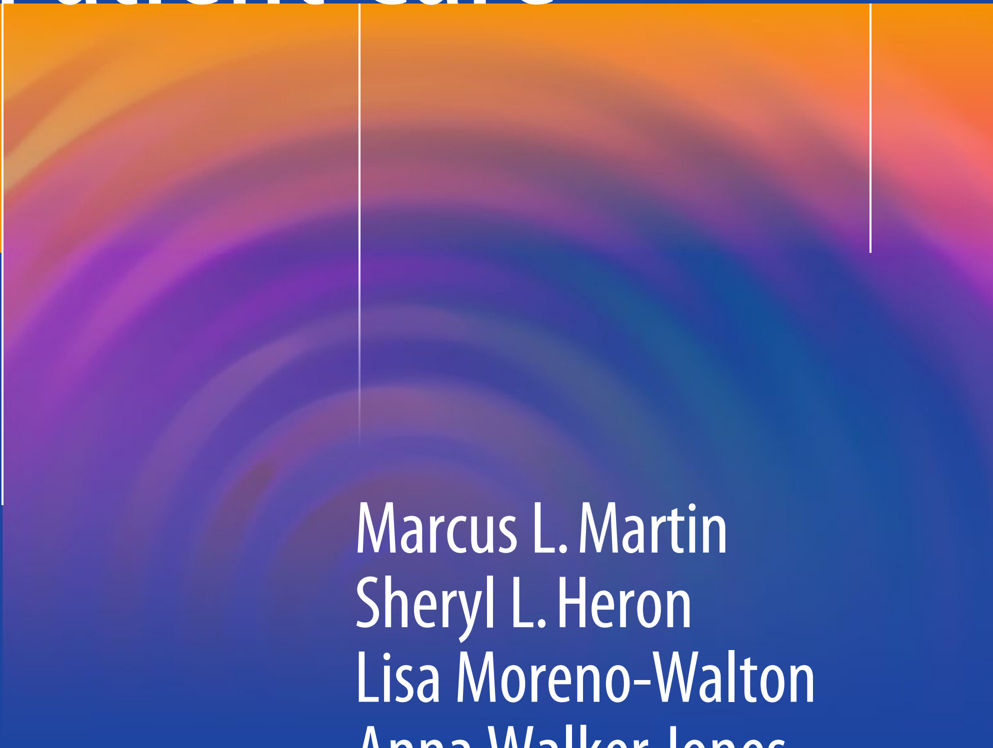
Diversity and Inclusion in Quality Patient Care



Marcus L. Martin
Sheryl L. Heron
Lisa Moreno-Walton
Anna Walker Jones
Editors

Springer

Diversity and Inclusion in Quality Patient Care

Marcus L. Martin • Sheryl L. Heron
Lisa Moreno-Walton
Editors

Anna Walker Jones
Managing Editor

Diversity and Inclusion in Quality Patient Care

Springer

Editors
Marcus L. Martin, M.D.
Vice President and Chief Officer for Diversity and Equity
Professor of Emergency Medicine
University of Virginia School of Medicine
Department of Emergency Medicine
Charlottesville, VA, USA

Sheryl L. Heron, M.D., M.P.H.
Professor of Emergency Medicine
Vice Chair – Administrative Affairs
Assistant Dean Clinical Education & Student Affairs
Emory University School of Medicine
Atlanta, GA, USA

Lisa Moreno-Walton, M.D., M.S., M.S.C.R.
Professor of Emergency Medicine
Director of Research
Director of Diversity
Department of Medicine
Section of Emergency Medicine
Louisiana State University Health Sciences Center – New Orleans
New Orleans, LA, USA

Managing Editor
Anna Walker Jones
Old Dominion School of Nursing '16
Office for Diversity and Equity
University of Virginia
Charlottesville, VA, USA

ISBN 978-3-319-22839-6 ISBN 978-3-319-22840-2 (eBook)
DOI 10.1007/978-3-319-22840-2

Library of Congress Control Number: 2015959022

Springer Cham Heidelberg New York Dordrecht London

Printed on acid-free paper

Springer International Publishing AG Switzerland is part of Springer Science+Business Media (www.springer.com)

Preface

Diversity and Inclusion in Quality Patient Care takes into consideration our multicultural society and the differences among patients. Above all, the book recognizes the influence of culture and the sensitive approach providers must take in delivering health care to the diverse groups they will encounter. As the population's demographics continue to change demographically, doctors, nurses, and other care providers will have to make quick decisions and provide appropriate treatment that patients of diverse backgrounds can respond to and understand.

The Monograph on Cultural Competency (editors Heron, Martin, Kazzi; http://www.med-ed.virginia.edu/courses/culture/), created in 2005 in partnership with the Council of Residency Directors (CORD) in Emergency Medicine and the Society for Academic Emergency Medicine's (SAEM) Diversity Interest Group (DIG), served as the framework for this book. Our authors have extensive backgrounds in emergency medicine, both in clinical and academic settings. Many of the contributing authors are members of the SAEM Academy for Diversity and Inclusion in Emergency Medicine (ADIEM), which was established in 2012. Three of the editors, Drs. Martin, Heron, and Moreno-Walton, are founding members of ADIEM and have served in key leadership positions on the ADIEM executive board. ADIEM members are committed to promoting diversity and inclusion in the emergency medicine (EM) professional workforce at all levels, furthering culturally competent delivery of emergency medical services, and eliminating healthcare disparities through research, education, and mentorship.

A growing body of research shows that a diverse workforce is more capable of relating to patients, detecting and addressing health disparities, and overcoming the challenges that face health care. We believe diversity and excellence are of equal importance, and that our healthcare workforce can't be excellent *without* diversity. Diversity accelerates our delivery of quality care to all people.

Failure to incorporate culture into the medical decision-making process can lead to misdiagnoses when prevalence of conditions among various cultural groups is not considered. This is evident when traditional remedies, understanding of illness and wellness, family dynamics, and neighborhood characteristics are not taken into account during the assessment and diagnostic phases of the physician-patient relationship.

In order to provide culturally appropriate care, healthcare providers must recognize the factors impeding cultural awareness, seek to understand the biases and traditions in medical education potentially fueling this phenomenon, and create a healthcare community open to individuals regardless of race, culture, sexual orientation, and religion and all things unique to each person. Clarity and understanding of these factors would lead to better communication of ideas and information between patients and their healthcare providers.

Included in the 33 chapters are teaching cases that provide real-life scenarios of various cultural groups who have presented to the emergency department. While these cases are representative, they are not exhaustive. They are presented in a similar format, highlighting attitudes and assumptions for the physician and for the patient and featuring appropriate Emergency Medicine Milestones that can serve as a useful guide in various educational settings.

Contributors to this book have a common hope of eliminating healthcare disparities and inequities and ensuring the delivery of culturally competent care. We realize that a curriculum on diversity and inclusion in quality patient care cannot be a "one size fits all" for every medical school, nursing school, residency, and physician assistant (PA) or nurse practitioner (NP) program. Therefore, we recommend that healthcare educators utilize this book as a resource to extract educational material specific for their programmatic and teaching needs.

We thank the many authors for their contributions. We also thank Leslie U. Walker and the staff of the University of Virginia Office for Diversity and Equity for their contributions in preparing this book.

Charlottesville, VA, USA Marcus L. Martin, M.D.
Atlanta, GA, USA Sheryl L. Heron, M.D., M.P.H.
New Orleans, LA, USA Lisa Moreno-Walton, M.D., M.S., M.S.C.R.
Charlottesville, VA, USA Anna Walker Jones, B.A.

Acknowledgements

It is our hope that Diversity and Inclusion in Quality Patient Care will serve many healthcare providers, educators, and learners who will utilize the material.

The support of the University of Virginia Office for Diversity and Equity (UVa ODE) was invaluable in the development of this book and is much appreciated.

We acknowledge the hard work of Leslie U. Walker, research administrative assistant for UVa ODE, for her communication with the authors and publisher and for her keen editorial eye in reviewing this book.

Diversity and Inclusion in Quality Patient Care would not be possible without the strong contributions of the many authors who are dedicated to providing culturally competent care.

Contents

Part I Chapters

1 **Defining Diversity in Quality Care** 3
Marc A. Nivet and Malika Fair

2 **Racial/Ethnic Health Care Disparities and Inequities: Historical Perspectives** 11
Savoy Brummer, Iris Reyes, Marcus L. Martin, Leslie Uldine Walker, and Sheryl L. Heron

3 **Educating Medical Professionals to Deliver Quality Health Care to Diverse Patient Populations** 23
Marcus L. Martin, Sheryl L. Heron, Lisa Moreno-Walton, Leslie Uldine Walker, and Anna Walker Jones

4 **Culturally Competent Faculty** 31
Georges Ramalanjaona and Marcus L. Martin

5 **Culturally Sensitive Care: A Review of Models and Educational Methods** 39
Antoine Leflore, Susan Sawning, and Cherri Hobgood

6 **Interpreter Services** 55
Yu-Feng Yvonne Chan, Kumar Alagappan, Saadiyah Bilal, Jan Hargrave, Suzanne Bentley, and Marcus L. Martin

7 **The Patient–Physician Clinical Encounter** 69
Thea James

8 **Spiritual Care Services in Emergency Medicine** 83
Mildred M. Best, Swami Sarvaananda, Jamela M. Martin, Pamela Gayle White, and Marcus L. Martin

9 Lesbian, Gay, or Bisexual (LGB): Caring with Quality and Compassion 101
Joel Moll and Paul Krieger

10 Culturally Competent Care of the Transgender Patient 113
Brandy Panunti

11 Looking Past Labels: Effective Care of the Psychiatric Patient 121
Leslie S. Zun and John S. Rozel

12 Disability and Access 131
Anne Beth Smith

13 Racial and Ethnic Disparities in the Emergency Department: A Public Health Perspective 137
Edward Stettner, Leon L. Haley Jr., and Sheryl L. Heron

14 Vulnerable Populations: The Homeless and Incarcerated 151
Ava Pierce

15 Vulnerable Populations: The Elderly 161
Anne Beth Smith

16 Vulnerable Populations: Children 169
Kevin Ferguson, John S. Misdary, Alex Diaz, and Darcy Mainville

17 Religio-cultural Considerations When Providing Health Care to American Muslims 179
Ugo A. Ezenkwele, Gholamreza Sadeghipour Roodsari, and Aasim I. Padela

18 Disparities and Diversity in Biomedical Research 189
Lynne Holden and Lynne D. Richardson

Part II Cultural Competency Case Studies: Transitional Introduction

19 Case 1: African-American Infant and Family 203
Sheryl L. Heron and Lynne D. Richardson

20 Case 2: Cambodian Refugee 207
Erika Phindile Chowa and Christian Arbelaez

21 Case 3: Sickle Cell Crisis 213
Bernard L. Lopez, Heather Hollowell Davis, Traci R. Trice, Leigh-Ann Jones Webb, and Marcus L. Martin

22 Case 4: Mongolian Spots 219
Heather Hollowell Davis, Leigh-Ann Jones Webb, and Marcus L. Martin

23 Case 5: Death Disclosure 225
Tammie E. Quest

24 Case 6: Coin Rubbing 229
Matthew M. Leonard, Bryant Cameron Webb,
Adetolu Olufunmilayo Oyewo, and Marcus L. Martin

25 Case 7: Toxic Ingestion 235
Claire Plautz and Marcus L. Martin

26 Case 8: Adolescent Indian Male Sikh 241
Sybil Zachariah and Swaminatha V. Mahadevan

27 Case 9: Intimate Partner Violence in the Gay Community 247
Simiao Li, Jason Liebzeit, and Michael A. Gisondi

28 Case 10: West Indian/Caribbean 253
Heather M. Prendergast

29 Case 11: American Indian 259
Diane Rimple

30 Case 12: Spiritualism in the Latino Community 263
Lisa Moreno-Walton, Marcus L. Martin, Leslie Uldine Walker,
Ruth E. Wong-Perez, and Janene Hecker Klein

31 Case 13: Islamic Patient 271
Tareq A. Al-Salamah and Lisa Moreno-Walton

32 Case 14: Pediatric Pain 277
Kevin Ferguson and Alex Diaz

Index 283

Editor Biographies

Marcus L. Martin, M.D. Dr. Marcus L. Martin is professor and past chair of the department of Emergency Medicine at the University of Virginia (UVa). He held the chair position from July 1996 to December 2006. Dr. Martin's emergency medicine responsibilities included the adult and pediatric emergency departments, chest pain unit, express care, Pegasus air ambulance, the Blue Ridge Poison Center, paramedic training program, emergency medicine residency program, and several emergency medicine fellowship programs. During his tenure at UVa, Dr. Martin served as assistant dean of the School of Medicine, assistant vice president for Diversity and Equity and associate vice president for Diversity and Equity, interim vice president and chief officer for Diversity and Equity, and, in 2011, appointed vice president and chief officer for Diversity and Equity. Dr. Martin is the principal investigator of the Virginia-North Carolina Alliance, a National Science Foundation-funded Louis Stokes Alliance for Minority Participation (LSAMP) program. He is the founder of Emergency Medicine Center for Education Research and Technology (EMCERT) and initiated the medical simulation program at the University of Virginia School of Medicine.

He earned his Bachelor of Science degrees in Pulp and Paper Technology (1970) and Chemical Engineering (1971) from North Carolina State University and was employed as a production chemical engineer at WESTVACO in Covington, Virginia. A member of the charter class of Eastern Virginia Medical School and the first African American graduate, he earned his medical degree in 1976.

Dr. Martin was commissioned by the US Public Health Service and later served as general medical officer at the Gallup Indian Medical Center in New Mexico. He completed emergency medicine residency training at the University of Cincinnati in 1981 and held a series of staff and administrative/teaching posts at Allegheny General Hospital in Pittsburgh.

He was a board member for 12 years and past president of the Society for Academic Emergency Medicine (SAEM). He is past president of the Council of Emergency Medicine Residency Directors. He is the recipient of the 2008 SAEM Diversity Interest Group Leadership Award, named the Marcus L. Martin, MD Leadership Award in his honor.

Sheryl L. Heron, M.D., M.P.H. Dr. Sheryl L. Heron is professor and vice chair of Administrative Affairs in the department of Emergency Medicine, the assistant dean for Medical Education and Student Affairs on the Grady Campus, and associate director of education and training for the Center for Injury Control at Emory University.

She attended Howard University College of Medicine and completed her emergency medicine residency training at Martin Luther King/Charles Drew Medical Center in 1996. Dr. Heron has lectured extensively on the medical response to Intimate Partner Violence, as well as Wellness/Work-Life Balance and Diversity/Disparate Care in Emergency Medicine.

She has received several awards including the 2011 Women's Resource Center's Champions for Change, Partnership against Domestic Violence's HOPE Award, the Woman in Medicine Award from the Council of Concerned Women of the National Medical Association, and the Gender Justice Award from the Commission on Family Violence and was named a hero of Emergency Medicine by the American College of Emergency Physicians.

Dr. Heron served as chair of the National Medical Association's Emergency Medicine section where she mentored several faculty, residents, and students in their career path within Emergency Medicine. Dr. Heron is the first recipient of the Marcus L. Martin, MD Leadership Award, presented during the SAEM annual meeting in Atlanta in 2009, and served as the inaugural president of the Academy for Diversity and Inclusion in Emergency Medicine (ADIEM) of SAEM.

Lisa Moreno-Walton, M.D., M.S., M.S.C.R. Dr. Lisa Moreno-Walton is the Nicolas Bazan Professor of Emergency Medicine, Department of Medicine, Section of Emergency Medicine, in the School of Medicine at Louisiana State University Health Sciences Center-New Orleans (LSUHSC-NO) and a member of the Board of Directors of American Academy of Emergency Medicine.

Dr. Moreno-Walton's academic and professional appointments are numerous. Along with her appointment as a full professor, she serves as Director, Division of Research, and Director of Diversity for the Section of Emergency Medicine at LSUHSC-NO, where she also directs the HIV and Hepatitis C testing programs. Dr. Moreno holds an academic appointment as clinical associate professor of surgery at Tulane University School of Medicine.

Prior to her appointment at LSUHSC-NO, Dr. Moreno served as a faculty physician in emergency medicine at North Bronx Health Care Network and at the Lincoln Medical and Mental Health Center, both in the Bronx, New York. She is board certified in Emergency Medicine and completed her residency training at the Jacobi-Montefiore program in the Bronx.

Dr. Moreno-Walton is the recipient of numerous teaching awards. She has developed graduate and postgraduate curricula for core content and research in emergency medicine and has mentored over 250 undergraduates and medical students, residents, and junior faculty to successful career development and research productivity.

Dr. Moreno-Walton earned a Master of Science in Clinical Research from Tulane University in June 2011. Since that time, she has been awarded 12 grants to study trauma, HIV, healthcare disparities, and most recently, hepatitis C virus.

She has given over 400 abstract presentations and 150 invited presentations and has more than 100 scholarly publications. Dr. Moreno has won 15 research awards and, in 2013, was named a National Institutes of Health PRIDE Research Scholar. She recently created a curriculum for developing emergency medicine research in resource-poor environments, a course which she teaches internationally. She lectures widely on the topics of cultural competency, healthcare disparities, HIV, and trauma.

