4 Providing Medical Care to Diverse Populations

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If we are to achieve a richer culture, richer in contrasting values, we must recognize the full gamut of human potentialities.

(Margaret Mead)

Introduction

It is not yet evident how strong of an influence diversity holds on clinical decision-making or quality of care. What remains unclear is the manner in which disparate patient characteristics function. The associated cognitive procedures are complex. Affordable care, access to care, and compliance with recommended treatment are examples of factors that influence health outcomes, but fail to provide a definitive explanation for variations that deviate from the norm. Explanations for these differences are lacking. The capacity for race and ethnicity to influence treatment and resource allocations, for example, is a decision process open to interpretation. This is problematic because the ability to evaluate a clinical decision requires understanding the many interrelated elements that contribute to judgment. In the end, there exists the need to evaluate clinical choices and to understand the extent to which patient attributes have the power to influence those determinations. This chapter will tackle the challenge of what it means to provide culturally sensitive healthcare to arguably the most diverse population on the planet. Although the information provided is focused on the healthcare environment, the concepts discussed are relevant to educators, diversity trainers, and professionals from other social sciences.

Background

The demographic shift of the American population from majority White to majority-minority is fast approaching. The boomer generation is majority White, and those younger than 35 are predominantly ethnic minorities [1]. The cultural and linguistic profile of the immigrant population as of 2016 shows a non-European entrance into the country. The Migration Policy Institute reports that while most people under 5 years old living in the United States describe speaking only English at home (78%), the rest of the population speaks Spanish, Chinese, Tagalog, Vietnamese, Arabic, or French [2]. More than half of the immigrant population has private healthcare coverage, and approximately 30% has public health insurance. Immigrants and refugees face stress-related mental health issues linked to their life situation, the need to acculturate to US culture, encounters with discrimination, and experiences with trauma [3]. Economic hardship and loss of status complicate the process of settling into an expatriate life.

Greenberg [3] outlined barriers to accessing mental health services for the immigrant population. They include:

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R. Parekh, N.-H. T. Trinh (eds.), *The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health*, Current Clinical Psychiatry,
https://doi.org/10.1007/978-3-030-20174-6_4

- Differences in symptom expression, understanding etiology and effective coping mechanisms
- Stigma of mental illness
- Language barriers and lack of interpreters
- Patient-provider cultural concordance
- Fear and mistrust of the healthcare system

As the United States goes through a ground swell of change in healthcare delivery, one fact remains unchanged: the population of patients treated will be more diverse. The country known as the melting pot of the world grew to its current status as a world leader due to the influx of new notions and confluence of diverse cultures that challenged the status quo and pushed the envelope of possibility. Whether we talk about a jazz funeral stepping to the beat of Louis Armstrong's syncopated rhythms or Neil Armstrong's "One small step," no one doubts that America placed an indelible imprint on the modern world. Although America met President Kennedy's challenge to land a man on the moon and return him safely to earth, decades later we still struggle to understand the man or woman standing next to us on terra firma. If one considers the number of cultures and subcultures that coexist in America, the complex calculations to go to the moon and back might seem relatively easy math compared to the many permutations of culture in our society.

This acknowledgment becomes increasingly important within the context of the national dialogue on health disparities and unequal treatment. The 2002 Institute of Medicine (IOM) report entitled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, repudiated the assumption that the American health delivery system was fair and equitable. A cornucopia of questions related to quality of care and access to care for groups on the social margins followed the groundbreaking study in quick succession. The synthesis of research exemplified by the report moved race and ethnicity into the forefront as important variables in the discourse on health outcomes for Americans. These variables symbolized conspicuous inconsistencies in the quality of health services that differed by ethnic group for people living in the United States. The channels of service to persons on the edges of society, compared to those available to the dominant social group, did not reflect parity. But who can possibly be an expert on so many diverse cultures that converge in waiting rooms across this country 24 h a day?

Health Disparities

The existence of inequitable treatment provided to patients with dissimilar sociodemographic details is one of the great ethical and analytic challenges in modern healthcare. Present-day research is a helpful means for sharing current thinking on variations in health status and the outcomes of health management as they relate specifically to ethnic populations. Contributing factors highlighted in the literature are socioeconomic realities, flawed systems, or inadequate training in cultural competency. Relevant to the last contributing factor of cultural competence, English proficiency, socioeconomic status, gender, sexual orientation, cognitive or physical ability, and religious or spiritual belief systems are inherently neutral social classifications that take on added dimension when linked with stigmatized or marginalized social groups. English proficiency and Hispanics, socioeconomic status and Blacks, or religion and Muslims are life characteristics that may be variables or proxies for yet another unidentified process when examining the intricacies of disparities in healthcare.

One of the most challenging possibilities is that health outcomes for diverse groups are impaired by bias in clinical decision-making. The integration of stereotypes, for example, into the information schema that health professionals maintain about minority patients raises questions that healthcare researchers can evaluate and understand. The implications for the provider and the patient are basic and fundamental: perfunctory or inadequate care must be avoided, because the presence of bias leads to moral and legal imperatives.

Nonclinical factors such as race may not consistently demonstrate the presence of bias. Socioeconomic status, for example, as an influence

on decision-making, may also result in debatable recommendation for treatment [4, 5]. Diagnostic failures linked to errors in judgment can stem from automatic thinking compared to a more consciously critical or analytic approach [6]. Stereotypes are a form of automatic thinking leading to assumptions and a faulty foundation for action.

Intersectionality

Most definitions of diversity include a broad-based description of the concept taking into consideration that different dimensions of social location are not mutually exclusive in understanding impact. Race, gender, and age, for example, are interconnected aspects of selfhood. These interdependent characteristics influence personal encounters, and their state of co-occurrence is known as intersectionality:

> Intersectionality is a way of understanding and analyzing complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other [7].

Intersectionality brings a more holistic view to understanding the dimensions of othering [8]. The importance of the construct to a healthcare paradigm embraces the idea that response to some aspect of identity based on flawed perceptions has import for the patient experience of care. The middle class, boomer, male, heterosexual, White provider may have a stressed encounter with a homeless, Black, transgender, millennial.

Cognitive Dissonance

Cognitive dissonance may provide insight into the lack of awareness that allows for discriminatory behavior. Red flags typically do not go up when socially undesirable reactions become part of interethnic encounters in which prejudice is called into question. Cognitive dissonance describes the mental reframing of a given situation that decreases the level of discomfort that might warn of the presence or employment of objectionable reactions. Rationalizations and justifications are utilized. These protective systems of self-esteem allow for differing perspectives on communication and behavioral missteps that breach effective patient engagement in a cross-cultural encounter.

Cultural Sensitivity and Clinical Practice

In a 2004 position paper, the American College of Physicians encouraged provider awareness of personal bias and stereotypes as an important course of action needed to understand the degree to which these factors could influence healthcare decisions. As a case in point, DelVecchio et al. [9] described the so-called medical gaze that results from professional training. This expression suggests the manner in which the clinician organizes information that pertains to a specific patient.

Of course, no clinician can be an expert on every culture of varied patients they treat. Every clinician, however, can gain insight and a degree of expertise about the culture of each patient by following a few simple guidelines.

