example on the importance of cultural competence and communication.”

Dr. Like stressed the need for cultural competence in all physician practices. “There are no cookbook approaches to care. Every clinical encounter is a cross-cultural encounter,” he declared.

Dr. Kountz added that unless and until we achieve a completely equitable society, cultural awareness must be accepted and practiced “if only for the sole purpose of improving our patients’ health outcomes. So let’s forget the rhetoric about political correctness, look at the data, and overcome the reluctance to consider culture.”

“As a community, primary-care providers have met the challenges that science has presented by learning about emerging conditions and applying that knowledge to the treatment of disease,” said Dr. Betancourt. “We now need to apply that same rigor to learning about racial and ethnic disparities, to learning about the impact of social and cultural factors, and to learning how this constellation of circumstances affects the quality of care we deliver. If we apply that rigor, if we take a moment to reflect and to determine how we as individuals might be able to further this process with every patient who enters our doors, I believe that in time we will eliminate disparities in health care.” ■

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