Dr. Moreno-Walton wrote the charter to found the Academy of Diversity and Inclusion in Emergency Medicine (ADIEM), Society for Academic Emergency Medicine (SAEM), and continues to serve on its Board. In 2013, she was the recipient of the Marcus L. Martin, MD Leadership Award presented during the SAEM meeting in Atlanta, Georgia. In 2014, she was the only physician in the United States to receive the Alpha Omega Alpha Professionalism Award for her work to eliminate healthcare disparities.

Anna Walker Jones, B.A. Anna Walker Jones received her Bachelor of Arts in English from Davidson College in 2006. In summer 2016, she will receive her Associate Degree in Nursing from Piedmont Virginia Community College and her Bachelor of Science in Nursing from Old Dominion University. She began working at the UVa Office for Diversity and Equity in 2013. Prior to working at the Office for Diversity and Equity, she served as a coordinating editor at LexisNexis Legal and Professional. She served as managing editor for *UVa in St. Kitts and Nevis*, published in fall 2015.

Contributors

Kumar Alagappan, M.D. Section of Emergency Medicine, Baylor College of Medicine, Houston, TX, USA

Tareq A. Al-Salamah, M.B.B.S., M.P.H. Department of Emergency Medicine, University of Maryland Medical Center, Baltimore, MD, USA

King Saud University, Riyadh, Saudi Arabia

Christian Arbelaez, M.D., M.P.H. Department of Emergency Medicine, Brigham and Women's Hospital, Boston, MA, USA

Suzanne Bentley, M.D., M.P.H. Emergency Department, Mount Sinai Medical Center, Elmhurst, NY, USA

Mildred M. Best, M.Div., M.S.S., B.C.C. Department of Chaplaincy Services and Pastoral Education, University of Virginia Hospital, Charlottesville, VA, USA

Saadiyah Bilal, M.D. Division of Emergency Medicine, Ben Taub General Hospital, Baylor College of Medicine, Houston, TX, USA

Savoy Brummer, M.D. Department of Emergency Medicine, St. Louis University, St. Louis, MO, USA

Yu-Feng Yvonne Chan, M.D., Ph.D. Icahn Institute for Genomics and Multiscale Biology, Icahn School of Medicine at Mount Sinai, New York, NY, USA

Erika Phindile Chowa, B.A., M.D. Department of Emergency Medicine, Brigham and Women's Hospital, Boston, MA, USA

Heather Hollowell Davis, M.D. Department of Emergency Medicine, Medstar Southern Maryland Hospital, Clinton, MD, USA

Alex Diaz, D.O. College of Osteopathic Medicine of the Pacific, Western University of Health Sciences, Pomona, CA, USA

Ugo A. Ezenkwele, M.D., M.P.H. Department of Emergency Medicine, Woodhull Medical and Mental Health Center, New York University School of Medicine, Brooklyn, NY, USA

Malika Fair, M.D., M.P.H. Department of Diversity Policy and Programs, Association of American Medical Colleges, Washington, DC, USA

Kevin Ferguson, M.D. Emergency Department, Kaweah Delta Health Center, Visalia, CA, USA

Michael A. Gisondi, M.D. Department of Emergency Medicine, Northwestern University Feinberg School of Medicine, Chicago, IL, USA

Leon L. Haley Jr., M.D., M.H.S.A., C.P.E. Department of Emergency Medicine, Emory University School of Medicine and Grady Memorial Hospital, Atlanta, GA, USA

Jan Hargrave, B.S., M.S. University of Louisiana, Lafayette, LA, USA

Sheryl L. Heron, M.D. M.P.H. Department of Emergency Medicine, Emory University School of Medicine and Grady Memorial Hospital, Atlanta, GA, USA

Cherri Hobgood, M.D. Department of Emergency Medicine, Indiana University School of Medicine, Indianapolis, IN, USA

Lynne Holden, M.D. Department of Emergency Medicine, Montefiore Medical Center, Bronx, NY, USA

Thea James, M.D. Emergency Department, Boston Medical Center, Boston, MA, USA

Anna Walker Jones, B.A. Old Dominion School of Nursing ‘16, Office for Diversity and Equity, University of Virginia, Charlottesville, VA, USA

Janene Hecker Klein, M.D. Heritage Valley Health System, Sewickley, PA, USA

Paul Krieger, M.D. Emergency Department, Mount Sinai Beth Israel Medical Center, New York, NY, USA

Antoine Leflore, M.D. Department of Emergency Medicine, Indiana State University School of Medicine, Eskenazi Health, Indianapolis, IN, USA

Matthew M. Leonard, M.D. Emergency Department, Suburban Hospital, Bethesda, MD, USA

Simiao Li, M.D., M.S. Department of Emergency Medicine, Northwestern University Feinberg School of Medicine, Chicago, IL, USA

Jason Liebzeit, M.D. Department of Emergency Medicine, Emory University School of Medicine, Atlanta, GA, USA

Bernard L. Lopez, M.D., M.S. Department of Emergency Medicine, Thomas Jefferson University Hospital, Philadelphia, PA, USA

Swaminatha V. Mahadevan, M.D. Department of Emergency Medicine, Stanford University School of Medicine, Stanford, CA, USA

Darcy Mainville, B.S., M.S.-4 School of Medicine, Loma Linda University, Loma Linda, CA, USA

Jamela M. Martin, M.S., B.S.N., Ph.D. College of Health Sciences, Old Dominion University, Norfolk, VA, USA

Marcus L. Martin, M.D. Department of Emergency Medicine, School of Medicine, University of Virginia, Charlottesville, VA, USA

John S. Misdary, M.D. Pediatric Emergency Department, St. Joseph's Children's Hospital, Tampa, FL, USA

Joel Moll, M.D. Department of Emergency Medicine, Virginia Commonwealth University, Richmond, VA, USA

Lisa Moreno-Walton, M.D., M.S., M.S.C.R. Professor of Emergency Medicine, Director of Research, Director of Diversity, Department of Medicine, Section of Emergency Medicine, Louisiana State University Health Sciences Center – New Orleans, New Orleans, LA, USA

Marc A. Nivet, Ed.D., M.B.A. Diversity Policy and Programs, Association of American Medical Colleges, Washington, DC, USA

Adetolu Olufunmilayo Oyewo, M.D. Department of Emergency Medicine, Emory University, Atlanta, GA, USA

Aasim I. Padela, M.D., M.Sc. Department of Medicine, The University of Chicago, Chicago, IL, USA

Brandy Panunti, M.D. Department of Endocrinology, Ochsner Medical Center, New Orleans, LA, USA

Ava Pierce, M.D. Department of Emergency Medicine, University of Texas Southwestern Medical Center, Dallas, TX, USA

Claire Plautz, M.D. Emergency Department, Sentara RMH Medical Center, University of Virginia Medical Center, Charlottesville, VA, USA

Heather M. Prendergast, M.D., M.S., M.P.H. Department of Emergency Medicine, University of Illinois, Chicago, IL, USA

Tammie E. Quest, M.D. Emory University School of Medicine, Atlanta, GA, USA

Georges Ramalanjaona, M.D., D.Sc., M.B.A. Department of Emergency Medicine, Mount Sinai School of Medicine, Baldwin, NY, USA

Iris Reyes, M.D. Department of Emergency Medicine, University of Pennsylvania Health System, Philadelphia, PA, USA

Lynne D. Richardson, M.D. Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York, NY, USA

Dianne Rimple, M.D. Department of Emergency Medicine, University of New Mexico, Albuquerque, NM, USA

Gholamreza Sadeghipour Roodsari, M.D., M.P.H. Emergency Department, King's County Hospital—SUNY Downstate Medical Center, Brooklyn, NY, USA

John S. Rozel, M.D., M.S.L. Western Psychiatric Institute and Clinic of University of Pittsburgh Medical Center, re:solve Crisis Network, Pittsburgh, PA, USA

Swami Sarvaananda, Ph.D., B.C.C. Department of Chaplaincy, University of Virginia, Charlottesville, VA, USA

Susan Sawning, M.S.S.W. University of Louisiana School of Medicine, Louisville, KY, USAA

Anne Beth Smith, M.B.Ch.B., F.C.E.M.(S.A.) Emergency Centre, George Regional Hospital, George, South Africa

Edward Stettner, M.D. Department of Emergency Medicine, Emory University School of Medicine and Grady Memorial Hospital, Atlanta, GA, USA

Traci R. Trice, M.D. Department of Family and Community Medicine, Thomas Jefferson University Hospital, Philadelphia, PA, USA

Leslie Uldine Walker, B.A. Office for Diversity and Equity, University of Virginia, Charlottesville, VA, USA

Bryant Cameron Webb, M.D., J.D. Department of Internal Medicine, New York-Presbyterian Hospital, New York, NY, USA

Leigh-Ann Jones Webb, M.D. Department of Emergency Medicine, New York-Presbyterian Hospital, Columbia University Medical Center, New York, NY, USA

Pamela Gayle White Chaplaincy Department, University of Virginia Medical Center, Charlottesville, VA, USA

Ruth E. Wong-Perez, M.D. Emergency Department, Heritage Valley Health System, Beaver, PA, USA

Sybil Zachariah, M.D. Department of Surgery, Division of Emergency Medicine, Stanford Hospital and Clinics, Stanford, CA, USA

Leslie S. Zun, M.D., M.B.A. Department of Emergency Medicine, Chicago Medical School/Sinai Health System, Chicago, IL, USA

Part I
Chapters

Chapter 1
Defining Diversity in Quality Care

Marc A. Nivet and Malika Fair

Introduction

In executive offices of health care organizations around the world, leaders discuss improving quality of care and outcomes for changing patient populations. Meanwhile, human relations or diversity officers explore ways to recruit health professionals from different backgrounds to create a more culturally competent workforce. It is time to join these two conversations together and understand the role diversity can play in quality patient care.

The most cited reason for increasing diversity in the health professions is the need to address health disparities among minority populations. While diversity plays a critical role in achieving this aim, there is an even more compelling reason to strive for diversity in the health professions: to produce better outcomes for all patients.

The Relationship between Health Care Quality and Health Equity

The two Institute of Medicine (IOM) reports—*To Err is Human* (1999) and *Crossing the Quality Chasm* (2001)—pushed the quality conversation into the spotlight. While physicians and other health care professionals have historically prioritized quality, few took a systematic approach to measuring patient outcomes or comparing performance indicators. The reports shocked the public and the health professions into focusing attention on the inconsistent quality in the United States health system.

M.A. Nivet, Ed.D., M.B.A. • M. Fair, M.D., M.P.H. (✉)
Diversity Policy and Programs, Association of American Medical Colleges,
Washington, DC, USA
e-mail: mfair@aamc.org

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_1

The IOM defines quality of care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” [1]. The Institute also defines the six aims or principles of quality care, now referred to as the six pillars: safe, effective, patient-centered, timely, efficient, and equitable [2]. This definition of quality is now widely accepted, and we have made strides towards improvement [3]. However, there has been more progress on some pillars than others, creating an imbalanced system and hampering our ability to achieve true quality.

One pillar that has lagged behind is health equity, or “equal access to available care for equal need, equal utilization for equal need, and equal quality for all” [3, 4]. Achieving health equity requires conditions in which people have the same opportunity for desired health outcomes and no one is disadvantaged by social position or circumstance. Until we see those “desired health outcomes” in all people—until we eliminate health disparities and achieve health equity—we cannot achieve true quality in health care.

Challenges to Health Equity and Quality Care

Major challenges face health care systems worldwide: shifts in patient demographics, uneven distribution of wealth and resources, health provider shortages, and unequal access to care [5–7]. In the USA, the Affordable Care Act presents opportunities to address these challenges, but increased access to health insurance does not guarantee equity of care [4, 8].

In 2012, minority births outnumbered those of whites for the first time, suggesting the demographics of the USA are quickly shifting. About half of the children under five are minorities, and predictions show that the country as a whole will be majority minority by 2043 [9, 10].

As the proportion of minorities in the USA grows, so does the urgency of addressing health disparities in these different groups. The Affordable Care Act and the expansion of Medicaid mean that more people who were previously excluded from our health system for financial reasons will now have increased access to care. This offers a true opportunity to improve the health of people in the USA. But financial coverage for care is only one part of the access and quality equation.

Without an intentional focus on health disparities and the gaps in care experienced by different segments of the patient population, the USA will miss this opportunity of improving health care for all. Countries around the globe face similar challenges and opportunities to deliver better and more equitable care to patients of diverse backgrounds [5].

Obstacles to Quality Care

According to the IOM, obstacles to quality care fall into three categories: underuse, overuse, and misuse. This framework can also be applied to health care disparities, or “differences in access to or availability of facilities and services” [11].

Underuse

Underuse results from difficulties accessing health care, but also from myths and misconceptions about minorities and their health care needs. Several studies have shown that physicians are less likely to prescribe adequate painkillers to minority and low-income patients [12]. A journal article published in 2013, based on data collected from the National Hospital Ambulatory Medical Care Survey from 2006 to 2009, showed that emergency department patients from low-income areas were less likely to receive opioid pain medications than those with similar pain levels from higher-income areas. Black and Hispanic patients were less likely to receive pain medication than white patients regardless of income level [13].

Overuse

In some cases, minority patients receive more of certain types of care. While better control of diabetes has led to lower rates of limb amputation, one study found the rate of limb amputation was five times higher among inner city African Americans when compared to suburban whites. The overuse of amputation (and underuse of aggressive treatment to preserve limbs) in these patients leads to increased disability and reduced quality of life [14].

Misuse

Some patients are less likely to receive standard of care than others. One study showed that black patients presenting for emergency care with the same chest-pain symptoms were less likely to receive the standard of care (EKG, aspirin, oxygen, and referral for catherization) than white patients [15].

Some of these inequities can be traced back to the underrepresentation of minorities in clinical studies. Even though most academic medical centers are located in urban areas surrounded by minority communities, these communities continue to be underrepresented in most studies [16]. Evidence-based guidelines for safe, efficient, and excellent care developed based on studies for a 70-kg white male may not apply to people who do not fit that description.

After revelations about the Tuskegee experiments (in which African American men were denied treatment for syphilis so that researchers could observe the natural course of the disease), many minorities were understandably apprehensive about participation in clinical trials. While that fear is waning now, there are still plenty of barriers for some populations to participate in health care research, such as transportation and the need to take off time from work. In addition, some factors most likely to facilitate participation in clinical research are physician communication and when “patients see themselves as similar to their physicians” [16, 17].

Benefits of Diversity

Diversity refers to the richness of human differences in socioeconomic status, race, ethnicity, language, nationality, sexual orientation, gender identity, religion, geography, abilities, age, personality, learning styles, and life experience [18]. When people of diverse backgrounds work together, their combined qualities, experiences, attributes, and skills can lead to innovative thinking and creative solutions to previously intractable challenges.

Merely putting people of different backgrounds together in the same place does not automatically benefit an organization or a society. Inclusion—the active, intentional, and ongoing engagement with diversity—is what brings out the benefits of diversity. We achieve inclusion by creating a climate and culture within an institution or a society that fosters belonging, respect, and value for all [18]. To unlock the benefits of diversity, we have to build an inclusive culture that leverages those differences for the greater good.

Combined with inclusion, diversity benefits quality of care in several different ways. A diverse health workforce is more able to deliver quality, patient-centered care to more people through:

- Improved access to care: Physicians from underrepresented groups are more likely to practice in areas that that are underserved, including rural areas and minority communities [19, 20].
- Improved learning environment: When people from different backgrounds learn or practice together, they become more comfortable asking each other questions and learning about different backgrounds. Then, they pull from those experiences when treating patients of different backgrounds [21].
- Increased cultural competence: Providers who are used to working with people from different backgrounds may recognize cultural differences more easily than providers who have worked only in homogeneous environments [22].
- Greater chance for physician–patient concordance: Patients who have some demographic concordance with their provider trust their physician more, have higher patient satisfaction ratings, and are more likely to adhere to treatment, which could lead to better outcomes. This is true when patient and provider are from the same race, but similar benefits derive if the provider speaks the same language or shares the same rural or urban background as the patient [17].
- Greater recognition of inequities in care: A more diverse workforce may recognize more readily when care is not being delivered equitably [23].

At the Association of American Medical Colleges (AAMC), we conduct surveys of medical students called the Matriculating Student Questionnaire and the Graduating Student Questionnaire. During the first week of medical school, students answer a series of questions about a wide range of topics, including their comfort in dealing with people who are different from them. Four years later, we ask the students the same questions to determine if their comfort level has changed. Our results show that students attending schools with the greatest diversity have the greatest increase in their comfort levels, which translates to improved cultural competency and ability to communicate with people from different backgrounds. In addition, graduating medical students indicate that students who attend medical schools with greater classroom diversity feel more prepared to provide culturally competent care and are more confident in dealing with patients whose backgrounds are different from their own [22].

Mahzarin R. Banaji, Ph.D., professor of social ethics at Harvard University and author of *Blindspot: Hidden Biases of Good People*, explains that our brains work differently when we feel a connection with someone, whether it is because we share an ethnicity, alma mater, geographic location, language, or other attribute. We actually use the same areas of the brain that we use to think about ourselves—paving the way to more empathy and compassion for each other. But when we live and study and work only with people like us, hidden biases persist and affect how we interact with people from different backgrounds. While we cannot totally eliminate hidden bias, she says, we can create a diversity of biases that helps us identify and relate with more people [24]. These are the "Dividends of Diversity," and they will go a long way to addressing health disparities and addressing the equity side of the quality equation [8].