First, culture needs to be defined. Even though the dictionary gives several definitions of culture, the ones relevant to this chapter include (a) the beliefs, customs, practices, and social behavior of a particular nation or group of people; (b) a group of people whose shared beliefs and practices identify the particular place, class, or time to which they belong; and (c) a particular set of attitudes that characterizes a group of people. Simply stated, culture describes the beliefs, behaviors, and values held collectively within a group, organization, region, or nation.

Including the information about a patient's cultural background makes sense in contemporary clinical practice for several reasons. Clinical decisions must have exacting quality and bear

scrutiny. High decision quality is an important goal and the ultimate example of good patient care [10]. Applying this information in a practical and workable way is a worthy goal. The process of making a decision is a particular example of information utilization, and illustrative mental models of population groups can be effective aids in care delivery. These cognitive models can be complex in design and result from processing extensive information—what is seen, read, and experienced must be accurately applied for effective care of the individual.

On an individual level, each patient presents as a product of several cultures, and each of these cultures influences the individual's beliefs about the way the world works and the way people should interact. Various cultural imprints determine a patient's behaviors, including social gestures, use of eye contact, facial expressions, manner of dress, and rituals for greeting. The patient's values, such as the importance of family life, career, religion, and social responsibility, all derive from some interplay of cultures in that individual's life trajectory.

As this textbook goes to press, Barack Obama is serving his second term as president. Divested of his role as leader of the country and using him as a model of a cultural being, how would a clinician meet the challenge of incorporating Mr. Obama's well-known cultural background into an understanding of who he is as a person? This is a complicated question from a clinical perspective. The president self-identifies as African American; however, this over simplifies his rich cultural heritage. *African* American may fit the president better than most that choose this cultural identity given his father is of African heritage and his mother was born in America. For the majority of African Americans, many generations separate them from the nearest relative of African ancestry. On the other hand, Mr. Obama knew his father's precise birthplace and the customs and religion of his relatives. Many of his close relatives, including a half brother, still live in Africa. The actual impact on personal identity and worldview of this cultural connection as it compares to other African Americans is an interesting point for discussion. For example, Mr. Obama spent much of his younger years living primarily with his White mother and grandmother. Even more pointedly, how similar was his boyhood in Hawaii to that of an African American boy growing up in Harlem? How was his experience at Harvard University like that of a young Black man attending Howard University? From the model of African American as a generic cultural designation, in what manner is any of this a pertinent context for the aspiring culturally sensitive clinician? How might any of this contribute to understanding the person receiving medical care or treatment?

Teaching Implications of Race and Ethnicity

Race and ethnicity have gained attention as important to understanding healthcare quality; more specifically, the influence of these factors on defining excellence in patient care is increasingly apparent. The significance of ethnic identity to assessment, care, and discharge planning are evident, and these domains of practice hold implication for the clinician-patient relationship as a function of clinical decision-making. Knowledge of the group as it relates to those who are culturally different often supersedes the customary value for the uniqueness of each individual.

The movement to describe and educate healthcare providers about cultural sensitivity and its inclusion in individual practice brings into closer range the issues raised by health disparities. Culturally competent care, cultural sensitivity, and culturally and linguistically appropriate care are examples of terminology that indicate a change in medical and nursing perspectives on health management and education. This nomenclature is comparative, and it orients clinical practice and principles of care to the unique end users of health services according to the cultural identity of patients, their families, and the communities in which they live. The consumer becomes the focus of the healthcare experience within this paradigm, while the resulting notion of equal treatment underscores

the importance of consistency in action, intention, and effect as essential qualities of good clinical practice. To a notable extent, such care is assumed impervious to inexplicable variation. For example, a Black physician, who attended Harvard Medical School, might find less common cultural ground with President Obama than might be assumed. Ethnicity as a basis for short cuts to understanding others can cause problems in the clinical relationship. On the other hand, becoming a cultural anthropologist for each patient from a different cultural background is untenable. Clinical tools are needed to gather information important to the context of care that is intended using the concept of cultural sensitivity. Such tools are nuanced with the social history of cultural groups.

Rawls [11] explored the difference between Black and White conversational codes of conduct. In a social environment, initial ingroup conversational encounters are managed differently: for Whites, introductory dialogue is focused on information gathering, and social credentials (occupation, place of residence, education) are established at the beginning; for Blacks, introductory talk separates into what is judged public or private in addition to nonhierarchical communication as the basis for relationship. Information itself is important to Whites, "White Americans prefer to build their conversations only after the production of categories" (p. 249). When the aforementioned processes do not occur, making sense of the interactions becomes problematic, and from a Black perspective, category questions require motive, i.e., the social history of the group creates guardedness. Caution is culturally prudent as it relates to type and amount of information shared.

An example of wariness relevant to healthcare is the quality and effectiveness of the contemporary clinical interview. The current interest in cultural sensitivity aids in understanding why African Americans are circumspect in their answers to certain questions. This tendency is relevant because clinical outcomes are dependent on analytic data as well as the best discretionary information collected from the patient.

The authors have created a series of rhetorical questions to help clinicians reflect on their own diversity. See Exercise 1 below:

Exercise 1

What is your cultural identity?

What is your race? Is this how you self-identify most of the time?

What is your gender? Is this also your gender expression?

What is your religion or spiritual tradition?

What is your ethnic heritage? In what way are you connected with its customs, beliefs, values?

What is your sexual orientation? What is the impact of culture/ethnic identity?

What is your socioeconomic status? Is it based in family support or autonomous living?

What is your political point of view and how is it informed by any aspect of your identity?

The longer the list of questions, the more obvious cultural diversity becomes. A self-examination based on this interview tool provides an awareness of personal identity. Most clinicians have never taken the time to think about the nuances of their own cultural diversity, so one would not be surprised that the average clinician likely knows even less about the patient's cultural complexities. Once a comprehensive understanding and appreciation of the patient's cultural background is established, the clinician can sidestep suppositions or stereotypes based on a single aspect of identity.

The term cultural diversity extends the notion to encompass ethnic variety, as well as socioeconomic and gender variety, in a group, society, or institution. Although ethnic, socioeconomic, and gender variety cover some of the cultural diversity encountered in patient populations, cultural diversity manifests in many other forms.

In Patient Care Services at Massachusetts General Hospital (MGH), there are seven pillars that define the populations of interest covered by a curriculum on cultural sensitivity and diversity. These are race/ethnicity, age, gender, socioeconomic status, sexual orientation, religion/spirituality, and physical/cognitive ability. These population groups have a social history that locates their position as the marginalized or

vulnerable in the terminology used in the discourse on unequal treatment and disparities.