Scott E. Page, author of *The Difference*, takes this a step further. He contends that diversity, more than ability alone, leads to improved performance and innovation. He has conducted rigorous scientific research that shows that people from different backgrounds, heuristics, experiences, and attributes can solve complex problems more quickly and completely than a homogeneous group. He argues compellingly that diversity is a driver of excellence [25].

The lack of diversity among health care professionals allows disparities to continue not because white physicians do not care or are insensitive to the needs of patients who are different from them, but because increasing diversity expands our potential to find creative solutions to our health care challenges, mitigate against disparities, and improve care overall.

Conclusion

Our understanding of diversity is evolving. We have moved from a perceived competition between the ideals of diversity and quality to a construct in which diversity is co-equal with excellence. While once there was the perception that we had to abdicate some aspects of excellence to achieve diversity, we now realize that diversity and excellence are equally important. We often hear administrators state a goal to be "diverse and excellent." The next step is the realization that our health care workforce cannot be excellent *without* diversity, that diversity actually accelerates our pace to delivering excellent quality care for all people.

References

1. Lohr K. Committee to design a strategy for quality review and assurance in medicare, eds. medicare: a strategy for quality assurance (vol. 1). Washington, DC: National Academy Press; 1990.
2. Institute of Medicine. Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system of health care in America. Washington, DC: National Academy Press; 2001.
3. Green AR, Tan-McGrory A, Cervantes MC, Betancourt JR. Leveraging quality improvement to achieve equity in health care. Jt Comm J Qual Patient Saf. 2010;36(10):435–42.
4. Goldberg A. It matters how we define health care equity. Commentary. Washington, DC: Institute of Medicine; 2012.
5. Campbell J, Buchan J, Cometto G, David B, Dussault G, Fogstad H, et al. Human resources for health and universal health coverage: fostering equity and effective coverage. Bull World Health Organ. 2013;91:853–63.
6. Saha S. More health for the money: an analytical framework for access to health care through microfinance and savings groups. Community Dev J. 2014;49(4):618–30.
7. Salsberg E, Grover A. Physician workforce shortages: implications and issues for academic health centers and policymakers. Acad Med. 2006;81(9):782–7.
8. Nivet M. Commentary: Diversity 3.0: a necessary systems upgrade. Acad Med. 2011;86(12):1487–9. doi:10.1097/ACM.0b013e3182351f79.
9. Census.gov [cited 2014 Nov 5]. Available from: http://blogs.census.gov/2012/05/17/majority-of-infants-now-minorities
10. Census.gov [cited 2014 Nov 5]. Available from: https://www.census.gov/newsroom/releases/archives/population/cb12-243.html
11. Health Services Research Information Central. Health disparities [Internet]. US National Library of Medicine [cited 2014 Nov 13]. Available from: http://www.nlm.nih.gov/hsrinfo/disparities.html.
12. Pletcher MJ, Kertesz SG, Kohn MA, Gonzales R. Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. JAMA. 2008;299(1):70–8. doi:10.1001/jama.2007.64.
13. Joynt M, Train MK, Robbins BW, Halterman JS, Caiola E, Fortuna RJ. The impact of neighborhood socioeconomic status and race on the prescribing of opioids in emergency departments throughout the United States. J Gen Intern Med. 2013;28(12):1604–10.
14. Feinglass J, Abadin S, Thompson J, Pearce WH. A census-based analysis of racial disabilities in lower extremity amputation rates in Northern Illinois, 1987-2004. J Vasc Surg. 2008; 47(5):1001–7.
15. Pezzin LE, Keyl PM, Green GB. Disparities in the emergency department evaluation of chest pain patients. Acad Emerg Med. 2007;14:149–56.
16. Schmotzer G. Barriers and facilitators to participation of minorities in clinical trials. Ethn Dis. 2012;22(2):226–30.
17. Street RL, O'Malley KJ, Cooper LA, Haidet P. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. Ann Fam Med. 2008;6:198–2005.
18. Group on Diversity and Inclusion. Definitions. Association of American Medical Colleges website [cited 2014 Nov 13]. Available from: https://www.aamc.org/members/gdi/about/
19. Association of American Medical Colleges. Analyzing physician workforce racial and ethnic composition associations: geographic distribution (Part II). Analysis in Brief. 2014 Aug;14(9).
20. Komaromy M, Grumbach K, Drake M, Vranizan K, Lurie N, Keane D, et al. The role of black and Hispanic physicians in providing health care for underserved populations. N Engl J Med. 1996;334(20):1305–10.
21. Milem JF, Chang MJ, Antonio AL. Making diversity work on campus: a research-based perspective. Association of American Colleges and Universities. 2005 [cited 2015 Jan 19]. Available from: https://siher.stanford.edu/AntonioMilemChang_makingdiversitywork.pdf.

22. Saha S, Guiton G, Wimmers PF, Wilkerson L. Student body racial and ethnic composition and diversity-related outcomes in US medical schools. JAMA. 2008;300(10):1135–45.
23. Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. Health Aff. 2002;21(5):90–102.
24. Banaji MR. Blindspot: hidden biases of good people. New York, NY: Delacorte Press; 2013.
25. Page SE. The difference: how the power of diversity creates better groups, firms, schools, and societies. Princeton, NJ: Princeton University Press; 2008.

Chapter 2
Racial/Ethnic Health Care Disparities and Inequities: Historical Perspectives

Savoy Brummer, Iris Reyes, Marcus L. Martin, Leslie Uldine Walker, and Sheryl L. Heron

Introduction

The five racial/ethnic categories of the US 1990 census were expanded to 14 categories for the 2000 census [1]. For the first time, people were allowed to choose more than one option. Seven million Americans identified themselves as more than one race (2.4 %). The US census at that time was estimated to be 75 % white, 12.5 % Hispanic, 12.3 % black, 3.6 % Asian, and 0.9 % Native American [2, 3]. The 2010 US Census illustrated even greater diversity and reported the US population to be 72 % white, 16 % Hispanic, 13 % black, 5 % Asian, and 0.9 % Native American [3]. Notable changes in the past decade include a 13 % increase in both Hispanic and Asian populations. By 2050, the US population is projected to be about 50 % white and 50 % comprising Asian, Hispanic, Native American, and African American [4]. Despite the rapidly changing ethnic/racial landscape in America, disparities in health care have perpetuated.

S. Brummer, M.D.
Department of Emergency Medicine, St. Louis University, St. Louis, MO, USA

I. Reyes, M.D.
Department of Emergency Medicine, University of Pennsylvania Health System, Philadelphia, PA, USA

M.L. Martin, M.D. (✉)
Department of Emergency Medicine, School of Medicine, University of Virginia, Charlottesville, VA, USA
e-mail: mlm8n@virginia.edu

L.U. Walker, B.A.
Office for Diversity and Equity, University of Virginia, Charlottesville, VA, USA

S.L. Heron, M.D., M.P.H.
Department of Emergency Medicine, Emory University School of Medicine and Grady Memorial Hospital, Atlanta, GA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_2

Discussion

History

In 1800, hundreds of slaves, including 200 owned by Thomas Jefferson, were inoculated with smallpox to test an experimental vaccine [5]. Additionally, Marion Sims, the father of modern-day gynecology, perfected his techniques on slaves, addicting them to narcotics postoperatively and then using the same slaves for repetitive surgery [6]. Post slavery, African Americans continued to be the subject of experimentation. The Tuskegee Study of Untreated Syphilis in the Negro Male, which began in 1932, studied the effects of untreated syphilis in study participants until 1972, despite the fact that penicillin was determined to cure the disease in 1947. The men studied were never told they had syphilis nor treated and therefore unknowingly passed the disease to their partners, who passed it to their children during childbirth [7]. More recently, the story of Henrietta Lacks, known to scientists as HeLa, describes a poor black tobacco farmer whose cells were taken without her knowledge in 1951. The HeLa cells became one of the most important tools in medicine, used for developing the polio vaccine, cloning, gene mapping, in vitro fertilization, and more [8].

The National Medical Association (NMA) was founded in 1895 during a time in US history when the majority of African Americans were disenfranchised and subjected to the aforementioned injustices inherent in a dual medical care system. The NMA has been and continues to be the nation’s oldest and largest organization of more than 30,000 African American physicians and the patients they serve [9].

In 2002, the Institute of Medicine concluded that racial and ethnic minorities “tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled” [10]. Similarly, a 2003 analysis of hundreds of clinical studies by Physicians for Human Rights found that many minority groups receive lower quality evaluation and treatment than white Americans for a wide range of medical conditions, even when those minority groups have health insurance [11].

Racial/Ethnic Disparities in Health Care

While racial and ethnic minorities currently represent only about one-third of the non-elderly US population, they represent more than half of uninsured Americans. Hispanics (30 %), Asian/Pacific Islanders (21 %), African Americans (19 %), and Native Americans (19 %) are more likely to have no usual source of health care than white Americans (15 %) [12].

Minorities in the US have poorer access to quality health care, higher incidence and mortality rates from cardiac/hypertension, diabetes, cancer, HIV/AIDS, adolescent and early adulthood (homicide, drugs, and alcohol), and medical problems during infancy [13]. Racial and ethnic disparities in cardiovascular services are found among patients even among those insured by Medicare and in VA settings [14–16]. Specific examples exist in concert with emergency cardiovascular care. In 1996, Allison et al. assessed the rate of receipt of thrombolysis, beta-adrenergic blockade, and aspirin in a retrospective medical record review of 4052 patients hospitalized in acute care hospitals in Alabama with a principal discharge diagnosis of acute myocardial infarction (AMI) [17]. After controlling for patient age, gender, clinical factors, severity of illness, and hospital characteristics, white patients were found to be 50 % more likely to receive thrombolytics than black patients. No differences were found in receipt of beta-blockers or aspirin by patient race. Carlisle et al. found that African Americans, Hispanics, and Asian Americans were significantly less likely than whites to receive coronary angiography, coronary artery bypass graft (CABG), and/or angioplasty, after controlling for primary diagnosis, age, gender, income, insurance type, and comorbid factors [18].

High blood pressure occurs in African Americans at a higher incidence, earlier age, and with greater severity than whites [19]. Early onset and greater severity of hypertension in African Americans leads to an 80 % higher stroke mortality rate, a 50 % higher heart disease mortality rate, and a 320 % greater risk of hypertension-related end-stage renal disease than seen in the general population [20]. One of the few studies to systematically examine the prevalence of hypertension and related diseases in Hispanics is the San Antonio Heart Study, which compared Mexican Americans with whites. Although Mexican Americans had a slightly lower prevalence of hypertension, they had a dramatically higher incidence of Type 2 diabetes and a 60 % higher mortality from cardiovascular disease than whites [21]. African American patients with diabetes are more likely to utilize hospital emergency departments with greater severity of symptoms and with fewer primary physician visits than whites [22].

A study of patients with end-stage renal disease (ESRD) from four regional networks in geographically diverse areas found that African American patients were less likely to be rated as appropriate candidates for transplantation, referred for evaluation, placed on a waiting list for a transplant, and to ultimately undergo the procedure compared to white patients [23]. Similar studies have found that white patients were more likely to be placed on transplant waiting lists before initiating maintenance dialysis than minority patients, and that African American patients were also found to be less likely to receive dialysis as an initial treatment for ESRD [24, 25].

Forty-four percent of all new HIV cases are African Americans and 21 % are Hispanics [26]. African Americans with HIV infection are less likely to receive antiretroviral therapy, less likely to receive prophylaxis for pneumocystic pneumonia, and less likely to receive protease inhibitors than non-minorities with HIV. These disparities remain even after adjusting for age, gender, education, and insurance coverage [27]. Hispanics have twice the risk of dying while being hospitalized as a result of HIV-related illness than whites do, after controlling for sociodemographic data and with the use of antiretrovirals prior to hospitalization not affecting outcome [28].

African Americans, particularly those in urban areas, are at a greater risk of morbidity and mortality due to asthma. Among the conditions contributing to the prevalence of asthma are socioeconomic factors, environmental conditions including air pollutants, and genetic predisposition. One study, after controlling for income, age, and marital status, found that African Americans were more likely than whites to access care in emergency rooms, were hospitalized more often, and were less likely to be seen by an asthma specialist [29].

The incidence of liver cancer among Asian American Pacific Islander (AAPI) males is dramatically higher than for whites. This is most likely explained by the high prevalence of hepatitis B carrier status, liver fluke infestation, and aflatoxin exposure among Asian immigrants [30, 31]. In addition, stomach cancer, although decreasing in incidence in the USA, is still the most common malignant neoplasm among Asians in China, Japan, and Korea and is especially important when considering immigration patterns to the USA [32].

Analgesia use in the emergency department has been noted as disparate in administration. One study found that Hispanics were twice as likely as whites to receive no pain medications [33]. A follow-up study revealed that African American patients with long-bone fractures were less likely to receive pain medications than white patients [34].

Racial/Ethnic Inequities in Health Care Providers

Traditionally, the Association of American Medical Colleges (AAMC) has classified underrepresented minority groups as black, American Indian, Mexican American, and Mainland Puerto Rican. This definition has now been coined as "underrepresented in medicine" due to legal pressures and the need for consistency in data collection. The AAMC definition of "underrepresented in medicine" is those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population [35].

Between the years of 1868 and 1910, 14 black medical schools were established, half of which also closed within this timeframe due to rising educational standards and lack of financial resources [36]. Following the 1910 Flexner Report, strict standards for medical schools were established and the total number of medical schools (black and white) was approximately halved by 1925 [37]. Only two black medical schools survived: Howard University and Meharry Medical College. Following passage of the Civil Rights Act of 1964 underrepresented minority student enrollment increased until 1974, but never surpassed 3 %. Subsequent to the AAMC Equal Representation Commitment in the early 1970s and the Robert Wood Johnson scholarships for minorities and females, the percent of underrepresented minorities in medical schools dramatically increased to over 8 %.

Tactics used to increase minority enrollment were tested by Allan Bakke in 1974 [38]. Bakke successfully challenged the UC Davis admissions policy at the California and US Supreme Court level by arguing that having separate application programs for minorities was unconstitutional under Title VI of the Civil Rights Act. The court ruling ended quotas in the California educational system. However, the Supreme Court did allow race to be a factor in considering applicants to reverse past discrimination [38]. The progress of previous years towards underrepresented minority matriculation continued to be affected by legislation in the 1990s. Proposition 209 of California (1996), Initiative 200 of Washington State (1998), and the Texas vs. Hopwood case representing Texas, Louisiana, and Mississippi (1996) either decreased or eliminated race and ethnicity as factors towards student admission policies. Underrepresented minority matriculation into medical schools increased in the 1990s in part due to Project 3000 by 2000. By 1994 the number of URMs increased to over 3000 in the first year class [39].

In 2003, the Grutter vs. Bollinger and Gratz vs. Bollinger court cases were heard. A 5 to 4 vote in the US Supreme Court upheld the decision to allow the University of Michigan to use race as a component in their admission policies. Justice Sandra Day O'Connor stated that the Constitution "does not prohibit the law school's narrowly-tailored use of race in admissions decisions to further a compelling interest in obtaining the educational benefits that flow from a diverse student body." However, the point system used by the University of Michigan's undergraduate program was deemed unconstitutional in a 6-to-3 vote as it was based on 150 points, 20 of which were counted by race. Chief Justice Rehnquist stated that the university had violated the Equal Protection Clause of the Constitution because of its mechanized formula determining the worth of race for admissions to a college. These two decisions have made clear that race can be used as a factor but not the only factor towards student admissions. In the 2013 Fisher vs. University of Texas Austin case, the Court again did not outlaw affirmative action. However it did state that affirmative action must be strictly reviewed. The Court explained that a university's use of race must meet a test known as "strict scrutiny" where a university's use of affirmative action will be constitutional only if it is "narrowly tailored" [40].

Applicants to US medical schools in 2014–2015 were comprised of 49.39 % White, 36.71 % Ethnic Groups Other than White, 4.53 % Other, 5.45 % Unknown Race/Ethnicity, and 3.84 % Non-US Citizen and Non-Permanent Resident [41]. Within the Ethnic Groups Other than White category, applicants who self-identified as African American comprised 7.79 % of the total applicant pool, while Hispanics comprised 8.20 % of total applicants. The applicant pool for these minorities is higher than their actual enrollment for that year. US medical school enrollment for 2014–2015 was comprised of 0.24 % American Indian or Alaska Native, 20.40 % Asian, 6.25 % Black or African American, 4.04 % Hispanic, Latino or of Spanish Origin, 0.14 % Native Hawaiian or other Pacific Islander, 55.60 % White, 1.40 % Other, 8.35 % Multiple Race/Ethnicity, 1.70 % Unknown Race/Ethnicity, and 1.93 % Non-US Citizen and Non-Permanent Resident [42]. Graduates of US medical schools for 2013–2014 were comprised of 0.14 % American Indian or Alaska Native, 20.47 % Asian, 5.81 % Black or African American, 5.13 % Hispanic, Latino, or of Spanish Origin, 0.02 % Native Hawaiian or Other Pacific Islander, 57.84 % White, 1.65 % Other, 6.46 % Multiple Race/Ethnicity, 0.41 % Unknown Race/Ethnicity, and 2.01 % Non-US Citizen and Non-Permanent Resident [43]. Data related to references [41–43] are summarized in Table 2.1.

Table 2.1 US medical school application, enrollment, and graduation rates by race/ethnicity [41–43]

	Graduates of US medical schools 2013–2014 (%)	Applicants to US medical schools 2014–2015 (%)	US medical school enrollment 2014–2015 (%)
White	57.84	49.39	55.6
Ethnic Groups Other than White	31.57	36.71	31.07
Multiple Race/Ethnicity	6.46	–[a]	8.35
Other	1.65	4.53	1.4
Unknown Race/Ethnicity	0.41	5.45	1.7
Non-US Citizen and Non-Permanent Resident	2.01	3.84	1.93

[a] Not included

Academic Medical Faculty

Data derived from the AAMC Faculty Roster System show that only 3.9 % of all faculty identify themselves as African American, Native American, Mexican American, or Puerto Rican [44]. Of all black faculty, 15.5 % teach at Howard University, Morehouse College of Medicine, or Meharry Medical College.

Promotion of the small numbers of minority physicians has been recently evaluated. Palepu et al. surveyed 3013 medical faculty members to evaluate the numbers of different ethnic groups attaining senior rank [45]. After adjusting for the medical school, department, years as a medical school faculty member, sex, tenure status, number of peer-reviewed publications, and receipt of grant funding, black and Hispanic groups were noted as less likely to receive senior rank defined as full professor or associate professor. In 2000, another JAMA article evaluated the promotion rates of various ethnic groups through a cohort study of medical school faculty during the 1980s and found that the promotion rate from assistant to associate professor was significantly lower for minorities when compared to whites [46]. Similar data were noted when evaluating the promotion of associate professors to full professors. Even after adjusting for variables such as sex, tenure status, medical school type, department, and receipt of NIH funds, the data indicated that minority faculty members were promoted at lower rates compared with majority faculty. Minorities in academics were less likely to be tenured or on tenure track, less likely to be an NIH recipient, and more likely to have positions at private medical schools. These data presented above may be indicative as to why many minority faculty practice at historically black institutions such as Meharry and Howard University or mainland Puerto Rican hospitals.

Lack of diverse faculty mentors may impede residents' satisfaction and benefits from mentorship relationships compared to white residents [47]. Too often, junior faculty members are not adequately prepared for the process of becoming principal investigators. Retention programs such as professional development sessions, mentorship, and community-building events are essential to all new faculty but are especially important for URMs. Minority faculty members often receive less mentoring than their nonminority peers [48]. Minorities should also be encouraged by their institutions to pursue faculty development programs, like those promoted by the Health Resources Services Administration and the Agency for Healthcare Research, that encourage minorities to not only enter academic medicine, but also to stay there [49, 50].

To improve minority numbers, low promotion rates in all areas of medicine must be adjusted. Minorities need to be appointed to academic departments and then promoted to meaningful roles that provide adequate leadership for resident development, community outreach, and addressing disparities of care within their prospective departments. The American College of Physicians published its position paper in the *Annals of Internal Medicine* in 2004, acknowledging the need for improving the diversity of medical school faculty and the rate at which they are promoted [51]. It echoed the need for minority faculty members who can act as mentors for minority students and improve the quality of curricula at medical schools by emphasizing the health care needs of minority populations.

Workforce

Approximately 13.5 % of all physicians identify as black or African American, American Indian or Alaska Native, and Hispanic or Latino [52]. Although blacks or African Americans comprise 13 % of the nation, they account for only 4 % of the physician workforce [53]. Among Asians, blacks or African Americans, and Hispanics or Latinos, women make up a greater percentage of younger physicians (age 29 and younger) compared to their male counterparts. In light of changing demographics of the US population, if this trend continues, it suggests a shift in future years toward even greater percentages of women in the physician workforce. In fact, this shift has already occurred among black or African American physicians, which is the only racial or ethnic group currently comprising a greater percentage of women than men. This difference is even more apparent among medical school applicants where women comprise roughly two-thirds of black or African American applicants [54]. The number of minority physicians affects the quality of care of minority populations. Racial and ethnic minorities are four times more likely to receive care from non-white physicians than white physicians [55]. Minority physicians have a greater percentage of their patients coming from minority communities. While black and Hispanic physicians account for only 4 % and 5 % of the physician population, they care for 25 % of black patients and 23 % of Hispanic patients [56]. Diversity among health professionals may improve the scientific understanding of the causes and consequences of racial and ethnic disparities [57].

Conclusion

Historically, racial and ethnic minorities have received a lower quality of health care than non-minorities even when access-related factors such as patients' insurance status and income are controlled. Access to minority physicians affects the quality of care of minority populations. Despite changing demographics, health disparities and inequities in the numbers of ethnically/racially diverse health care providers perpetuate. Overall numbers of underrepresented minorities (URM) graduating from medical schools continue to be far less than their percentages in the population. Among Asians, blacks or African Americans, and Hispanics or Latinos, women make up a greater percentage of younger physicians (age 29 and younger) compared to their male counterparts. Successful methods and strategies to address these concerns should be sought and utilized. Organizations such as the NMA have and continue to bridge the historical gap for URM physicians and focus on addressing health care disparities. These disparities and inequities must continue to be addressed aggressively and continuously through training, research, recruitment, and retention of health care providers and researchers from underrepresented minority groups.

Recommendations

- To improve minority educational opportunities, academic administrators from both public and private medical schools and residencies must be familiar with affirmative action legislation and judicial decisions so that they can make individual applicant decisions without fear of legal retribution.
- Early mentorship and shadowing programs for minorities can encourage their presence in medicine.
- Residency programs must create mentorship opportunities.
- Cultural competency training including the history of health care disparities should be included in medical school curriculum.
- Disparities and inequities must be addressed aggressively and continuously through training, research, recruitment, and retention of health care providers and researchers from underrepresented minority groups.
- Effective strategies for attracting, training and retaining minorities in health care careers should be sought from those with proven track records including organizations such as the National Medical Association (NMA).

References

1. United States Census Bureau [Internet]. U.S. Department of Commerce. [cited 2015 Apr 1]. 1990 Census; [about 2 p]. Available from: http://www.census.gov/main/www/cen1990.html
2. United States Census Bureau [Internet]. U.S. Department of Commerce. [cited 2015 Apr 1]. Major differences in subject-matter content between the 1990 and 2000 census questionnaires; [about 6 p]. Available from: http://www.census.gov/population/www/cen2000/90vs00/

3. Humes KR, Jones NA, Ramirez RR. Overview of race and Hispanic origin: 2010. U.S. Census Bureau. 2011;C2010BR-02:1-23.
4. Passel JS, Cohn D. U.S. population projections: 2005–2050. Washington, DC: Pew Research Center; 2008.
5. Race, Health Care and the Law: speaking Truth to Power [Internet]. Dayton, OH: Vernellia R Randall; c2008 [updated 2010 Mar 3; cited 2015 Apr 1]. Base of distrust; [about 20 p]. Available from: http://academic.udayton.edu/health/05bioethics/slavery02.htm
6. Sartin JS. J. Marion Sims, the father of gynecology: hero or villain? South Med J. 2004;97(5): 500–5.
7. About the USHPS Syphilis Study. Tuskegee University. c. 2015. Available from: http://www.tuskegee.edu/about_us/centers_of_excellence/bioethics_center/about_the_usphs_syphilis_study.aspx.
8. Skloot R. The immortal life of Henrietta lacks. New York: Crown; 2010.
9. National Medical Association [Internet]. Silver Spring, MD: National Medical Association; [cited 2015 Apr 14]. About Us: history; [about 2 p.]. Available from: http://www.nmanet.org/index.php?option=com_content&view=article&id=3&Itemid=4
10. Smedley BD, Stith AY, Nelson A. Unequal treatment: confronting racial and ethnic disparities in healthcare. Washington, DC: National Academies Press; 2002.
11. Physicians for Human Rights.org [Internet]. New York: Physicians for Human Rights; c. 2011. Available from: http://physiciansforhumanrights.org/
12. Lillie-Blanton M, Rushing OE, Ruis S (The Henry J. Kaiser Family Foundation). Key facts: race, ethnicity and medical care. Menlo Park, CA: The Henry J. Kaiser Family Foundation; 2003 Report No.: 6069.
13. Centers for Disease Control and Prevention. CDC health disparities and inequalities report – United States, 2013. MMWR 2013 Nov 22;62(Suppl 3).
14. Gornick ME, Egers PW, Reilly TW, Mentnech RM, Fitterman LK, Kucken LE, et al. Effects of race and income on mortality and use of services among Medicare beneficiaries. N Eng J Med. 1996;335(11):791–9.
15. McBean AM, Gornick MD. Differences by race in the rates of procedures performed in hospitals for Medicare beneficiaries. Health Care Financ Rev. 1994;15(4):77–90.
16. Mirvis DM, Graney MJ. Impact of race and age on the effects of regionalization of cardiac procedures in the department of veterans affairs health care system. Am J Cardiol. 1988; 81:982–7.
17. Allison JJ, Kiefe CI, Centor RM, Box JB, Farmer RM. Racial differences in the medical treatment of elderly Medicare patients with acute myocardial infarction. J Gen Intern Med. 1996;11(12):736–43.
18. Carlisle DM, Leake BD, Shapiro MF. Racial and ethnic differences in the use of invasive cardiac procedures among cardiac patients in Los Angeles County, 1986 through 1988. Am J Public Health. 1995;85(3):352–6.
19. Go AS, Mozaffarian D, Roger VL, Benjamin EJ, Berry JD, Borden WB, et al. Heart disease and stroke statistics-2013 update: a report from the American Heart Association. Circulation. 2013;127:e6–245.
20. Wali RK, Weir MR. Hypertensive cardiovascular disease in African Americans. Curr Hypertens Rep. 1999;1(6):521–8.
21. Pickering TG. Hypertension in Hispanics. J Clin Hypertens. 2004;6(5):279–82.
22. Chin MH, Zhang JX, Merrell K. Diabetes in the African-American Medicare population: morbidity, quality of care, and resource utilization. Diabetes Care. 1998;21(7):1090–5.
23. Epstein AM, Zyanian JZ, Keogh JH, Noonan SJ, Armistead N, Cleary PD, et al. Racial disparities in access to renal transplantation. N Eng J Med. 2000;343(21):1537–44.
24. Kasiske B, London W, Ellison MD. Race and socioeconomic factors influencing early placement on the kidney transplant waiting list. J Am Soc Nephrol. 1998;9(11):2142–7.
25. Barker-Cummings C, McClellan W, Soucie JM, Krisher J. Ethnic differences in the use of peritoneal dialysis as initial treatment for end-stage renal disease. JAMA. 1995;274(23): 1858–62.

26. Centers for Disease Control and Prevention. Estimated HIV incidence in the United States, 2007-2010. HIV Surveillance Supplemental Report 2012 Dec;17(4). [cited 2015 Apr 1]. Available from: http://www.cdc.gov/hiv/pdf/statistics_hssr_vol_17_no_4.pdf
27. Shapiro MF, Morton SC, McCaffrey DF, Senterfitt JW, Fleishman JA, Perlman JF, et al. Variation in the care of HIV-infected adults in the United States: results from the HIV cost and services utilization study. JAMA. 1999;281:2305–75.
28. Cunningham WE, Mosen DM, Morales LS, Andersen RM, Shapiro MF, Hays RD. Ethnic and racial differences in long-term survival from hospitalization for HIV infection. J Health Care Poor Underserved. 2000;11(2):163–78.
29. Zoratti EM, Havstad S, Rodriguez J, Robens-Paradise Y, LaFata JE, McCarthy B. Health service use by African Americans and Caucasians with asthma in a managed care setting. Am J Respir Crit Care Med. 1998;158(2):371–7.
30. Centers for Disease Control and Prevention (CDC). Hepatitis B virus: a comprehensive strategy for eliminating transmission in the United States through universal childhood vaccination. MMWR Morb Mortal Wkly Rep. 1991 Nov 22; 40(RR-13):1-19.
31. Nomura A, Stemmermann GN, Chyou PH, et al. *Helicobacter pylori* infection and gastric carcinoma among Japanese American in Hawaii. N Engl J Med. 1991;325:1132–6.
32. Permanente K. A provider's handbook on culturally competent care: Asian and Pacific Island American population. Oakland, CA: Kaiser Permanente National Diversity Council; 1999.
33. Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. JAMA. 1993;269(12):1537–9.
34. Todd KH, Lee T, Hoffman JR. The effect of ethnicity on physician estimates of pain severity in patients with isolated trauma. JAMA. 1994;271:925–8.
35. Association of American Medical Colleges [Internet]. Washington (DC): AAMC. [cited 2015 Apr 1]. Underrepresented in Medicine Definition; [about 2 p]. Available from: https://www.aamc.org/initiatives/urm/
36. Baker RB, Washington HA, Olakanmi O, Savitt TL, Jacobs EA, Hoover E, et al. Creating a segregated medical profession: African American physicians and organized medicine, 1846-1910. JAMA. 2009;101(6):501–12.
37. Miller LE, Weiss RM. Revisiting black medical school extinctions in the Flexner era. J Hist Med Allied Sci. 2012;67(2):217–43.
38. Posner RA. The Bakke case and the future of affirmative action. Calif Law Rev. 1979; 67(1):171–89.
39. Nickens HW, Ready TP, Petersdorf RG. Project 3000 by 2000: racial and ethnic diversity in US medical school. N Engl J Med. 1994;331(7):472–6.
40. Legal Information Institute [Internet]. Ithaca, NY: Legal Information Institute. [cited 2015 Mar 17]. Fisher v. University of Texas at Austin; [about 24 p]. Available from: http://www.law.cornell.edu/supremecourt/text/11-345
41. AAMC. FACTS: Applicants, matriculants, enrollment, graduates, MD/PhD, and residency applicants data [Internet]. Washington, DC: Association of American Medical Colleges; 1995-2015 [cited 2015 Mar 9]. [Figure], Table 8: Applicants to U.S. medical schools by selected combinations of race/ethnicity and sex, 2013-2014 and 2014-2015. Available from: https://www.aamc.org/data/facts
42. AAMC. FACTS: applicants, matriculants, enrollment, graduates, MD/PhD, and residency applicants data [Internet]. Washington, DC: Association of American Medical Colleges; 1995-2015 [cited 2015 Mar 9]. [Figure], Table 28: Total U.S. medical school enrollment by race/ethnicity and sex, 2013-2014 and 2014-2015. Available from: https://www.aamc.org/data/facts
43. AAMC. FACTS: Applicants, matriculants, enrollment, graduates, MD/PhD, and residency applicants data [Internet]. Washington, DC: Association of American Medical Colleges; 1995-2015 [cited 2015 Mar 9]. [Figure], Table 29: Total U.S. medical school graduates by race/ethnicity and sex, 2012-2013 and 2013-2014. Available from: https://www.aamc.org/data/facts
44. US Medical School Faculty. Association of American Medical Colleges. Washington, DC: US Medical School Faculty; 1997. p. 1997.

45. Palepu A, Carr PL, Friedman RH, Amos H, Ash AS, Moskowitz MA. Minority faculty and academic rank in medicine. JAMA. 1998;280(9):767–71.
46. Fang D, Moy E, Colburn L, Hurley J. Racial and ethnic disparities in faculty promotion in academic medicine. JAMA. 2000;284(9):1085–92.
47. Yehia BR, Cronholm PF, Wilson N, Palmer SC, Sisson SD, Guilliames CE, et al. Mentorship and pursuit of academic medicine careers: a mixed methods study of residents from diverse backgrounds. BMC Med Educ. 2014;14:26.
48. Beech BM, Calles-Escandon J, Hairston KG, Langdon SE, Latham-Sadler BA, Bell RA. Mentoring programs for underrepresented minority faculty in academic medical centers: a systematic review of the literature. Acad Med. 2013;88(4):541–9. doi:10.1097/ACM.0b013e31828589e3.
49. Health Resources and Services Administration [Internet]. U.S. Department of Health and Human Services [cited 2015 Apr 1]. Grants; [about 1 p]. Available from: http://bhpr.hrsa.gov/grants/index.html
50. Health Resources and Services Administration [Internet]. U.S. Department of Health and Human Services [cited 2015 Apr 1]. Diversity; [about 1 p]. Available from: http://bhpr.hrsa.gov/grants/diversity/index.html
51. American College of Physicians. Racial and ethnic disparities in health care: a position paper of the American college of physicians. Ann Intern Med. 2004;141(3):226–32.
52. Association of American Medical Colleges [Internet]. [cited 2015 Mar 11]. Diversity in the physician workforce facts & figures: 2014; [about 22 p]. Available from: http://aamcdiversityfactsandfigures.org/section-ii-current-status-of-us-physician-workforce/
53. United States Census Bureau [Internet]. [cited 2014 Sep 11]. USA; [about 2 p]. Available from: http://quickfacts.census.gov/qfd/states/00000.html
54. Castillo-Page L. Diversity in medical education: facts & figures 2012. Washington, DC: Association of American Medical Colleges, Diversity Policy and Programs; 2012.
55. Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. JAMA. 1995;273(19):1515–20.
56. Saha S, Taggart SH, Komaromy M, Bindman AB. Do patients choose physicians of their own race? Health Aff (Millwood). 2000;19(4):76–83.
57. Smedley BD, Butler AS, Bristow LR, editors. In the nation's compelling interest: ensuring diversity in the health care workforce. Washington, DC: The National Academies Press; 2004.