Consider that an ethnic minority patient may view her or his cultural background differently than may be assumed by a nonminority clinician. For instance, Dr. Jones learns that his new patient, Jian X., grew up in China. He assumes that she prefers traditional Chinese medicine interventions and refers her to the new Alternative Therapies Clinic for acupuncture to treat her carpal tunnel syndrome. Dr. Jones feels a sense of satisfaction with the referral to a new hospital service established to support and serve a diverse population. Jian, however, is disappointed that Dr. Jones did not simply prescribe a pill to relieve the pain and inflammation. In China, questioning a doctor's authority equates to disrespect, therefore Jian does not consider asking for an alternative to the prescribed therapy. If he knew Jian better, Dr. Jones would have understood that Jian identifies herself first as an engineer, second as a woman, and third as a Chinese immigrant. As a structural engineer, she makes decisions based on math and science. Jian would have welcomed a discussion about the evidenced-based advantages of one anti-inflammatory medication over another, but she reticently accepted the treatment Dr. Jones prescribed based on his well-intentioned assumption about her. Her firm relies on Jian to meet a deadline on a major project, so she needs relief as quickly as possible. Her dilemma includes scheduling an appointment with acupuncturist in 3 days or taking a prescription that might offer relief in a matter of minutes or hours. The cultural context for Jian's problem illustrates the need for clinicians like Dr. Jones to take a culturally sensitive approach based on actually understanding the patient's needs rather than assuming they do.

Clinicians are more likely to approach the challenges of care for a multiethnic and multilingual population more effectively, if cultural knowledge and resources commensurate with needs are available to them. These newly identified demands of good care require updated responses. Knowledge reflecting the domains of perception, memory, and judgment endemic to the individual practitioner moves new questions to the forefront of healthcare and disparities research. If scientific inquiry is to be thorough, there is an unavoidable question in the search for answers to health disparities. What if differential treatment is the result of ethnic bias by the healthcare provider?

Ethnic Bias in Clinical Decision-Making

In answer to the concern about a level of competence in clinical practice as well as quality and safety in care delivery to the increasing dominance of a multicultural society in the United States, a course of action to address these issues became a part of the national healthcare debate.

In 2004, the Agency for Healthcare Research and Quality (AHRQ) and the Office of Minority Health (OMH) established a research agenda to identify the components of cultural competence. From an organizational perspective, the effectiveness of this approach began to appear in the literature Betancourt et al. [12]. Nursing models that captured concepts such as expertise, skill development, knowledge, and awareness gained attention Campinha-Bacote [13]. Such efforts addressed issues of mixed performance in health outcomes evidenced in the literature comparing population groups, and it has been possible to audit research and produce studies demonstrating care below par based on ethnic background. However, there is not enough complied evidence to give legitimacy to the claim of ethnic bias in clinical decision-making such that the process can objectively test positive for its presence.

Figure 4.1 is a conceptual model of proposed influences on clinical decision-making as it relates to unfamiliar ethnic minority culture. It is a conceptualization by the authors of the decision maker who does not choose the prevailing treatment for an ethnic minority patient. Although the choice may remain clinically defensible, the alternative may not hold the same standing as the more prevalent treatment option. In such a scenario, the cognitive construct of the patient held by the decision maker is open to interpretation.

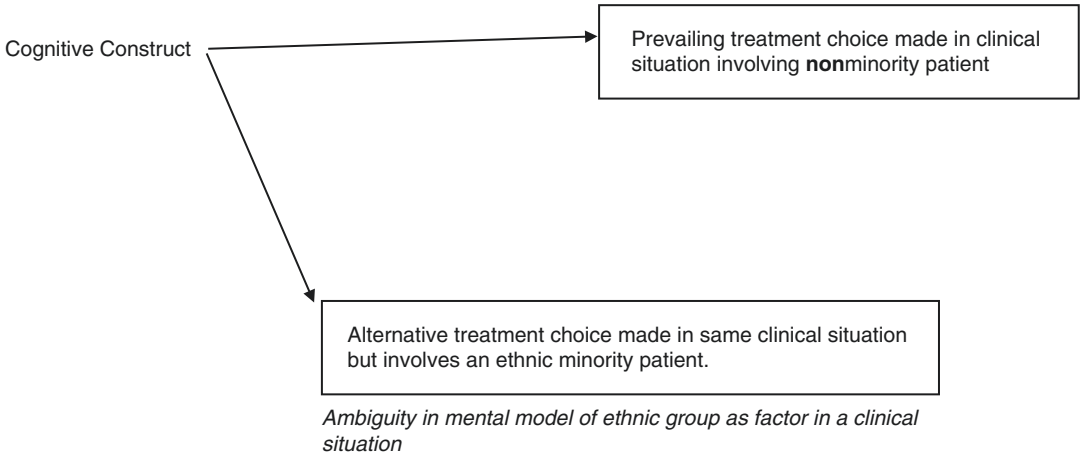

Fig. 4.1 Treatment dichotomy: cognitive construct for treatment decisions involving the ethnic minority patient

Identity Theory

Identification is the idea that persons perceive themselves as having a social as well as a personal identity. Social identity connects the individual with those considered "the same." The identity (social or individual) that dominates is situational, however, and theory suggests social comparison as a third aspect of the dynamic superimposed on the dyad of identity concepts. This specific instance incorporates the perspective that each individual also seeks an evaluation of self in comparison to those who are similar.

Social identity theory dates from 1979 as developed by social psychologist Tajfel, who studied intergroup relations. Theoretical concepts included the interaction between personal identity and social identity Brown and Capozza [14]. Tajfel suggested that group assignment creates a situation in which individuals construct a positive sense of self, based on group inclusion. An ingroup and out-group awareness is associated with embracing a group identity constructed from characteristics considered common among those who comprise the group. It is unclear if these attributes are generally viewed as diagnostic of group membership or merely symbolic.

A group trait idiosyncratic to a shared identity is a complex construct. It is a difficult supposition to ascertain among large numbers of disparate individuals. Nevertheless, popular culture allows for such familiar generalizations about social groups. These abstract properties are well known, but conspicuously undesirable as descriptors, because using them served to marginalize. African Americans, for instance, have a unique American history in relation to social inequities, but despite a context of racism and discrimination, Black people forged a cogent cultural and group identity. Within the characteristics of this distinctiveness, a fuller understanding of the relationship between cultural coherence, health status, and clinical decision-making may emerge. By what means ethnic or cultural identity functions, as a factor in healthcare decisions, remains unexplained.

The theoretical tenets of social identity theory and related scholarly perspectives on the principles of group membership do not nullify the concept of a self-determining personal identity. While individual perceptions and feelings can be affected by the ideas and opinions of others, it can also be assumed that each person within the group remains an autonomous thinker. This premise suggests the elements of a stereotype may be pliable to personal frames of reference in addition to models disseminated by the dominant social group.

The fluidity between the dominance of social identity or personal identity is a question of situational demands. There is the implication that trait consistent factors exist, and together consti-

tute identity categories. It is conceivable within the context of this reasoning that the individual incorporation of a category means enfolding stylized traits that are consistent and recognizable to the individual member of a group, the associated principal group, and to the general social order.

Exercise 2
Consider your responses to Exercise 1 then rank them in the order that you feel best describes your core identity. Jian ranked her profession as the most important part of her identity followed by her gender then her immigrant status. Which aspect of personal identity holds priority in your self-concept? Which part of your individual cultural identity comes in second, third, and so forth? Did some aspects of your unique cultural identity seem more difficult to rank than others? What aspect of your cultural fingerprint drives your decision process? Patients may make medical decisions based on their unique cultural priorities, so we as clinicians should be mindful of this.