Chapter 3
Educating Medical Professionals to Deliver Quality Health Care to Diverse Patient Populations

Marcus L. Martin, Sheryl L. Heron, Lisa Moreno-Walton, Leslie Uldine Walker, and Anna Walker Jones

Introduction

The essence of diversity is the uniqueness of the individual. That uniqueness manifests in many ways, including reaction to societal influences. Both health care providers and health care receivers bring their uniqueness to interactions within the health care system. In 1978, a seminal article by Arthur Kleinman and colleagues articulated the importance of culture in health care [1, 2]. Organizations and individual authors may define cultural competence differently, but most definitions are variants of one developed by mental health researchers 25 years ago. For the individual, cultural competence is defined as the "integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group" [3]. For a system or organization, cultural competence is defined as "a set of congruent behaviors,

---

M.L. Martin, M.D. (✉)
Department of Emergency Medicine, School of Medicine,
University of Virginia, Charlottesville, VA, USA
e-mail: mlm8n@virginia.edu

S.L. Heron, M.D., M.P.H.
Department of Emergency Medicine, Emory University School of Medicine
and Grady Memorial Hospital, Atlanta, GA, USA

L. Moreno-Walton, M.D., M.S., M.S.C.R.
Professor of Emergency Medicine, Director of Research, Director of Diversity,
Department of Medicine, Section of Emergency Medicine, Louisiana State University Health
Sciences Center – New Orleans, New Orleans, LA, USA

L.U. Walker, B.A.
Office for Diversity and Equity, University of Virginia, Charlottesville, VA, USA

A.W. Jones, B.A.
Old Dominion School of Nursing '16, Office for Diversity and Equity,
University of Virginia, Charlottesville, VA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_3

attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations." The culturally competent physician and health care system are sensitive to patients with expectations differing from those inherent in the assumed European–American norm. Individuals from the following cultural groups bring unique views and needs to American health care settings:

- At-risk groups (people with limited financial resources, the old, the young)
- Ethnically and racially distinct groups
- Immigrants, migrants, refugees
- Gay men, lesbians, bisexuals, transgender people
- People with disabilities

Predicated on theories that language and culture affect health care beliefs, choices, and treatment, the idea of cultural competence is an explicit statement that "one-size-fits-all" health care cannot meet the needs of an increasingly diverse US population. The 2002 report from the Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" contributes to a growing body of federal and state laws, regulations, and standards seeking to guarantee that health systems respond to diverse linguistic and cultural needs by becoming culturally competent [4].

Examples of negative health consequences that result from ignoring culture include missed diagnoses because of lack of familiarity with the prevalence of conditions among certain cultural groups; failure to take into account differing responses to medication; lack of knowledge about traditional remedies, leading to harmful drug interactions; and diagnostic errors resulting from miscommunication [5–7], which occur even more commonly in patients with Limited English Proficiency [8]. These miscommunications can lead to medical errors impacting patient safety. Moreover, without an awareness of cultural differences, physician–patient interactions can be unsatisfying and unproductive for both doctors and their patients. The Institute of Medicine (IOM) has cited many papers addressing both quality of care and disparities in care [4, 9]. One recommendation is to integrate cross-cultural education into the training of current and future health professionals to improve the quality of health care and health care communication [3]. The Liaison Committee on Medical Education (LCME), which accredits US and Canadian medical schools, has set a standard that "the faculty and medical students of a medical education program must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments" [10].

Attention to cultural competence is also addressed by the Accreditation Council for Graduate Medical Education (ACGME) using the outcomes-based milestones, a framework which includes patient-centered communication and professionalism [11]. A systematic review of the literature on the effect of cultural competence programs on ethnic minority patient-centered health care demonstrates effectiveness of patient-centered care models on clinician/practitioner cultural knowledge, awareness, and sensitivity and indicates the need for further research to determine whether this increase in patient knowledge translated into better practice and improved patient outcomes [12].

The challenge has been in implementing education in health disparities. To address the issue, a multi-institution qualitative questionnaire of 18 medical schools addressed the challenges for curricular development, including integrating new material into a full curriculum, adding curriculum work and sustaining the new curriculum. Solutions offered included engaging stakeholders, advocacy through participation on committees and in communities, identifying funding sources and developing sustainable products [13].

The Culturally and Linguistically Appropriate Services (CLAS) standard is another resource intended to advance health equity, improve quality, and help eliminate health care disparities. It is important to note that some states have proposed or passed legislation pertinent to cultural competence training of their state's health professionals [14]. Health care providers' perceptions of patients will result in differences in management recommendations. This stereotyping unintentionally effects the way medical professionals form impressions of and treat patients from different backgrounds [15]. Critical to this process is the awareness that every individual has inherent implicit biases and the tendency to psychological shortcuts which cause us to simplify complex situations [15]. Psychological shortcuts frame our opinions and management of patients. Stereotyping or implicit biases are deeply imbedded in our subconscious human cognition, and when complex situations are simplified we gain confidence in our ability to understand, predict, and potentially control situations and people that we encounter [16]. This is particularly true for health care providers working under pressure in the emergency setting, where the time of encounter is relatively brief.

Discussion

Sources of racial and ethnic disparities in health care include health systems as a whole, health care providers, patients, and health care plan managers [4]. Bias, stereotyping, prejudice, and clinical uncertainty may also contribute to these disparities. Innovative approaches to training health care providers in cultural competency can reduce the problems created by unintended bias and stereotyping [15]. A greater understanding of the prevalence and influence of these processes is needed, and should be sought through education and research [4].

Programs to educate health care providers and their patients can help the professional integrate cross-cultural information and improve the approach to the patient, and can empower the patient regarding access to care and treatment options. Health professionals should be aware that subconscious processes can impact interactions with patients from other racial, ethnic, cultural, religious, or socioeconomic groups. Cultural competence training can help prepare individuals to understand the perspective of a patient from a different background or culture.

Cultural competence goes beyond cultural awareness or sensitivity. The concept refers to an ongoing commitment and institutionalization of appropriate practice and policies for diverse populations [17, 18]. Cultural competence has been advocated as a matter of social justice [19, 20]. However, it has also been posited as a mechanism for changing the health outcomes of minority Americans. In 2000, Brach and Fraser, in a landmark article based on a review of the cultural competence literature, developed a model for reduction of disparities, encompassing nine cultural competence techniques: interpreter services, provider/staff recruitment and retention, cultural competence training programs, coordination with traditional healers, use of community health workers, culturally competent health promotion, inclusion of family and/or community in decision-making, immersion into another culture, and administrative and organizational accommodations [21].

Health care professionals have a myriad of opportunities to enhance cultural competence–in professional societies, on hospital staffs, at universities, and in private offices. In our roles as teachers, students, and leaders, we can seek ways to learn about culturally identified groups and to demonstrate sensitivity to our patients and our peers. Neglecting our responsibility as individuals and health systems to be aware of culturally diverse groups is the equivalent of medical malfeasance. This is particularly notable in the Emergency Department, a setting known for caring for at-risk groups from diverse backgrounds. There have been several papers published in the Emergency Medicine literature that address diversity and disparities that include the need to develop curricula on cultural competence and to examine implicit bias [22–24].

Federal and state policies that seek to guarantee that health systems respond to health disparities can only be appropriately addressed through educating health professionals in cultural competence. Although the importance of cultural competence has been recognized since the late 1990s, current federal and state regulations manifest considerable variability in the degree of cultural competence training required by graduate medical education programs [25]. In order to properly address and correct disparities for a diverse patient population, as defined by policy language, interventions must be developed and implemented which increase the competence of medical professionals currently in the field. The responsibility to engage in this type of education extends not only to systems at the organizational level but also to health care professionals at the individual level.

Various educational models and methods have been developed for use at the individual and system level. Successful cultural competence training programs must first identify the contributing factors to health care disparities and provide education to address each one. Any cultural competence training program should be tailored to the unique needs of the patient and physician population at the development stage and routinely monitored after implementation. Internal evaluation should be conducted to assess the productivity of any chosen intervention. As with any new initiative, research should be continued to develop a sound intervention. Individual models for cultural competence training, reviews of various models, as well as general articles on the subject were gathered and reviewed for this discussion.

Basic components of cultural competence routinely addressed in training programs include training on interpreter services, recruitment and mentoring to retain diverse physicians, and development of trusting patient–provider communication [25, 26]. Three main approaches to teaching cultural competence described by the

IOM's report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" are Multicultural/Categorical, Cultural Sensitivity/Awareness, and Cross-Cultural [4]. Each approach has its own values and challenges. The Multicultural/Categorical approach aims to acquire specific cultural knowledge about patients. The Cultural Sensitivity/Awareness approach aims to increase students' awareness of their own cultural backgrounds and other cultures. The Cross-Cultural or "skills-based" approach teaches providers to uncover their patients' own sense of culture to create a treatment plan with input from the patient [26].

Steps should be taken to reinforce the effectiveness of any program after training has ended. In order to ensure the long-term success of and adherence to the values of cultural competence training programs, Gertner et al. argued that first and foremost a strategic plan at the organizational level should be implemented to improve physician buy-in and long-term application. Using Lehigh Valley Health Network in Allentown, Pennsylvania as an example, Gertner et al. provided a planning framework and guide to creating a sense of commitment to the teachings of cultural competence training programs. This framework emphasized the need for development and application of strategic goals, objectives, and implementation tasks for culturally competent provision of care in addition to surveying both patients and staff about their own experiences and cultural awareness. It is important to remember that any aspect of the hospital system lacking in competence is not a failure, but rather an opportunity for improvement. The following measures can be taken: develop a cultural material repository; recruit and retain diverse employees; create baseline assessment for measuring cultural competency for network members; standardize collection of patient race, ethnicity, and language preference data, ensure and sustain language appropriate services; and provide evidence-based cultural education [27].

Disparities in health care are not new; however, the focus on correcting these disparities is a relatively new idea. With any new policy comes potential resistance. Maria B. J. Chun revealed challenges that arose while implementing her cultural competence program [28]. She outlined potential factors that impact receptivity to cultural training such as the variances in the "cultures" of individuals in the target group, obtaining buy-in, using validated assessment tools, and the general lack of a standardized definition of culture and method for culture training, which creates a feeling of disconnect on behalf of the participants from what is being discussed [28].

Simon et al. provided a commentary of Chun's article [28, 29]. The commentary included additional considerations to foster more buy-in and long-term use of cultural competence training including the following: that the underlying motivation for recognizing culture is that culture is intertwined with an individual's health beliefs, values, preferences and practices; that culture shapes lifestyles and beliefs that ultimately impact on one's risk for and subsequent response to health conditions; that cultural competence involves more than the ability to learn to respond to a set of static cultural customs, values and beliefs; that an ethnic group-focused, rather than a patient-focused, pedagogy may overlook the importance of social factors in cross-cultural encounters; and, the concepts that underlie clear, patient-centered communication should be interjected into cultural competence training [30].

Using the various educational models that are available and the commentaries provided by professionals experienced in implementing cultural competence training programs, health professionals can choose the appropriate cultural competence training that fits one's provider, patient, and system needs.

Conclusion

To offset medical errors caused by unfamiliarity with nuances of certain cultural groups and to generally improve the quality of health care, it is wise to integrate collaborative cross-cultural education into training of our current and future health care professionals. Opportunities for education exist at all levels of health care. In this chapter, we discussed cultural competence education opportunities for the individual health care provider. Developers of cross-cultural training programs must first identify the contributing factors to health care disparities in order to educate professionals on how each factor should be addressed. The responsibility to engage in this type of education falls on not just the health system at the organizational level, but also on health care professionals at the individual level.

While the impact of culture on health care outcomes has been long known [2], health outcome disparities did not become an issue of focus until the IOM report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" [4] was released in 2002. Despite awareness, health care disparities continue to exist. In 2013, the Centers for Disease Control and Prevention documented worse health outcomes for individuals from underrepresented minority groups in every diagnostic category analyzed, except death from suicide and narcotics abuse, where Whites prevailed [4]. As individual physicians and health care professionals, we have an obligation not only to provide culturally competent care to our patients but to influence the systems in which we work and to support the training of a diverse, culturally competent work force. The evidence to support the impact of culturally competent care exists. With the availability of educational models for implementation, we can look forward to a decrease in health care outcomes disparities in the coming years.

Recommendations

- Health care providers should work towards achieving cultural sensitivity, awareness, and openness by seeking and engaging in educational opportunities related to cultural competence.
- Cross-cultural education should be integrated into the training of current and future health care providers to improve the quality of health care and patient–provider communication.

- Developers of cross-cultural training programs must first identify the contributing factors to health care disparities in order to educate professionals on how each factor should be addressed.
- Cross-cultural training programs should be tailored to the unique needs of the patient and physician population in the development stage and progress routinely monitored after implementation.
- Research should be ongoing to develop cross-cultural curricula, sound intervention plans, and to examine implicit bias.
- Basic cultural competence techniques should include training on the following: interpreter services, recruitment and mentoring to retain diverse physicians, implicit bias and patient–provider communication skills.
- A strategic plan at the health system level should be implemented to improve physician buy-in and long-term application.
- Programs should be designed to educate health care providers as well as patients.
- Internal evaluation should be conducted to assess the productivity of any chosen intervention.

Acknowledgement The authors acknowledge the authors of the manuscript "Training of Medical Professionals and the Delivery of Health Care as Related to Cultural Identity Groups," published in the Monograph on Cultural Competency from which this chapter is adapted [1].

References

1. Scott C, Martin ML, Hamilton G. Training of medical professionals and the delivery of health care as related to cultural identity groups. In: Heron SL, Martin ML, Kazzi AA, editors. Monograph on cultural competency. Charlottesville, VA: University of Virginia School of Medicine; 2006. http://www.med-ed.virginia.edu/courses/culture/.
2. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med. 1978;88(2):251–8.
3. Cross TL, Bazron BJ, Dennis KW, Isaacs MR. Towards a culturally competent system of care: a monograph on effective services for minority children who are severely emotionally disturbed. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center; 1989.
4. Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: Institute of Medicine, National Academy Press; 2002.
5. Lavizzo-Mourey R, Mackenzie ER. Cultural competence: essential measurements of quality for managed care organizations. Ann Intern Med. 1996;124(10):919–21.
6. Lawson WB. The art and science of the psychopharmacotherapy of African Americans. Mt Sinai J Med. 1996;63(5-6):301–5.
7. Moffic HS, Kinzie JD. The history and future of cross-cultural psychiatric services. Community Ment Health J. 1996;32(6):581–92.
8. DeCamp LR, Kuo DZ, Flores G, O'Connor K, Minkovitz CS. Changes in language services use by US pediatricians. Pediatrics. 2013;132(2):e396–406. doi:10.1542/peds.2012-2909.
9. Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press; 2001.
10. Liasion Committee on Medical Education. Functions and structure of a medical school: standards for accreditation of medical education programs leading to the MD degree. Washington, DC: Liasion Committee on Medical Education; 2014.