Teal and Street have proposed four elements for culturally competent communication in the medical encounter [15]. They list communication repertoire, situational awareness, adaptability, and knowledge about core cultural issues [15]. Betancourt and colleagues noted that cultural differences between physician and patient may place barriers to effective communication, which translates to patient dissatisfaction, poor adherence to treatment plans, and adverse health outcomes [16]. Others point to improved health outcomes with patient-centered communication [17, 18]. Moreover, a culturally sensitive clinician should be able to realize and respond to the sociocultural differences between physician and patient [19]. While patient-centered care provides for improved care for all individual patients, culturally competent care emphasizes appropriate and equitable distribution of care in patients from diverse and disadvantaged backgrounds [20]. We posit that patient-centered care enhances culturally sensitive care and lies at its core. Without a patient-centered approach, those patients who present from outside the mainstream parts of our society will feel marginalized and likely not return to treatment unless emergency situations force them to come back.

Communication: Reading Between the Lines

Let us look at each facet of culturally competent communications in the medical encounter as described by Teal and Street. First, the clinician must possess a communication repertoire. The clinician's communication repertoire multiplies the effectiveness of sensitive interaction between the caregiver and the patient. According to Shapiro, a culturally competent communication repertoire includes basic attitudes of empathy, caring, and respect that form the foundation of all clinical encounters [21–24]. Fundamental communication skills build upon active listening, acknowledging sociocultural aspects of illness, inviting patient perspectives, inquiring about socioeconomic implications of treatment, and empowering patients to make decisions [25–27]. The goal of effective communication in any clinical encounter is twofold: obtaining accurate information from the patient and providing the pertinent information that the patient needs to make decisions about treatment.

Learning tradition dictates that initial clinical evaluations are organized in a standard format starting with a chief complaint then moving to the history of present illness followed by medical history, family history, and social history. Those who work with children and adolescents place special emphasis on a developmental history. All clinicians, however, should consider including a cultural history in every initial evaluation. Some clinicians delegate the cultural information about the patient to the social history, and this usually suffices, if the patient comes from a similar cultural background as the clinician. However, adding a separate cultural history for any patient coming from a different background than the clinician, or one not represented by mainstream culture, is beneficial. The cultural history serves as a valuable source of information for anyone who reads the patient's chart. Moreover, this type of documentation should be viewed as a process instead of simply part of the initial evaluation.

Think of a cultural history as an evolving process. It begins with the initial evaluation and continues to grow with each subsequent encounter.

Of course, the clinician-patient relationship will need nurturing. Sometimes, a gradual accumulation of cultural information is the most effective and efficient approach to gather information. Consider the case of Mr. M., a Mexican migrant fruit picker in California's central valley. His "green card" expired several months ago, but his poor English prevented him from finding the appropriate authorities to renew his worker visa status. Unfortunately, Mr. M. found himself in the emergency room after he accidentally gashed his left hand due to a slip of the pruning knife. As the young resident tried to establish rapport by learning about the patient's cultural background through the use of an interpreter, Mr. M. became visibly anxious. The resident persevered with further questions, such as: How long have you been in the United States? Where did you live in Mexico? Do you have other family members living with you here? The resident intended for the questions to establish a connection and rapport, but they worked in the opposite direction. Mr. M. feared that the clinician wanted this information to pass it along to the immigration authorities. After the resident finished suturing the wound and giving Mr. M. instructions for after-care, she asked him to return in a week for suture removal. Mr. M. smiled and nervously thanked her. He, however, dared not return to the hospital, since he thought immigration officials would be waiting to deport him.

In retrospect, the resident could have chosen less threatening questions or simply deferred these types of questions until she gained his trust. She did not know about her patient's visa status, and that can be forgiven. However, she missed the escalating anxiety Mr. M. exhibited and she did not adjust her approach. Teal and Street refer to this ability to perceive and attend to the nuances in the patient's behavior as situational awareness.

Awareness: Keeping an Eye on the Compass

Situational awareness along with self-awareness comprises the second of the four critical elements in culturally competent communication [15]. Sometimes subtle, such behavioral changes usually signal a problem or misunderstanding in the patient-clinician relationship. The patient may perceive race base cues from the clinician during the encounter. Maintaining self-awareness related to bias, prejudice, micro-aggressions, and cultural miscues can influence body language and interpersonal reactions that can derail the clinical encounter. According to Epstein and Street, situational and self-awareness enhance communication to clear up confusion, deal with disagreements, and come to a common understanding of the medical problem and the preferred treatment options [17]. Situational and self-awareness result from "mindfulness" in the medical encounter. The term "mindfulness" refers to a new form of psychotherapy based on cognitive behavioral therapy that draws upon Eastern meditative techniques [28, 29]. In essence, mindfulness allows the clinician to fully focus on the patient in the present moment.

Conversely, the role of race-ethnicity in a mental model is provocative. As a social construct, its connotation is not typically positive. Placing race-ethnicity in the data set of information available to a decision maker is nettlesome since it evokes unsettling historical matters and causes doubt and uncertainty about contemporary ones. It is also difficult to concede that in any given situation, race-ethnicity is insensible to another. To say the concept does not register negatively is not to say it has no register. The manner in which it correlates as data in a decision schema is presently undefined; consequently, the probability that the concept indicates a point of uncertainty or ambiguity in the decision process by its simple existence is worthy of consideration. If the race-ethnicity construct is included as a variable, it is a reasonable expectation that its use is credible. In other words, it is important to understand whether race-ethnicity indicates a narrowly defined group, or whether it more appropriately serves as a parenthetical determining factor within the context of other issues. Stereotypes associated with race-ethnicity are sometimes a proxy for a combination of qualities belonging to a person. On the other hand, it

may be imposed on characteristics outside personality. More specifically, is race-ethnicity irreducible and not able to be further divided or simplified into component parts?

In mindfulness groups, one of the more memorable exercises involves eating a piece of chocolate. Each member of the group receives a single candy as a group leader guides the participants through a full appreciation of that one piece of chocolate. The leader instructs the group to savor the aroma then relish the texture and color. Over the course of several minutes, group members experience every detail of the small treat before they taste it. Most people have never focused on a piece of chocolate so intensely, so they never fully appreciated the essence of chocolate. Unfortunately, the time-pressures of managed care rarely allow clinicians to savor complex cultural diversity that each patient brings to the encounter. Physicians and other practitioners rush to obtain diagnostic information with the goal of a quick and efficient move to treatment. Like someone who mindlessly gobbles a piece of chocolate barely tasting or enjoying the experience, clinicians miss out on the cultural flavors that make clinical encounters so rich. The pressures of acuity and third party payers drive interactions to the contemporary care environment.

Imagine, instead, a mindfulness approach to each patient encounter. In this scenario, each clinician becomes a discerning expert on patients from very diverse background. Once she or he adopts the mindfulness mindset, that clinician can appreciate the unique ways that a person's race, religion, ethnic background, sexual orientation, gender and/or age, come together as the richly textured cultural identity of a patient. The interface between race, religion, ethnic origin, sexual orientation, gender, age, and a number of other elements produce cultural identity as it is currently understood. The patient and the clinician may not be culturally congruent, but this offers opportunity for the professional and personal growth, especially for clinicians who wish to understand the variety of human experience that diversity offers.

Ethnocentrism

Ethnocentrism—or the perspective that the culture of the ingroup is the definition of normal—serves as the boundary marker for a group that dominates. For example, *historically European* and *biomedical* are labels for what is familiar and approved in the operating standards accepted by the American healthcare system. This is especially true in meeting the requirements of the marketplace (e.g., care costs, funded research) as an influence on care delivery. However, this viewpoint may have run its course with the latest census, because the dominant group has reached a tipping point with the mass arrival of non-European populations [30]. Ethnocentrism was once the prototypical model of care delivery, since the demographics of the United States reflected the European roots of the nation. What holds the attention is the international sources of these new demographics flow from countries customarily treated as lacking in global value or importance (e.g., third world countries, war torn countries, developing countries). Upon residence in the United States, census designations force adoption of checklist identities culturally informed by the American experience. More specifically, African becomes Black and Mexican becomes Hispanic, and the consequence of this is that different immigrant groups now dominate communities that are the focus of a contemporary public health agenda. In Massachusetts, for example, the gain in state population for the last census was dependent on immigration. New immigrants arrived to the state from South and Central America, India, China, Russia, Vietnam, and the Caribbean [31]. Ethnicity and health disparities are two typically correlated variables.

The characteristics associated with ethnic identity have the potential to inform a more comprehensive understanding of a group's social identity. The latter involves the larger concepts of categorization (Black, Muslim, southerner), identification (ingroup, out-group), and social comparison. Ethnic identity with its cluster of descriptive features (race, religion, language, history, etc.) has the capacity to more precisely outline the features that constitute a social identity.

Once the link between social identity and ethnic identity has been established, it becomes possible to explore the interpersonal and intergroup relationships that are often problematic in the clinical setting.

Ethnocentrism is often cited as an example of an ingroup perspective [32], and attached to these categories are value judgments [33], because the ingroup designation creates boundaries and conscious articulation of differences motivated by comparisons. The anticipated outcome from such processes is a positive sense of self-worth stemming from group inclusion. The notion that social identity is created by its designate and adopted freely by them is incorrect, since it mistakes social identity for group identity. Prejudice and stereotypes by the social identity designators make this proposition questionable. To the contrary, these negative influences are often the impetus to disestablish a social identity and when the creation of a group-based identity is the outgrowth of a circumscribed social existence the results demonstrate a high degree of refinement [34, 35]. This cultivation is typically given disproportionate meaning outside the social structure of the relevant group. An emblematic illustration is the way African American frankness is misconstrued. Outside its cultural paradigm, it may seem to be brusque or socially incorrect behavior.

Negative Social Frames

The difference between the patient's and the clinician's cultural identities can lead to inaccuracies in communication. Sometimes a language barrier exists between the patient and the clinician. Interpreters can be invaluable in such situations. A contemporary subtext to this focus is the issue of citizenship. Since the 1970s there has been a decrease in European immigration to the United States. An increase in the numbers of people coming into the country from Latin America and Asia replaced this reduction. This new influx of people created concern in the native-born population about the potential loss of a core American identity Grant Makers Health [36]. A perceived state of perpetual foreignness of some populations is a source of resentment that targets immigrants as largely illegal, poor, and heavy consumers of tax dollars. Such stereotypes of ethnic groups may contribute to unequal treatment in care. Ethnocentrism was once the prototypical model of care delivery as mentioned earlier.

Today, technology allows for small or remote facilities to connect with interpreter services via electronic audio or audiovisual conferencing devices. An interpreter often provides cultural insights. Nevertheless, specific skills are needed to work effectively with this valuable resource. For example, the clinician should observe the patient while the interpreter asks questions in the patient's native language or receives information in the other language. It is instinctive to look at the person speaking, i.e., the interpreter; however, the focus of an interpreter-facilitated clinical interaction remains connecting with the patient and not the interpreter. Attention to the patient allows for observation of the patient reaction to questions and any discomfort associated with the answers. A mindfulness approach applies in this case even with major language barriers between the clinician and patient.

At other times, an accent, medical jargon, or idiomatic expression can lead to misunderstandings. The clinician must observe the patient closely to discern whether any change in body language or facial expression signals a problem. Using situational awareness and self-awareness permits clinicians to remain mindful in the moment with their patients and prevents miscommunication in sharing information and arriving at an appropriate treatment plan acceptable to the patient.

In a mindfulness-based patient encounter, the clinician must pay attention to her/his own cultural identity and beliefs while realizing the stereotypes and prejudices she or he might hold about persons from the patient's demographic group [29]. This, however, comprises only a fraction of the equation: self-awareness. A mindfulness-oriented clinician also must assess the patient's spoken and unspoken reactions to her or his behaviors: situational awareness. The patient's reactions may manifest as changes in facial expressions, shift in posture, choice of words, tone of voice, or even an

awkward silence. Although this sounds like sound advice for any patient interaction, clinicians should show particular vigilance for these signals whenever they meet with patients from cultures quite different from their own.

Discomfort with ethnic bias as a factor in clinical decision-making is related to uncertainty about the existence of the antipathy usually associated with race prejudice (Hobson 2001) [37]. Inveterate dislike as opposed to a random, negative reaction based on a real time event challenges the traditional image of the egalitarian and objective clinician. This latter depiction is the more customary portrayal of the health professional and is not usually part of public dispute. Nevertheless, the experience of African Americans with the healthcare system is sometimes pictured differently. A 1999 special report supported by Seattle Public Health explored the experience of 51 African American patients through an interview project. Those questioned related incidents in which they described differential treatment, and many occurrences included a "perceived negative attitude" from healthcare professionals further detailed as behavior that was "rude," "cold," "inattentive," and "belittling." "The perceived negative attitude exhibited by health care providers or their staff members were not reported as hostile but as uncaring or rude behavior" (p. ix). The respondents were patients from approximately 30 different health centers and recalled experiences as early as 10 months previous to the interview. Types of perceived discrimination captured by the report were: differential treatment, perceived negative attitude, treated as dumb, made to wait, ignored, pain ignored, inflicted unnecessary pain, racial slur, harassed, being watched, and health personnel exhibited fear (Hobson 2001) [37].

While the Hobson study outlined examples of behaviors identified as discriminatory by the respondents, it was not the purpose of the study to examine another unexplored phenomenon within its chosen scenario. More specifically, the responding behavior from the study subjects to the actions and manner of the clinicians was not part of the inquiry, so the interplay between patient and provider is raw material for further research. With reciprocal feelings as context for the clinical encounter, it is reasonable to surmise a type of relationship not subject to control of the will. In the contemporary healthcare system, it is becoming less and less likely that patient and provider have more than a sporadic and incidental relationship, and they are very often not known to one another. Expanding the premise further includes acknowledgment that development of expertise is based on accumulated knowledge of the typical patient. This emblematic patient becomes a point of comparison and is affectively representative for each clinician of what is reasonable or excessive, characteristic or embellished. The emotional reaction of the Hobson [37] study (Hobson 2001) subjects and their responding behavior poses an interesting scenario of stimulus and response between patient and provider. In particular, Rosenthal [38] posits that when the provider is interacting with an out-group member stereotypically viewed as "loud, hostile, lazy, criminal and low intelligence" (p. 132).