11. Beeson M, Christopher T, Heidt J, Jones J, Promes S, Meyer L. The Emergency Medicine Milestone Project. The Accreditation Council for Graduate Medical Education and the American Board of Emergency Medicine; 2012.
12. Renzaho AMN, Romios P, Crock C, Sønderlund AL. The effectiveness of cultural competence programs in ethnic minority patient-centered health care--a systematic review of the literature. Int J Qual Health Care. 2013;25(3):261–9. doi:10.1093/intqhc/mzt006.
13. Carter-Pokras O, Bereknyei S, Lie D, Braddock CH, National Consortium for Multicultural Education for Health Professionals. Surmounting the unique challenges in health disparities education: a multi-institution qualitative study. J Gen Intern Med. 2010;25 Suppl 2:S108–14. doi:10.1007/s11606-010-1269-1.
14. Think Cultural Health [Internet]. [cited 2014 Jun 23]. Available from: https://www.thinkculturalhealth.hhs.gov/Content/clas.asp
15. Stone J, Moscowitz GB. Non-conscious bias in medical decision making: what can be done to reduce it? Med Educ. 2011;45(8):768–76. doi:10.1111/j.1365-2923.2011.04026.x.
16. Project Implicit [Internet]. 2011[cited 2014 Jun 23]. Available from: https://implicit.harvard.edu/implicit/education.html
17. Denboba DL, Bragdon JL, Epstein LG, Grathright K, Goldman TM. Reducing health disparities through cultural competence. J Health Educ. 1998;29 Suppl 5:S47–53.
18. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998;9(2):117–25.
19. Kennedy S, Stubblefield-Tave B, Smith C. Report on recommendations for measures of cultural competence for the quality improvement system for managed care. Cambridge, MA: Abt Associates; 1999.
20. Richardson LD. Patients' rights and professional responsibilities: the moral case for cultural competence. Mt Sinai J Med. 1999;66(4):267–70.
21. Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Med Care Res Rev. 2000;57 Suppl 1:181–217.
22. Heron SL, Lovell EO, Wang E, Bowman SH. Promoting diversity in emergency medicine: summary recommendations from the 2008 Council of Emergency Medicine Residency Directors (CORD) Academic Assembly Diversity Workgroup. Acad Emerg Med. 2009;16(5):450–3. doi:10.1111/j.1553-2712.2009.00384.x.
23. Bowman SH, Moreno-Walton L, Ezenkwele UA, Heron S. Diversity in emergency medicine education: expanding the horizon. Acad Emerg Med. 2011;18 Suppl 2:S104–9. doi:10.1111/j.1553-2712.2011.01184.x.
24. Moll J, Krieger P, Moreno-Walton L, Lee B, Slaven E, James T, et al. The prevalence of lesbian, gay, bisexual, and transgender health education and training in emergency medicine residency programs: what do we know? Acad Emerg Med. 2014;21(5):608–11. doi:10.1111/acem.12368.
25. Ambrose AJ, Lin SY, Chun MB. Cultural competency training requirements in graduate medical education. J Grad Med Educ. 2013;5(2):227–31. doi:10.4300/JGME-D-12-00085.1.
26. Kutob RM, Bormanis J, Crago M, Harris Jr JM, Senf J, Shisslak CM. Cultural competence education for practicing physicians: lessons in cultural humility, nonjudgmental behaviors, and health beliefs elicitation. J Contin Educ Health Prof. 2013;33(3):164–73. doi:10.1002/chp.21181.
27. Gertner EJ, Sabino JN, Mahady E, Deitrich LM, Patton JR, Grim MK, et al. Developing a culturally competent health network: a planning framework and guide. J Healthc Manag. 2010;55(3):190–204. discussion 204-5.
28. Chun MB. Pitfalls to avoid when introducing a cultural competency training initiative. Med Educ. 2010;44(6):613–20. doi:10.1111/j.1365-2923.2010.03635.x.
29. Simon MA, Chang ES, Dong X. Partnership, reflection and patient focus: advancing cultural competency training relevance. Med Educ. 2010;44(6):540–2. doi:10.1111/j.1365-2923.2010.03714.x.
30. Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report-United States, 2013. MMWR. 2013;62 Suppl 3: 1–189.

Chapter 4
Culturally Competent Faculty

Georges Ramalanjaona and Marcus L. Martin

Introduction

The US population has become more diverse: ethnic minorities now comprise 30 % of the US population and will be the majority by 2050 [1]. The current US population consists of more than 100 ethnic groups and 500 American Indian groups, and documentation notes that all US ethnic minorities lag behind their European counterparts on almost every health indicator, including access to care, health care coverage, and life expectancy, while surpassing white groups in all acute and chronic disease rates [2]. As previously mentioned in this textbook, the rationale for these health care disparities include barriers to routine access to preventive care, lower cultural competency skills among health care practitioners, and insufficient proportional representation of minorities in our health professions [3]. Furthermore, a growing body of literature shows the impact of sociocultural factors, race, and ethnicity on health care decisions, and that patient–provider communication is directly linked to patient satisfaction and health outcomes [4].

The ACGME recognizes cultural diversity training as a necessary skill for delivering effective patient care [5]. Traditionally, EM faculty serves a dual purpose: as teachers and role models for EM residents and medical students, and as practitioners. An expert panel review of the Association of American Medical Colleges (AAMC) reported the beneficial impact of faculty involvement for cultural competency exposure [6]. Carney et al. reported the beneficial impact of an academic-community partnership between the University of Vermont College of Medicine

---

G. Ramalanjaona, M.D., D.Sc., M.B.A. (✉)
Department of Emergency Medicine, Mount Sinai School of Medicine, Baldwin, NY, USA
e-mail: gramalan@optonline.net

M.L. Martin, M.D.
Department of Emergency Medicine, School of Medicine, University of Virginia,
Charlottesville, VA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_4

and the United Way of Chittenden County Volunteer Center. "Public health projects are designed, through partnerships with community nonprofit agencies, to be effective in addressing community issues while helping prepare students to become problem-solvers in population health" [7]. Since that report, more medical schools have worked to achieve both recommended competencies and required standards by designing educational initiatives in partnership with communities.

It is important to define the role of the culturally competent EM faculty, delineate a cultural competency curriculum aimed at improving EM faculty skills, devise a Faculty Development Program (FDP) specific for EM faculty, and integrate these functions in a clinical setting as well as in academic life.

Discussion

Cultural competency is defined as learned skills that help to understand cultural differences and facilitate communication between populations who have different ways of understanding health, disease and body [8]. Cultural competency extends beyond simple awareness or sensitivity and should be defined as the ability to effectively use cultural knowledge and skills in cross-cultural encounters. The EM faculty should then be skilled at understanding their patients' cultural values within the context of medical practice, as well as their own belief system.

The Agency for Healthcare Research and Quality (AHRQ) published nine major cultural competency techniques, which can reduce health disparities [9]. These techniques include interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotions, inclusion of family and community members, immersion into another culture, and administrative and organizational accommodation. However, these techniques are only general approaches to the problem and do not address outcomes in EM.

Several educational interventions have been advocated to improve cultural competency for faculty, including implementation of a cultural competency curriculum, and establishment of FDPs specific for cultural diversity. Cultural competency education for faculty should be viewed as a continuum, starting with initial exposure to cultural competency training in the medical school curriculum, then graduate medical education, then faculty development initiatives. The Liaison Committee on Medical Education (LCME) set standards for the development of cultural competency training as part of the medical school curriculum [10]. These standards require that a cultural diversity curriculum to be taught as part of undergraduate medical education, and that the curriculum can be divided into three interdependent conceptual approaches focusing on attitudes, knowledge, and skills:

- Cultural sensitivity/awareness approach: This should be taught in the first and second years of medical school. Its goal is to improve the provider's awareness of the impact of socioeconomic factors on a patient's health values, beliefs, and behaviors, as well as on the quality of care and outcome.

- Multicultural/categorical approach: This should be taught throughout undergraduate medical education. The primary focus is to increase the student's knowledge of cross-cultural issues by teaching relevant methods of community assessment and evidence-based factors (i.e., historical and epidemiological factors) that may influence health behaviors.
- Cross-cultural approach: This should focus on acquiring skills and is taught during clinical years. This approach's primary goal is to integrate medical interviewing and communication skills with sociocultural and ethnographic tools of medical anthropology. This approach lays the foundation to care for a culturally diverse patient population.

Flores and colleagues' 2000 survey of all US and Canadian medical schools reported that only 8 % of schools have established a separate course on cultural competency [11]. Moreover, while many of the existing cultural competency curricula target medical students, only a few studies report such curricula among medical school faculty, who will in turn shape residents and medical students' attitudes and behavior toward these issues [12, 13]. In 1997, Welch evaluated a three-part workshop on cultural competency designed for department chairs and course directors of an academic institution [14]. The conceptual design and workshop content are based on a well-known experiential approach for training in cross-cultural sensitivity and awareness: individuals' attitudes toward cultural-ethnic differences can be changed if they are first aware of their own inherent values and biases [15]. After they gain this awareness, training focuses on knowledge and skills of diverse groups. Attitudes will continue to change as individuals question previously held beliefs and biases.

Based on this concept, a series of three workshops is developed: first, building knowledge and personal awareness of differences, then building knowledge and skills (with a focus on the individual), and lastly, building knowledge and skills (with a focus on an organization). In an evaluation of the workshop series by participating faculty based on a 5-point Likert scale (5 high to 1 low), the overall score for content was 4.10; the organization score was 4.32; teacher effectiveness was 4.26 and usefulness of exercise videos was 4.86. The written and verbal feedbacks recommend offering this workshop annually, continuing the use of role playing and experiential activities, and requesting more workplace specific activities. Although these results are encouraging, baseline evaluation and follow-up measures of faculty members toward diversity are not done, thus limiting the evaluation of the efficacy of this training.

Addressing the need of teaching cultural competency curricula in graduate medical education (GME), the specialty of Family Practice (FP) published Core Curriculum guidelines on culturally sensitive and competent health care following the results of two national surveys of FP residency programs in 1985 and 1998 [16]. In 1985, a national survey of all FP residency training programs with a 71 % response rate indicates that only 3 % had a written curriculum (defined as having a bibliography, course objectives); and 22 % had a non-written curriculum, for a total of 25 % of FP residencies having a curriculum devoted to cultural competency [17].

In 1998, the Society of Teachers of Family Medicine conducted a national mail survey of all FP residency programs to determine the status and educational content of multicultural curricula, and to identify the impending and facilitating factors to the implementation of such curricula, as well as activities that could help residency programs improve their multicultural training [18]. Fifty-eight % of responding programs had an informal curriculum, 28 % had a formal curriculum, and 14 % had no curriculum on cultural diversity. Programs with a formal curriculum taught more content, employed more educational methods, used more evaluation techniques, and felt more successful than those with an informal curriculum. The top three factors that facilitated implementation of multicultural curricula were presence of a culturally diverse patient population and faculty and residents' multicultural interests. Conversely, a lack of faculty interest and expertise in cultural diversity were cited as major problems for programs with informal and no curricula. Therefore, faculty expertise and interest in cultural diversity played an important role in facilitating and implementing multicultural curricula in FP. Other specialties such as Internal Medicine and Pediatrics have reportedly started formal cultural diversity curricula as well [19, 20].

Regarding EM, the leadership of the Society for Academic Emergency Medicine (SAEM) took an essential first step in recognizing cultural competency as an integral part of EM curricula and residency program accreditation. SAEM established a 2-year task force in conjunction with the Council of Emergency Medicine Residency Directors (CORD) to develop a model curriculum on cultural diversity. It includes a case-based discussion, standardized curriculum, didactic sessions on cultural competency, bedside teaching and mentorship, and educational exchange programs to improve experiences with cultural diversity [21].

Ferguson et al. described a unique FDP designed to improve the ability of clinical faculty to integrate cultural competency and advocacy education into clinical training [6]. This training, known as "teaching the culture of the community", was integrated into the training of community preceptors from 13 medical schools in New York and New England. It consisted of interactive lectures followed by large group exercises culminating in small group exercises on cultural needs assessment, patient-centered interviewing, participant evaluation, and self-reported change data from the first 2 years of the program (1999–2001). The participants included family physicians as a majority (42 %), with the remaining preceptors being internists and pediatricians. Sixty percent (60 %) of trainees were female, 52 % had been in practice less than 10 years, 47 % had less than 3 years of teaching experience, and 53 % were involved in the care of the underserved population as defined in a federally funded community health center. Results displayed an overall high level of participant satisfaction (averaged above 4.0 on a Likert scale of 5: 1 low, 5 excellent). There was a statistically significant improvement in the overall rating of the program and the clarity of the objectives in 2000–2001 compared to 1999–2000. Before the curriculum, 5.4 % of participants planned to change their teaching practice or behavior compared to 30.2 % after the last workshop. In this short-term study, cultural competency training was successfully integrated into an existing FDP for community-based preceptors.

Integration of cultural competency curricula in clinical practice and medical education leads to redefining the role of faculty. First, role modeling is an integral part of graduate medical education (GME), crucial in shaping attitudes, behavior, values, and ethics of medical trainees, and an important influence on the career choices of residents [22]. Some studies report that attending physicians who are considered role models differ from their other colleagues. Using a multicenter case–control study of attending physicians, and IM house staff of four teaching hospitals, Wright et al. identified 5 attributes associated with being an excellent role model [23]. These attributes included spending more than 25 % of one's time teaching, spending 25 or more hours per week teaching and conducting rounds, stressing the importance of the doctor–patient relationship, teaching psychological aspects of medicine, and having served as a chief resident. These attributes represent acquired or modifiable behavior, which is under the control of the individual faculty member, meaning that with the appropriate advice, training, and environment, more attending physicians may become excellent role models. Second, a new role of faculty as patient advocate emerged and included interfacing with local community leaders to improve the cultural competency curriculum. Therefore, "culturally competent faculty" is redefined as "faculty who acquired clinical and sociocultural skills necessary to effectively eliminate racial disparities in health outcomes" [24]. Prior exposure to cultural diversity education emerges as a significant predictor for sociocultural attitude dimensions, not whether a physician is a faculty member or a resident [25].

Thus, from a social learning perspective, faculty members previously exposed to diversity training can be culturally competent and transform their own experiences into training cases for other colleagues. This new concept, albeit important, may increase faculty responsibilities at a time when they are already under great pressure to generate more revenue, rather than spending more time acquiring sociocultural skills. A 2005 systematic review of health care providers using standardized and validated measures by Beach et al. showed that cultural competencies improve knowledge, attitude, and skills of health professionals as well as patient satisfaction [26].

Promoting diversity among students and faculty at all levels of medical school should be part of a conceptual model for diversity [27]: although minority groups represent 30 % of the US population, they only comprise 13 % of the medical student body, 6 % of practicing physicians, and 3 % of medical school faculty. Moreover, minority faculty are less likely to be promoted and less than 2 % of senior leadership in health care management are minority. This lack of diversity in health care leadership may hamper its ability to adapt to the challenging demands of an increasingly diverse population. Promoting a diverse health care workforce enhances tolerance and cultural awareness of minority patient populations and directly affects patient outcome [28]. Methods to increase clinician development include:

- Developing hiring practices that value diversity
- Setting up minority training programs
- Encouraging mentoring for underrepresented students, residents and junior faculty
- Developing policies that ensure a fair environment for all personnel.

Key elements for a successful FDP include an institutional commitment to develop policies and procedures that integrate cultural competency curriculum, recruiting and retaining ethnically diverse faculty, establishing an FDP which emphasizes mentoring and role modeling, and implementing a formal means of consultation with the local community to be served for the needs and appropriateness of the intervention.

Conclusion

Given the current trend and future demographic changes in the US population, sociocultural diversity in health care and medical education will be a priority for our health care policy makers, as well as for our medical educators. The best approach yet to achieve this goal is to integrate cultural competency training into our GME and FDP. EM faculty as part of educational leadership has the moral obligation and opportunity to educate our future leaders about the benefits of cultural competency curricula. However, there is a paucity of literature (which should be reversed) on the role of EM faculty to enhance cultural diversity curricula, to serve as role models and mentors for EM residents and to embrace the new role as patient advocate.

Despite reported progress in cultural diversity education, several challenges remain:

- Lack of development of valid strategies to evaluate the impact of a cultural competency curriculum on EM faculty and GME [29]
- Lack of evidence showing effectiveness of these programs on patient satisfaction, health outcome, and quality of care [30]
- Limited workforce diversity

Recommendations

These recommendations should be carried out at multiple levels of our educational and governmental institutions and include:

- Incorporate cultural competency as a formal part of EM residency curricula. This process will require fundamental changes in accreditation and certification policies by ACGME. This program requirement for diversity training will be integrated at the FDP and Continuous Quality Improvement levels [31].
- Accept cultural competency as an essential part of the EM curriculum program accreditation sponsored by leadership of EM organizations (SAEM, ACEP, CORD). SAEM initiated a task force in collaboration with CORD to establish a model curriculum in cultural competency.

- Implement a special FDP to integrate cultural competency training across all levels of leadership which can change the institutional climate and specifically target faculty who have not been exposed to such curricula in the past. Evaluation of the effectiveness of such a program should be done by objective, evidence-based criteria.
- Adopt cultural competency training as a prerequisite for certification for state medical licensure in all 50 states. Several states have enacted such laws, including New Jersey, New York, Ohio, Washington, and California [32].
- Develop an institutional policy focused on improving workforce diversity.

References

1. US Bureau of the Census (2010).
2. Institute of Medicine. Examining unequal treatment in American Health Care. Washington, DC: National Academy of Sciences; 2002.
3. Gabriel BA. Confronting “unequal treatment”: the Institute of Medicine weighs in on health care disparities. AAMC Reports. 2002;11(9):6–7.
4. Kagawa-Singer M, Kassim-Lakha S. A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcome. Acad Med. 2003;78:577–87.
5. Tang TS, Fantone JC, Bozynski ME, Adams BS. Implementation and evaluation of an undergraduate sociocultural medicine program. Acad Med. 2002;77(6):578–85.
6. Expert Panel on Cultural Competence Education for Students in Medicine and Public Health. Cultural competence education for students in medicine and public health: report of an expert panel. Washington, DC: Association of American Medical Colleges and Association of Schools of Public Health; 2012.
7. Carney JK, Maltby HJ, Mackin KA, Maksym ME. Community-academic partnerships: how can communities benefit? Am J Prev Med. 2011;41(4 Suppl 3):S206–13.
8. Kai J, Spencer J, Wilkes M, Gill P. Learning to value ethnic diversity—what, why and how? Med Educ. 1999;33:616–23.
9. Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Med Care Res Rev. 2000;57 Suppl 1:181–217.
10. Liaison Committee on Medical Education [Internet]. Washington, DC: LCME; c2001 [cited 2015 Feb 6]. LCME Standards, Publications, and White Papers; [about 2 p.]. Available from: www.lcme.org/standard.htm (2014).
11. Flores G, Gee D, Kastner B. The teaching of cultural issues in US and Canadian medical schools. Acad Med. 2000;75:451–5.
12. Robins LS, Fantone JC, Hermann J, Alexander GL, Zweifler AJ. Improving cultural awareness and sensitivity training in medical school. Acad Med. 1998;73(10 Suppl):S31–4.
13. Barondess JA. The GPEP report: III. Faculty involvement. Ann Intern Med. 1985;103(3): 454–5.
14. Welch M. Enhancing awareness of diversity and cultural competence: a workshop series for department chairs and course directors. Acad Med. 1997;72(5):461–2.
15. Nile LN. Developing diversity training for the workplace: A guide for trainers. Washington, DC: NMCI Publications; 1995.
16. Culhane-Pera KA, Like RC, Lebensohn-Chialvo P, Loewe R. Multicultural curricula in family practice residencies. Fam Med. 2000;32(3):167–73.
17. McConarty PC, Farr F. Culture as content in family practice residencies. Presented at the Society of Teachers of Family Medicine annual Spring meeting. San Diego. 1986.