Rosenthal [38] either as the one patient of the day or the tenth from the specified ethnic group, the effect on care deserves inquiry. With feelings as context for the clinical encounter, there is sound basis to surmise the possibility of a strained and unacknowledged tension in a cross-cultural interaction. While it may be true that not all clinical encounters involve the activation of ethnic bias, the resulting hypothesis exploring the kinds of data that increase or decrease the presence of bias, prejudice and discrimination in thought and practice becomes a worthy goal. Rosenthal [38] goes further "Research can shed light on the way racial biases are activated and how they persist, fostering the development of empirically validated strategies to neutralize the effects of these stereotypes" (p. 139).

Bodenhausen et al. [39] did the work of investigating the influence of affect on perception and behavior between ingroup and out-group members. In their writing, the authors acknowledge "psychologists have known that, through experience, certain stimuli come to elicit consistent affective reactions" (p. 321). The barrage of social messages about ethnic groups has not abated with the passage of time, and in the absence of censure, the amount of such information absorbed by any individual is open to conjecture. Whenever there is no social contact to

contravene about the information communicated, the patient becomes an avatar of those socially embedded messages. Bodenhausen et al. observed that the amount of research scrutinizing the characteristics that explain affect concomitant with stereotypes is insufficient.

The experience of any clinician with social difference may be limited. It is not unusual for the work environment to be the primary contact for significant interactions between cultural groups. Awareness of this paradox informs the chosen method for engaging clinicians in a learning experience with diversity. In Patient Care Services at MGH learning experiences are experiential and interactive. The use of games, case studies, profiles of local communities and neighborhoods as well as educational offerings on topical events are a few approaches to making diversity "come to life" for staff and employees.

Healthcare Environment and Diversity

Part of the decision-making process in healthcare is to gauge the seriousness of signs and symptoms as a subjective report from the patient and the clinical distress they cause. An objective assessment of this account from the patient is the responsibility of the nurse and doctor. The consequence to this within the set of circumstances that constitute a cross-cultural interaction is the pivotal point of the following research.

The contemporary environment for clinical practice is fast paced and technologically sophisticated. A diverse patient population with multifaceted needs make care delivery intricate and often pressured. The discourse on economics of care presently joins the prevailing business case for care in the form of quality, safety, and evidence-based practice. Regulations and the debate for better-managed resources make the element of time an important factor that helps determine practice characteristics. The 20-min patient visit is a standard constraint on present-day practice, and as previously mentioned, short time frames facilitate the automatic processes involved with stereotype activation. This conceptual model of the healthcare environment represents the cross-cultural encounter and the environment that influences it (Fig. 4.2).

Sometimes the patient might not appear so different from clinician; however, situation awareness makes subtle difference more obvious. For example, Sally Hendricks, NP felt something was wrong as she handed her patient a prescription for the newest antidepressant medication to

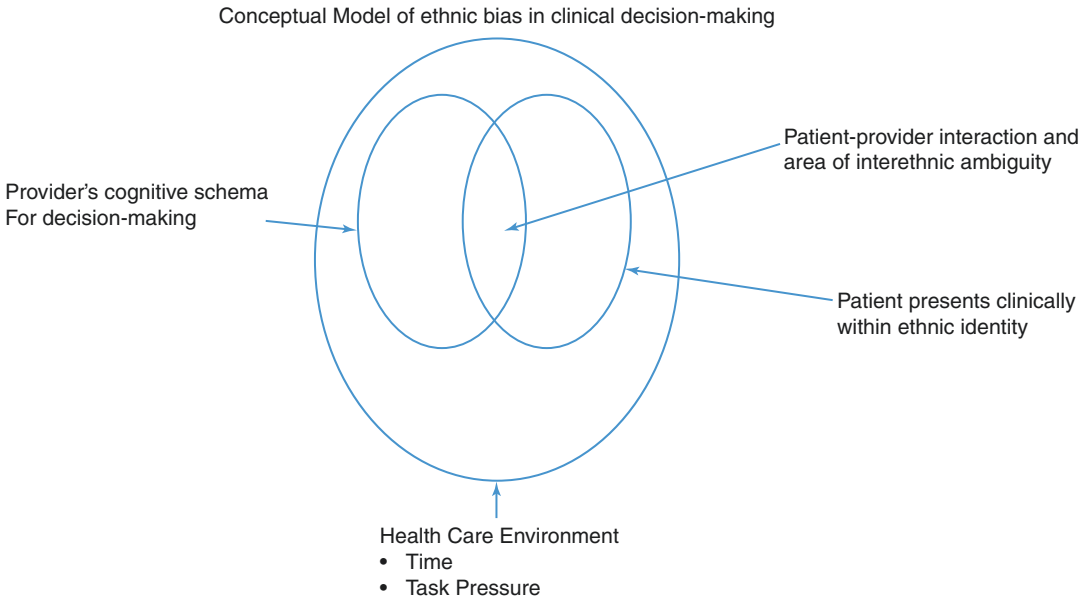

Fig. 4.2 Conceptual model of ethnic bias in clinical decision-making

hit the market. Calvin W, a 37-year-old restaurant owner, took a deep breath as he took the prescription, folded it, and slipped it into his pocket without looking at it. His raised eyebrow indicated that something bothered him, but the nurse practitioner could not identify the problem. He told her that he knew he had depression and his symptoms fully met the criteria for major depression, so the diagnosis was not the issue. The side effect profile of this new medication offered substantial efficacy with few side effects; therefore, fear of untoward reactions did not explain his reaction. Calvin W appeared to be middle class based on his attire and manners, so Sally did not suspect that he experienced a great deal of financial strain since the recession of 2008. Mr. W. happens to be struggling to keep his restaurant open and, at the same time, pay child support. Perhaps the stress of being a single man with responsibilities to his family and employees contributed to his depression; nonetheless, Sally did not realize he could not afford to pay for the prescription, which meant that he would not start treatment. Sadly, the nurse practitioner missed the socioeconomic issues that often become the proverbial "elephant in the room." She assumed that he shared her middle class security.

According to the US Census of 2010, about 20% of the non-elderly population are uninsured [40]. Interestingly, of the uninsured, 46% are White, 31% are Hispanic, 16% are Black, and 5% are Asian American [40]. Today, more and more people are slipping from one socioeconomic class to a lower one, which causes embarrassment and a great deal of difficulty adjusting for that person and/or family. Moreover, a self-employed middle class person might not be able to afford insurance that provides the basic coverage a person on welfare receives for free. Cultural differences are often obvious, but not always. Calvin W came from a middle class White neighborhood like Sally, but circumstances caused him to slip down the socioeconomic ladder recently. Some patients feel uncomfortable talking about certain subjects, such as economic problems, sexual practices, and the like; nevertheless, clinicians may need to rely on situational awareness to recognize clues that something might be amiss and a cultural misunderstanding is in the making. Subtle signals, such as the ones above, indicate that a cultural bias might be impairing the interaction, which leads to major implications for effective treatment.

Aside from economic disparities, the National Healthcare Report from the AHRQ from 2011 indicated that Blacks and Hispanics with major depression were less likely to receive treatment during the 12-month observation period compared to Whites [40]. In addition, the report noted that Black adolescents and adults received treatment for alcohol and substance abuse problems more frequently than their White and native American counterparts [40]. Perhaps clinicians make stereotypic assumptions about certain racial or ethnic groups, and this translates into disparities in healthcare delivery. Such disparities might be avoided if clinicians challenged their biases through self-awareness in the doctor patient encounter. Thus, situational and self-awareness serve as the second part of the culturally competent care equation. However, self-awareness plus situational awareness does not necessarily equal culturally sensitive medical care.

Adapting: Changing Course in the Encounter

Another part of the equation involves adaptability. Of course, perceived similarities between physician and patient can enhance the dynamic relationship; however, patients within any cultural group show a wide range of individual variability [41]. Additionally, clinicians today frequently encounter patients from cultures and backgrounds quite different from their own. In either case the physician/clinician/researcher must adapt their approach to accommodate the sociocultural health beliefs of such varied patients [15]. Of note, patients who actively participate in medical visits tend to receive more responsive care from their physicians [42]. Patients become more active in treatment whenever the physician offers more facilitative interactions [15]. Physicians facilitate interactions with their

patients by taking a reflective demeanor that adjusts to the patients cultural and personal beliefs while in the therapeutic moment of the appointment [15]. Although Schon suggests that such reflection and the subsequent adaptation to the situation should happen during the encounter, sometimes a reflection after the fact reveals aspects of situational and self-awareness that slipped past the physician during the busy visit [15, 43]. Adaptability integrates awareness with action.

Consider Dr. Nguyen's dilemma: Mrs. L. is a 63-year-old Hmong widow, who presented to the Ambulatory Care Clinic for the treatment of a possible urinary tract infection. The receptionist intentionally put Mrs. L. into Dr. Nguyen's schedule, because the initial screening information indicated that the patient emigrated from Vietnam, and so did Dr. Nguyen. Unfortunately, the receptionist did not know that Hmong people identify more with their ethnic background than a particular country. Fortunately, Dr. Nguyen did. Therefore, he paid particular attention to the patient's body language and facial expression to maintain situational awareness while filtering his stereotypic view of the Hmong people that he learned from his older family members to incorporate self-awareness into the interview. From the moment he met Mrs. L., Dr. Nguyen sensed that the patient seemed suspicious of him. Instead of jumping into a review of systems, he decided to shift and reminisce about the beauty of the Vietnamese landscape, which was so different than of East Boston. As Dr. Nguyen described some of his favorite places in Vietnam, Mrs. L. slipped into a smile as she nodded in agreement while Dr. Nguyen described the lush landscape around the region that the patient spent her childhood. Once he saw the smile, Dr. Nguyen then switched to a sadder tone of voice as he mentioned that he has never been able to find pho, a Southeast Asian soup, that tasted as good as pho he ate as a boy in rural Viet Nam. Although Dr. Nguyen knew little about the Hmong culture, he expected that she shared his disappointment of the American version of a Southeast Asian cuisine.

Of course, he hit the mark, and Mrs. L. started to explain her dismay of finding fresh ingredients for her cooking. Dr. Nguyen secured her trust without stepping into the quagmire of politics that likely caused Mrs. L. to act in a guarded and suspicious way with him at first. At that point, the review of systems and other medical information gathering flowed smoothly. Dr. Nguyen maintained situational and self-awareness and then adapted his approach to meet Mrs. L. on a human-level sharing pleasures and disappointment. This allowed Mrs. L. to relate to Dr. Nguyen as person, not someone possibly from another political party that persecuted her people after America withdrew troop from Vietnam.

Core Knowledge: Continuing Cultural Education

To complete the equation, a culturally competent clinicians must know about core cultural issues in the patients they treat [15]. Carrillo and colleagues suggest that clinicians should focus more on core cultural issues of an individual patient rather than culture of the group to which the patient belongs [44]. This prevents the clinician from relying on stereotypes related to such attributes as race, age, gender, religion, ethnicity, or socioeconomic status. The authors feel this applies not only to clinicians but also to researchers and educators as well.

Likewise, patients may identify primarily with one or two major features of their cultural background, i.e., a Chinese American man or a Latina woman from Costa Rica. However, such stereotypes only scratch the surface. Simply adding one layer, such as marital status, makes the cultural identity of these two individuals more complex. What if the Chinese American man were married to the Costa Rica woman in the example above? Of course, the plot thickens by adding one more layer. Now, imagine that they had a boy and a girl, who were fraternal twins. How would the children identify themselves from a cultural point of view? Might the son identify more with his father's Chinese heritage or the daughter with her mother's? Does

their twin status impact their cultural identity? These and many more questions attest to the complicated interactions of different cultures in this hypothetical couple and their children.

Implications of Diversity and Clinical Practice

Recently, the United States and a number of other Western countries experienced major shifts in demographics due to immigration patterns. According to Annelle Primm, M.D., M.P.H., director of minority and national affairs at the American Psychiatric Association, minority births exceeded White births in 2011, and 50% of 3- and 4-year-olds were White, while the remaining 50% were non-White [40]. This means that today's majority may become tomorrow's minority. In the end, clinicians must acquire skills to manage patients from cultures other than their own. For example, a Black internist identifies herself as member of the minority, but she must understand core cultural issues of other minorities and even those of the majority group to facilitate a culturally sensitive medical encounter. With patients from so many cultures converging in waiting rooms, can anyone ever achieve enough knowledge to gain true cultural sensitivity?

Of course, assimilating knowledge about our patients' core cultural issues poses certain challenges, but technology provides part of the solution. Only a few decades ago, learning about the customs and mores of patients from foreign countries or different backgrounds than clinician's own typically required a trip to the library. Even a decade ago, the clinician would still need to find a computer to search the Internet for such information. Now, however, such information is at hand with handheld devices, i.e., smart phones, electronic tablets, and other devices.

Another source of information comes from colleagues. As the population grew more diverse, equal opportunity employment laws shifted hiring practices. As a result, the very homogenous White male medical staff of the 1950s evolved to the spectrum of diversity we see in medicine today. This diversity provides ready resources in our institutions for cultural consultation. To take full advantage of these resources, clinicians should think outside of their department and even their profession. For instance, John, a physical therapist, felt frustrated that Mrs. K. showed little motivation to complete the exercise program he prescribed each week. She came to live with her son in Texas after her husband passed away in Pakistan at age 80. Instead of giving up, John contacted Dr. Shah, an orthopedic resident from Pakistan, whom he met at a case conference 2 weeks earlier. Given that physical therapy requires a great deal of hands-on treatment, Dr. Shah wondered whether the patient's very strict Muslim background caused her to be uncomfortable with a man, other than her husband, holding her hand and touching her as John needed to do to help her during the session. He suggested that a female physical therapist might make her feel more comfortable in the aspects of therapy that required hands-on assistance. It did. John stayed involved with the case by giving verbal support, but Mrs. K. seemed much more motivated and comfortable with Cathy, one of the female physical therapists in the group, who took over the hands-on treatment. Colleagues offer a valuable resource for cultural consultations, so take advantage of their expertise even if that person works in a different department or area of your institution.