18. STFM Group on multicultural health care and education. Theme day: enhancing cultural competency education in family medicine. Presented at the STFM annual Spring meeting. Seattle. 1999.
19. American Academy of Pediatrics Committee on Pediatric Workforce. Culturally effective pediatric care: education and training issues. Pediatrics. 1999;103(1):167–70.
20. Bobo L, Womeodu RJ, Knox Jr AL. Principles of intercultural medicine in an internal medicine program. Am J Med Sci. 1991;302(4):244–8.
21. Hamilton G, Marco CA. Emergency medicine education and health care disparities. Acad Emerg Med. 2003;10(11):1189–92.
22. Wright SM, Carrese JA. Serving as a physician role model for a diverse population of medical learners. Acad Med. 2003;78(6):623–8.
23. Wright SM, Kern DE, Kolodner K, Howard DM, Brancati FL. Attributes of excellent attending-physician role models. N Engl J Med. 1998;339(27):1986–93.
24. Chin JL. Culturally competent health care. Public Health Rep. 2000;115:25–33.
25. Tang TS, Bozynski ME, Mithcell JM, Haftel HM, Vanston SA, Anderson RM. Are residents more comfortable than faculty members when addressing sociocultural diversity in medicine? Acad Med. 2003;78(6):629–33.
26. Beach MC, Price EG, Gary TL, Robinson KA, Gozu A, Palacio A, et al. Cultural competence: a systematic review of health care provider educational interventions. Med Care. 2005;43(4):356–73.
27. Kripalani S, Bussey-Jones J, Katz MG, Genao I. A prescription for cultural competence in medical education. J Gen Intern Med. 2006;21(10):1116–20.
28. Padela AI, Punekar IRA. Emergency medical practice: advancing cultural competence and reducing health care disparities. Acad Emerg Med. 2009;16:69–75.
29. Betancourt JR. Cross-cultural medical education: conceptual approaches and frameworks for evaluation. Acad Med. 2003;78(6):560–9.
30. Quirk ME, DeWitt T, Lasser D, Huppert M, Hunniwell E. Evaluation of primary care futures: a faculty development program for community health center preceptors. Acad Med. 1998;73(6):705–7.
31. Accreditation Council for Graduate Medical Education. The 2014 ACGME annual educational conference [brochure]. Available from: education.hurleymc.com/files/gme/uploads/2014-ACGME-EdConfBrochure.pdf
32. Quality interactions: The key to high-value health care [internet]. [cited 2015 Feb 6]. State Licensing Requirements for Cultural Competency; [about 1 p.]. Available from: www.quality-interactions.org/cultural_competence/cc_statelicreqs.html

Chapter 5
Culturally Sensitive Care: A Review of Models and Educational Methods

Antoine Leflore, Susan Sawning, and Cherri Hobgood

Introduction

The Institute of Medicine (IOM) was charged by Congress with assessing the extent of racial and ethnic health care disparities, evaluating the potential sources of disparities, and recommending interventions to eliminate disparities. In its landmark report in 2002, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, the IOM concluded, "Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled." Additionally, one of the two overarching goals of Healthy People 2010 was to eliminate racial and ethnic health disparities [1].

Disparities have been documented in physician recommendations for cardiac revascularization rates of reperfusion therapy, coronary angiography, and in-hospital death after myocardial infarction [2]. In emergency medicine, disparities have been shown in pain management, authorization for emergency visits by managed care organizations, and in emergency department management of asthma [3–6].

The IOM study committee examined a number of areas in looking for the causes of these disparities. In the clinical encounter itself, they found evidence that stereotyping, biases, and uncertainty on the part of the health care providers can all contribute to unequal treatment. In 2005, data by Weissman et al. demonstrated that

---

A. Leflore, M.D.
Department of Emergency Medicine, Indiana State University School of Medicine,
Eskenazi Health, Indianapolis, IN, USA

S. Sawning, M.S.S.W.
University of Louisiana School of Medicine, Louisville, KY, USA

C. Hobgood, M.D. (✉)
Department of Emergency Medicine, Indiana University School of Medicine,
Indianapolis, IN, USA
e-mail: chobgood@iu.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_5

trainees felt the medical education system had poorly prepared them to deliver culturally competent care [7]. Although there have been advances in preparing trainees to deliver culturally competent care, there remains a significant deficit in training programs and methods. Greysen et al. demonstrated that awareness of racial/ethnic health care disparities remain low but is amendable to intervention [8]. This lack of awareness of health care disparities prevents health care providers from having a framework to assess what sociocultural factors might influence patient care. In a diverse sample of clinical specialties, one third to one half of respondents reported receiving little or no instruction in specific areas of cross-cultural care beyond what was learned in medical school. Residents in general surgery and emergency medicine were significantly more likely to report a lack of cross-cultural training during their residencies when compared with other specialties.

The increasing diversity of the US population, as well as documented health disparities, mandates that the health care workforce be trained to care for patients from different backgrounds and cultures. Amongst a number of core competencies, the Accreditation Council of Graduate Medicine Education (ACGME) and the Liaison Committee on Medical Education (LCME) have specifically mandated that graduate training programs and medical schools teach cultural competency through communication skills and professionalism. There is no consensus or evidence supporting the best educational model or an assessment of those models. Kripilani et al. suggested a 9-item prescription for cultural competence that promotes a more active and integrated approach to multicultural issues throughout medical school training [9]. In recent years, the American Association of Medical Colleges (AAMC) developed the Tool for Assessing Cultural Competency Training (TACCT) to assess cultural competency training in medical schools and provide medical schools and graduate medical education programs with a suggested rubric. The purpose of this chapter is to describe a selection of educational models currently used for cultural competency teaching in undergraduate and postgraduate medical education and identify assessment methods that can be used to measure cross-cultural skills acquisition.

Discussion

Culturally competent health care has been described as “sensitive to the health beliefs and behaviors, epidemiology, and treatment efficacy of different population groups”[1].

The Office of Minority Health defines cultural and linguistic competence as:

> a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations …‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities [10, 11].

These principles of cultural competence have been codified in the LCME standards with the following criteria: “Students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments” [2]. Similarly, the ACGME has defined its competency standards for patient care and interpersonal communication skills by requiring that residents are able to provide “patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health” and “communicate effectively and demonstrate caring and respectful behaviors while interacting with patients and their families” [3]. Emergency medicine has also specifically defined its own standards for communication competency: emergency physicians must be able to “demonstrate respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences in patients and other members of the health care team” [4]. These cohesive standards spanning the educational continuum make it clear that cultural competence education must be integrated into our training programs at every learner level. In fact, they must be inculcated into the lifelong learning of every competent emergency physician.

Barriers to Implementation of Cultural Competency Education

Successful change within the educational environment mandates the exploration of current attitudes and practices that represent barriers to the implementation of more culturally sensitive care. We will briefly explore two major classes of barriers: (1) educational barriers, e.g., what and how we teach, and (2) professional barriers, e.g., how we model what we value by what we do.

Educational barriers take many forms and often start very early in medical school training. As one of the first acts of medical education, students are taught to perform the core clinical skills: history and physical examination. Becoming competent at this task implies learning and performing what Good calls “clinical narratives” [5]. For example, a competent clinical narrative links the uncertainty of therapeutics and science with patient care. A student performing a clinical narrative would craft physician patient communication that, for example, expresses the uncertainty of the biomedical science behind and efficacy of a new cancer treatment in a professional and caring manner that helps the patient understand why they need, and will benefit from, the recommended therapy. As students achieve the most basic skill level in the performance of the clinical narrative, they elicit all the information the patient can provide and use this to discuss and diagnose. As students advance in skill and medical knowledge, the acquisition of advanced clinical material leaves little room for a focus on the cultural intricacies of patients’ presentations [5]. Students are pushed to “[sharpen] their biomedical ‘gaze’ and [develop] their clinical reasoning,” often at the expense of addressing “the ‘psychosocial’ aspects of patients’ illnesses, social histories and emotional states, and their lives outside of the hospitals and clinics," leaving this important patient information irrelevant and non-contributory to everyday rounds and presentations [5]. This method is continually reinforced throughout training. Because there is no reinforcement for evaluating and valuing all aspects of patients, including their culture and beliefs, students learn to diminish those parts of patients that are outside of the mainstream clinical narrative.

Anne Fadiman illustrates this in her book on medical multiculturalism, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, when she states, "Western medicine is one-sided. Doctors endure medical school and residency in order to acquire knowledge that their patients do not have…it would be asking a lot of them to consider, much less adopt, the notion that their view of reality is only a view, not reality itself" [12]. This statement challenges the traditional perspective generated by medical training and forces the consideration of adopting a more culturally responsive, patient-centered focus for care.

Professional Barriers

In addition to what and how students and residents are taught, focus must be placed on the methods that inculcate and reinforce desired behaviors. Students often report receiving conflicting messages between what they learn in the classroom and what they observe in the clinical setting. This variance often leads to confusion about which values to uphold and appropriate behaviors to demonstrate [7, 12]. Senior residents and attending physicians often reinforce behaviors that may be maladaptive to embracing cultural awareness. In a typical clinical training environment, the trainees' efforts are often focused on providing patient care that will impress and gain the approval of senior members of the team for the purposes of grading, evaluation, and career promotion. If the attending or senior residents do not place value on enhanced cultural awareness, then this appraisal-based focus may lead to the modeling and reinforcement of negative traits at the expense of understanding the cultural components of the patient. Over time, these behaviors become established, and the student learns to evaluate patients' social–cultural aspects less and less [13]. Although much instruction may take place in settings with diverse patient populations, the trainees, faculty, and senior members of the medical team may not see diversity as a priority [10]. When educators present cultural information, they may have too simple an understanding of culture and may inadvertently foster and perpetuate rigid stereotypes of what members of a particular culture believe, do, or want [11]. Faculty and senior residents who model cultural awareness and value culture from the perspective of the patient are strong professional models for the development of culturally sensitive learners.

Summary of Representative Educational Models

To identify what educational models for teaching cultural competency currently exist, a computerized literature search of the National Library of Medicine was performed using the PubMed search engine. The following terms were included as both Medical Subject Headings (MESH) and as text words: cultural competency, cultural, cultural diversity, multicultural, mental competency, competence, clinical competence, ethnology, education, medical, medical education, internship, residency. Limits of the search were "English language," and "2006 to current." Search results yielded 78 articles, which were reviewed for their applicability of the educational methods or curricula to cultural competency education. A full review of all articles is outside the scope of this article; however, we selected a representative sample of educational offerings that give educators an overview of the types of educational interventions that have addressed this topic. The following educational models were selected based on their illustrative nature and unique applicability to teaching cultural competency in the ED settings. Other selected educational models are listed in Table 5.1.

Culture of the Community Model: University of Massachusetts Medical School [10]

This is an ongoing cultural competency faculty development program adopted from the university standards. This program uses behavioral modeling to directly and indirectly elevate the quality of faculty teaching. The program's 18-month curriculum focuses on integrating cultural diversity into the training of community preceptors. This content is delivered in four 2-day workshops and has been adopted by 13 medical schools in New England. The curriculum uses the GNOME (Goals, Needs, Objectives, Methods and Evaluation) concept and active learning techniques such as interactive lectures, role-play exercises on cultural needs assessment, patient-centered interviewing, feedback on cultural issues, and the use of the community, to enhance cultural understanding. This type of intermittent program, which uses a variety of teaching methods, can be applied to any learner type: students, residents, and faculty. It will also integrate well into traditional EM conference schedules or large regional or national meetings.

Culture and Diversity Course Model: Wake Forest University [33]

This course is a theoretically based, year-long cultural competency training program for second-year medical students based on the 27 core competencies outlined in the American Medical Student Association's Promoting, Reinforcing and Improving Medical Education project (AMSA PRIME). This course's goals include effective communication, self-directed independent learning, critical thinking and problem-solving,

Table 5.1 Representative educational methods used to teach cultural competency

Author	Specifically used for cultural competency	Description
Portfolios		
Gordon [14]	No	Longitudinal portfolio focused on self-reflection and self-evaluation. Faculty review for both formative and summative feedback
Cultural immersion		
Crampton [15]	Yes	Cultural immersion program with emphasis on health needs assessment and cultural exposure
Kamaka [16]	Yes	5-day CME cultural immersion program focusing on cultural aspects of health, traditional healing, and impact of culture on MD–Pt relationship
Godkin [17]	Yes	Coordinated longitudinal curriculum of linguistic, cultural, and clinical immersions
Campbell [18]	Yes	21 surgery residents participated in the inaugural Operation Smile Regan Fellowship to learn cultural competency
Literary models		
Shapiro [19]	No	Multi-session seminar series which uses poetry, short stories and other literary media to explore relationships and difficult patient interactions
Clinical experience		
Hatem [20]	Yes	Two educational programs for professionalism education: Resident as teacher and Bedside teaching
Esfandiari [21]	Yes	Six-week classroom and clinical experience in tropical health and disease. Two weeks of classroom work followed by a 4-week clinical immersion experience
Takayama [22]	Yes	Pediatric residents receive 18 hours of instruction in diversity training, cultural issues, and fieldwork sessions
Simulation models		
Brainin-Rodriquez [22, 23]	Yes	Video prompts focus culture-based discussions and guides development of best practices for culturally sensitive interviews
Altshuler [24]	Yes	Six-station standardized patient cultural OSCE administered to pediatric residents. Written formative feedback based on checklist evaluation instruments
Chun [25]	Yes	Utilization of standardized patient examinations to assess surgical resident's ability to care for a patient with a different background
Hochberg [26]	Yes	OSCE evaluation of surgery residents with SP's and incorporating use of interpreter for Thai-speaking women. Subsequent teaching involves six 1-h interactive seminars
Didactic models		
Goleman [27]	Yes	Four-unit curriculum focused on the development of knowledge, skills, and attitudes needed to span barriers of culture, economics, gender, and education

(continued)

Table 5.1 (continued)

Author	Specifically used for cultural competency	Description
Nunez [28]	Yes	Defines educational milestones for women's health and cross-cultural objectives and identifies instructional methods and paired evaluation tools
Kagawa-Singer [29]	Yes	Provides an anthropological perspective on culture and defines the RISK model (Resources, Identify, Skills, Knowledge) for decreasing miscommunication across cultures
Rosen [30]	Yes	1.5-day workshop using lecture, teaching OSCEs, and small group discussion format. Use the CHAT (Culture and Health-Belief Assessment Tool) to elicit a patient's explanatory model
Musolino [31]	Yes	A 4 module program focusing on accountability and mutual respect; Attitudes, Beliefs, and Expectations: Disparity of Care and Relationships; Systems Diversity: Solutions to Cultural Clashes; and Cross-Cultural Communication. Emphasizes cultural competency across disciplines rather than gender, race, or ethnicity
Integrative models		
Carpenter [32]	Yes	Medical school curriculum that involves for cultural immersion, lectures, PBL cases, standardized patients, selectives in Native Hawaiian Health, and other cultural activities for both medical students, residents, and faculty

and facility with technology, all focused on obtaining cultural competency. The course incorporates interactive lectures, videos, simulation, demonstration, role plays, workshops, patient interviews (including those with interpreters), community-based service-learning, and online problem-based learning cases. The course design incorporates Howell's levels of competence to move students from an unconscious incompetence (Level 1) to a conscious competence (Level 3), as well as Bennett's developmental model that includes six developmental stages [34, 35]. This is another excellent example of a mixed-method, active learning educational intervention.

This intervention's curriculum is grounded in specific competencies and a theoretical framework that make assessment and skill acquisition discretely measurable. It is an excellent structure for residency training programs to emulate as they address EM-specific competencies. The longitudinal nature of this curriculum allows easy integration into a standing EM conference schedule.