Possibly the best, cultural resource remains the patient. Most patients happily share information about their own culture within the context of the trusting relationship. As described earlier, suspicions about the motives of the clinician can be problematic. Building trust in the cross-cultural encounter becomes the foundation of a successful clinical experience. Avoiding questions that arouse concern about immigration or internal revenue agents is paramount. Begin the interview with benign questions, such as:

- What is the weather like in your hometown of Caracas at this time of year?
- I know that no one can cook as well as your mother, but do any of the restaurants in town serve Cambodian food close to the kind your mother made?
- How do you say "hello" in Cantonese?

Clinicians benefit from cultural curiosity. A question stemming from sincere interest suggests a receptive and supportive provider. Additionally, cultural diversity presents in a myriad of permutations. Individuals who appear to be culturally similar may differ in several significant perspectives, e.g., economic status, sexual orientation, or religion. Cultural curiosity often uncovers differences that otherwise might go unrecognized. The trusting patient will confide and reveal as a sign of confidence in the clinician.

A number of other political and social factors also play a role. Interestingly, advances in science and medicine have, in themselves, helped create cultural diversity. For example, patients now have access to medical procedures to transform themselves from one gender to another. Even though hormonal and surgical procedures result in remarkable physical changes, our understanding of the psychological isolation or marginalization experienced by patients at various stages of the transgender process requires much further research.

According to Hayes-Bautista, true cultural competence in medicine must hinge on large-scale, rigorous, science-based approaches to understanding the connections between culture, behavior, and epidemiology [45]. He points to the Latino epidemiological paradox to make his case [45, 46]. Latino populations show reduced risks for the top three causes of death compared to non-Hispanic Whites. The mortality rate in the Latino population is 35% lower for heart disease, 43% lower for cancer, and 25% lower for strokes [47]. Interestingly, these outcomes cannot be attributed to high income, higher educational levels, or easy access to the highest quality of healthcare [45]. However, careful investigation of Latino life, including diet, family structures, religious beliefs, and many other aspects of culture, might give clues to this paradox that could be used to improve the health of non-Hispanic populations [45].

Conclusion

Although this chapter presented a paradigm for providing medical care to patients from different cultural backgrounds and using examples of situations a clinician might encounter, other approaches to culturally sensitive healthcare delivery exist and work equally well. As described above, a successful clinical encounter with culturally diverse patients results from a simple equation in which the clinician uses effective communication aligned with situational and self-awareness. Adaptability multiplied by a core of cultural knowledge adds to the probability of success in the cross-cultural encounter. Race, religious beliefs, ethnic background, nationality, gender, sexual orientation, marital status, and numerous other aspects of social demographics give clues to cultural identity. Mental health providers, as well as all other persons delivering healthcare services, should understand the complex connections between each of these clues, so that interventions that would lead to better outcomes override those that might hinder treatment due to a lapse in cultural sensitivity. The population we treat appears so diverse, because of the amalgam of cultural traits that makes up each individual's heritage. Moreover, each patient constructs a hierarchy of cultural traits in which one may overshadow another. For instance, is race more important than religious beliefs? (or lack of religious beliefs) The answer may be situational, culturally embedded, or irrelevant.

Intersectionality is an effective framework to bring focus to the underlying structure of information presumed to have bearing on the patient as a social being. Membership in a social group is fluid. This variability is greatly influenced by interactions loaded with the baggage of object lessons and representative patterns of behavior recognized from negative lived experiences. The issue for the clinician is the development of skill and understanding that serve as countervailing evidence that aspects of identity are not negative influences on the therapeutic encounter. Viewed as a problem domain, culturally sensitive care must point to methods and insights that produce solutions. Clinicians must demonstrate the conscious ability to express recognition of elements of identity as data. This data is defined as pieces of information that function to make more specific the meaning of perception, perspective, and reasoning within the context of the culture-based encounter.

The incorporation of the aforementioned data comes with a caveat. Unconscious bias may block cognitive dissonance. Absent the necessary knowledge and exposure to diversity, it is possible for the clinician to be incognizant of care compromised by bias or prejudice. This is especially true in decision-making that is unchecked and unchallenged. Clinical rounds, case presentations, and consultations become critically important education tools to develop expertise in caring for a culturally and linguistically diverse patient population. This type of proficiency requires a many-sided viewpoint and mind-set to form a therapeutic alliance. A frame of reference to approximate equivalent meaning is part of this skill building know-how.

The literature is replete with such subjects as implicit associations, cognitive load, aversive racism, and unequal treatment as indirect evidence of the impact that bias can have on the quality of care provided to ethnic minorities. However, to solve the problem of disparities, a paradigm shift in the approach to research is necessary. A more vigorous multidisciplinary strategy would advance the work with a renewed sense of urgency. Dovidio et al. [48] made the point that findings from social psychology and the health disparities literature are not organized into an interconnected knowledge base. In like manner, Drevdahl et al. [49] have offered the same research challenge to nursing stemming from its focus on cultural competence as the best-yet effectively unproven intervention to eliminate disparities. These authors have argued that in the discipline of nursing cultural competence, there currently lacks consensus on theoretical models, definition of relevant terms, or the identification of skill sets that define competence for clinicians. Until the nature of this specific competence is characterized, it will remain impossible to evaluate the situation that defines the point at which a clinician is operating at nothing more than a satisfactory standard. Fulfilling all requirements of safe nursing practice in the performance of autonomous decision-making symbolizes an entry-level execution of the concept that can be applied to mental healthcare. Clinical reasoning in nursing allows a great deal of latitude in scope of practice as an indication of expertise. On the other hand, cultural competence connotes a level of acumen that goes beyond what is merely adequate and moves practice forward to exceptional quality and ability. While not all disciplines favor the concept of cultural competence over cultural sensitivity, skill acquisition is more aligned with the former principle. The advancement of nursing practice is linked to its capacity to respond to a diverse patient population. To disregard this competence would be to have nursing practice remain in a fixed state and reducible to its past rather than its evolving relevance to the future.

In the end, mental health clinicians should develop a core of cultural competence to understand patients from diverse backgrounds, but they must exercise cultural sensitivity in interacting with each individual patient. No psychiatrist, psychologist, social worker, specialized nurse, or other mental health provider can possibly acquire a knowledge base adequate to understand all the nuances of ethnicity, race, gender, or other element of diversity that one will encounter in clinical practice today. Nevertheless, every clinician should be able to learn the important information specific to an individual patient so that each encounter with a patient evolves from a culturally sensitive approach and one relevant to the situation that caused the patient to seek treatment.

This chapter began with the example of President Obama. It appears apropos to end with a quote by President Kennedy:

> If we cannot end now our differences, at least we can help make the world a safe place for diversity. (John F. Kennedy)

Acknowledgments Thank you to Ms. Taquesha Dean for all of her administrative help during the writing of this chapter.

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