Portfolio Model: University of Sydney [12]

Personal and Professional Development (PPD) is one of four key themes integrated throughout this longitudinal medical training program. The goals of the PPD program are to foster compassionate, ethical, and professional behavior; teamwork;

rational decision-making; self-awareness; commitment to colleagues, and appropriate professional skills. This model is specifically designed to promote self-directed learner awareness using prompts that are then translated into personal portfolios reflecting each student's explorations of the PPD goals and curriculum. Year-end interviews are conducted by faculty who have read the students' portfolios and are trained to generate a meaningful dialogue that promotes awareness and understanding of the curricular issues. Some of the prompts used to stimulate students' self-reflection include: notes on ethical dilemmas and evidence of a systematic approach to resolving them, and notes on readings in the humanities, social sciences, or elsewhere. This type of self-reflection model could easily be incorporated into medical student rotations or residency training programs, as culturally challenging cases are seldom lacking in the ED. The model has the advantage of forcing residents and students to ask questions that address the cultural issues for each of their clinical encounters as they search for their portfolio entries. It also forces an examination of personal biases, which are not often explored in the large group lecture-type setting.

Immersion Model: Wellington School of Medicine and Health Sciences [36]

The Immersion Model is designed to promote learning about other cultures and provide opportunities for students to learn some of the principles associated with cultural safety, which may in turn address the problem of unconscious inherited racism in medical training. The model is a 1-week immersion program for third-year medical students in which they are placed in a remote region with one of the New Zealand tribes to learn about the culture and to assess health needs. As more and more residents seek international electives, this type of elective offering, if well-structured, could provide in-depth experiences with culture that may be difficult to replicate within the traditional hospital setting. Programs adopting this type of immersion method should carefully establish their learning objectives and goals for the experience in advance. Self-reflection, critical appraisal, and teaching others about the experience from the lens of culture and health care, rather than a travelogue approach, will make immersion experiences more robust.

Cross-Cultural Communication and Negotiation Models

In addition to specific educational models, several cross-cultural communication and negotiation models exist to assist students, residents, and physicians in gaining important cultural information during a physician–patient interview. These critical skills underpin all successful cross-cultural clinical encounters. A summary of these models is cited in the Association of American Medical Colleges' *Cultural Competence for Medical Students: Assessing and Revising Curriculum* [37, 38] provided in Table 5.2.

Table 5.2 Models of Effective Cross-Cultural Communication and Negotiation [32]

Models	Descriptions
BATHE [39] *B*ackground (What is going on in your life?) *A*ffect (How do you feel about what is going on?) *T*rouble (What troubles you most?) *H*andling (How are you handling that?) *E*mpathy (This must be very difficult for you.)	The BATHE model is a psychotherapeutic screening tool for anxiety, depression, and situational stress disorders
BELIEF [40] *B*eliefs about health (What caused your illness/problem?) *E*xplanation (Why did it happen at this time?) *L*earn (Help me to understand your belief/opinion.) *I*mpact (How is this illness/problem impacting your life?) *E*mpathy (This must be very difficult for you.) *F*eelings (How are you feeling about it?)	The BELIEF instrument is a cultural interviewing tool for preclinical medical students that does not require diagnostic or therapeutic skills
Eliciting Patient Information and Negotiating [41] Identify core cross-cultural issues Explore the meaning of the illness Determine the social context Engage in negotiation	A patient-based cross-cultural curriculum for residents and medical students that teaches a framework for analysis of the individual patient's social context and cultural health beliefs and behaviors. The curriculum consists of five thematic units taught in four 2-h sessions. The goal is to help physicians avoid cultural generalizations while improving their ability to understand, communicate with, and care for patients from diverse backgrounds
ESFT model for communication and compliance [42] *E*xplanatory model *S*ocial risk for non-compliance *F*ears and concerns about the medication *T*herapeutic contracting and playback	The ESFT Model for Communication and Compliance is an individual, patient-based communication tool that facilitates the screening of barriers to compliance and illustrates strategies for interventions that could improve patient outcomes

(continued)

Table 5.2 (continued)

Models	Descriptions
ETHNIC [43] *E*xplanation (How do you explain your illness?) *T*reatment (What treatment have you tried?) *H*ealers (Have you sought any advice from folk healers?) *N*egotiate (mutually acceptable options) *I*ntervention (agreed on) *C*ollaboration (with patient, family, and healers)	The ETHNIC model provides a simple framework for facilitating culturally competent care
Kleinman's questions [44] What do you think has caused your problem? Why do you think it started when it did? What do you think your sickness does to you? How severe is your sickness? Will it have a short or long course? What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment? What are the chief problems your sickness has caused for you? What do you fear most about your sickness?	Kleinman's questions provide a means to explore the patient's cultural influences. The questions guide the provider in examining specific health beliefs held by the client. This strategy is an example of a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application
LEARN [45] *L*isten with sympathy and understanding to the patient's perception of the problem *E*xplain your perceptions of the problem *A*cknowledge and discuss the differences and similarities *R*ecommend treatment *N*egotiate treatment	The LEARN model is an educational framework that helps health providers improve communication, heighten awareness of cultural issues in medical care, and obtain better patient acceptance of treatment plans

(continued)

Table 5.2 (continued)

Models	Descriptions
Model for Cultural Competency in Health Care [46] Normative cultural values Language issues Folk illnesses return Patient/parent beliefs Provider practices	This model for cultural competency in health care can be used to guide clinicians in interactions with any cultural group
Models	Description
"Review of Systems" domains of the Social Context [47] Social stressors and support network Change of environment Life Control Literacy	"Review of Systems" analyzes social barriers to the delivery of adequate health care. The physician can then collaborate with the patient to develop methods of dealing with medical and social barriers
The Ask Me 3 [48] 1. What is my main problem? 2. What do I need to do? 3. Why is it important for me to do this?	Ask Me 3 is a patient education program designed to improve communication between patients and health care providers, encourage patients to become active members of their health care team, and promote improved health outcomes. The Ask Me 3 framework provides three questions for clients to ask health care providers to better understand their health

©2005 Adapted from AAMC, Reprinted with permission

Assessment Methods

The effectiveness of any educational intervention must be measured to ensure success and give data for improvement. Several methods can be used to measure the acquisition of culturally competent knowledge, skills, and attitudes. Our literature review identified very few methods validated specifically to measure competency as a result of cultural training. Betancourt's notes in his article "Cross-Cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation" state that to date, there are limited published assessment methods that measure student and resident cultural competency skills [49]. He hypothesizes that the lack of evaluation and assessment tools may be due in part to a lack of consensus regarding what competencies should be achieved. Additionally, there are significant challenges that cross-cultural evaluation poses: social desirability bias and its influence on survey and interview responses when attempting to measure attitudes; the variability among different cultural groups; and the resistance among students and residents to discussing personal perceptions about race, ethnicity, and culture.

Betancourt suggests a three-legged-stool model of evaluating attitudes, knowledge, and skills. To assess attitudes, he suggests a variety of methods, including standard surveying and structured interviewing; however, he notes that these two methods are often lengthy, cumbersome, and labor-intensive and that to truly assess change in attitudes, certain "key questions" should be embedded within other kinds of evaluation or long surveys. He also suggests using self-awareness assessment via facilitated small group discussions and role plays to evaluate attitudes, as well as measuring attitudes as part of an objective structured clinical exam (OSCE) to allow standardized patients to comment on students' attitudes. Lastly, Betancourt suggests that the "gold standard" to evaluate attitudes would be video/audiotaped real clinical encounters between a student or resident and a patient, which would allow a faculty member to provide feedback to the learner.

To assess knowledge, Betancourt suggests using standard evaluation tools such as pretests and posttests, unknown clinical cases, presentation of clinical cases, and OSCEs; however, he cautions against testing knowledge of the behaviors and customs of certain cultural groups since this can lead to stereotyping and send the message that culture is static. Instead, Betancourt suggests evaluating students' knowledge of evidence-based cultural issues and knowledge of frameworks that promote patient-centered information-gathering.

Lastly, to assess skills, Betancourt suggests assessment through presentation of clinical cases, OSCEs, and through video/audiotaped clinical encounters.

Additionally, the ACGME's Toolbox of Assessment Methods is an excellent resource for assessment methods [50]. It includes a description of 13 assessment methods and references to articles where more complete and in-depth information about each method can be found. These methods include 360° evaluation, chart-stimulated recall oral examination, checklist evaluation, global rating of live or recorded performance, objective structured clinical examination, case logs, patient surveys, portfolios, record review, simulations and models, standardized oral examination, standardized patient examination, and multiple choice written examination. All of these methods can be adapted to assess cultural competency attitudes, knowledge, and skills.

Emergency Medicine Perspective

Emergency medicine educators must be leaders in cultural competency education. Our practice paradigm of "any patient any time" demands that we be well trained to handle diverse cultural expectations, practices, and perspectives on health care. In order to achieve this goal, both educators and trainees must acknowledge and address the current limitations of our educational systems and design and implement effective curricula to ensure that every emergency physician is trained to deliver culturally competent care. This will be accomplished by a variety of curricular mechanisms, but all will be designed to foster the learners' ability to examine their personal values associated with culture and to examine how forms of ethnocentrism impact health and health care.

Conclusion and Recommendations

Emergency medicine educators can play a major role in closing the well-identified gap between health care and health outcomes in cultural and racial minorities. Educators and trainees alike must recognize these disparities as critical issues confronting all of medicine and EM should focus specific training on the attitudes and knowledge gaps that perpetuate the problem in the ED setting. The development of effective cultural training and curricula in emergency medicine must provide our graduates the skills needed to be effective, culturally competent practitioners. The development and implementation of cultural training programs is an important means of enhancing our understanding and awareness of the importance of culture to all the patients we serve and improving the cultural appropriateness of our health care delivery.

References

1. US Department of Health and Human Services. With understanding and improving health and objectives for improving health. Healthy People 2010. 2010;2(2nd ed).
2. Vaccarino V, Rathore SS, Wenger NK, Frederick PD, Abramson JL, Barron HV, et al. Sex and racial differences in the management of acute myocardial infarction, 1994 through 2002. N Engl J Med. 2005;353(7):671–82.
3. Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. JAMA. 1993;269(12):1537–9.
4. Todd KH, Deaton C, D'Adamo AP, Goe L. Ethnicity and analgesic practice. Ann Emerg Med. 2000;35(1):11–6.
5. Lowe RA, Chhaya S, Nasci K, Gavin LJ, Shaw K, Zwanger ML, et al. Effect of ethnicity on denial of authorization for emergency department care by managed care gatekeepers. Acad Emerg Med. 2001;8(3):259–66.
6. Rand CS, Butz AM, Kolodner K, Huss K, Eggleston P, Malveaux F. Emergency department visits by urban African American children with asthma. J Allergy Clin Immunol. 2000;105(1 Pt 1):83–90.
7. Weissman JS, Betancourt J, Campbell EG, Park ER, Kim M, Clarridge B. Resident physicians' preparedness to provide cross-cultural care. JAMA. 2005;294(9):1058–67.
8. Greysen SR, Siegel B, Sears V, Solomon A, Jones K, Bradley EH. Residents' awareness of racial and ethnic disparities in cardiovascular care. J Grad Med Educ. 2011;3(3):417–20. doi:10.4300/JGME-D-10-00190.1.
9. Kripalani S, Bussey-Jones J, Katz MG, Genao I. A prescription for cultural competence in medical education. J Gen Intern Med. 2006;21(10):1116–20.
10. Office for Minority Health. Assuring cultural competence in healthcare: recommendations for national standards and an outcomes-focused research agenda. 2006. Available from: http://minorityhealth.hhs.gov/Assets/pdf/checked/Assuring_Cultural_Competence_in_Health_Care-1999.pdf.

11. Liaison Committee on Medical Education. Accreditation standards. 2006. Available from: http://www.lcme.org/publications/2015-16-functions-and-structure-with-appendix.pdf
12. Fadiman A. The spirit catches you and you fall down: a Hmong child, her American doctors, and the collision of two cultures. New York: Farrar, Straus, and Giroux; 1997.
13. Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department. Multicultural caring: a guide to cultural competence for Kaiser Permanente health professionals. Oakland, CA: Kaiser Permanente; 2000.
14. Gordon J. Assessing students' personal and professional development using portfolios and interviews. Med Educ. 2003;37(4):335–40.
15. Crampton P, Dowell A, Parkin C, Thompson C. Combating effects of racism through a cultural immersion medical education program. Acad Med. 2003;78(6):595–8.
16. Kamaka ML. Cultural immersion in a cultural competency curriculum. Acad Med. 2001;76(5):512.
17. Godkin M, Ferguson W, Diop D. A required interclerkship on multiculturalism for third-year medical students. Acad Med. 2002;77(5):469.
18. Campbell A, Sullivan M, Sherman R, Magee WP. The medical mission and modern cultural competency training. J Am Coll Surg. 2011;212(1):124–9.
19. Shapiro J, Lie D. Using literature to help physician-learners understand and manage "difficult" patients. Acad Med. 2000;75(7):765–8.
20. Hatem CJ. Teaching approaches that reflect and promote professionalism. Acad Med. 2003;78(7):709–13.
21. Esfandiari A, Drew CR, Wilkerson L, Gill G, Drew CR. An international health/tropical medicine elective. Acad Med. 2001;76(5):516.
22. Takayama JI, Chandran C, Pearl DB. A one-month cultural competency rotation for pediatrics residents. Acad Med. 2001;76(5):514–5.
23. Brainin-Rodriquez JE. A course about culture and gender in the clinical setting for third-year students. Acad Med. 2001;76(5):512–3.
24. Altshuler L, Kachur E. A culture OSCE: teaching residents to bridge different worlds. Acad Med. 2001;76(5):514.
25. Park ER, Chun MB, Betancourt JR, Green AR, Weissman JS. Measuring residents' perceived preparedness and skillfulness to deliver cross-cultural care. J Gen Intern Med. 2009;24(9):1053–6.
26. Hochberg MS, Berman RS, Kalet al, Zabar SR, Gillespie C, Pachter HL. The professionalism curriculum as a cultural change agent in surgical residency education. Am J Surg. 2012;203(1): 14–20.
27. Goleman MJ. Teaching pediatrics residents to communicate with patients across differences. Acad Med. 2001;76(5):515–6.
28. Núñez AE. Transforming cultural competence into cross-cultural efficacy in women's health education. Acad Med. 2000;75(11):1071–80.
29. Kagawa-Singer M, Kassim-Lakha S. A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. Acad Med. 2003;78(6):577–87.
30. Rosen J, Spatz ES, Gaaserud AM, Abramovitch H, Weinreb B, Wenger NS, et al. A new approach to developing cross-cultural communication skills. Med Teach. 2004;26(2):126–32.
31. Musolino GM, Burkhalter ST, Crookston B, et al. Understanding and eliminating disparities in health care: development and assessment of cultural competence for interdisciplinary health professionals at The University of Utah-a 3-year investigation. J Phys Ther Educ. 2010;24(1): 25–36.
32. Carpenter D-AL, Kamaka ML. Kaulukukui, MK. An innovative approach to developing a cultural competency curriculum; efforts at the John A. Burns School of Medicine, Department of Native Hawaiian Health. Hawaii Med J. 2011;70(11):15–9.
33. Crandall SJ, George G, Marion GS, Davis S. Applying theory to the design of cultural competency training for medical students: a case study. Acad Med. 2003;78(6):588–94.
34. Hobgood CD, Riviello RJ, Jouriles N, Hamilton G. Assessment of communication and interpersonal skills competencies. Acad Emerg Med. 2002;9(11):1257–69.

35. DelVecchio-Good M-J. American medicine: the quest for competence. Berkeley: University of California Press; 1995.
36. Inui TS. A flag in the wind: educating for professionalism in medicine. Washington, DC: Association of American Medical Colleges; 2003.
37. American Association of Medical Colleges. Cultural competence education for medical students: assessing and revising curriculum. 2005. Available from: https://www.aamc.org/download/54338/data/culturalcomped.pdf
38. Reynolds PP. Reaffirming professionalism through the education community. Ann Intern Med. 1994;120(7):609–14.
39. Stuart MR, Lieberman JR. The fifteen-minute hour: applied psychotherapy for the primary care physician. New York: Praeger; 1993.
40. Dobbie AE, Medrano M, Tysinger J, Olney C. The BELIEF Instrument: a preclinical teaching tool to elicit patients' health beliefs. Fam Med. 2003;35(5):316–9.
41. Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. Ann Intern Med. 1999;130(10):829–34.
42. Betancourt JR, Carrillo JE, Green AR. Hypertension in multicultural and minority populations: linking communication to compliance. Curr Hypertens Rep. 1999;1(6):482–8.
43. Levin SJ, Like RC, Gottlieb JE. ETHNIC: a framework for culturally competent ethical practice. Patient Care. 2000;34(9):188–9.
44. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med. 1978;88(2):251–8.
45. Berlin Jr EAFW. A teaching framework for cross-cultural health care. Application in family practice. West J Med. 1983;139(6):934–8.
46. Flores G. Culture and the patient-physician relationship: achieving cultural competency in health care. J Pediatr. 2000;136(1):14–23.
47. Green AR, Betancourt JR, Carrillo JE. Integrating social factors into cross-cultural medical education. Acad Med. 2002;77(3):193–7.
48. Michalopoulou G, Falzarano P, Arfken C, Rosenberg D. Implementing Ask Me 3 to improve African American patient satisfaction and perceptions of physician cultural competency. J Cult Divers. 2010;17(2):62–7.
49. Wilkes M, Raven BH. Understanding social influence in medical education. Acad Med. 2002;77(6):481–8.
50. ACGME/American Board of Medical Specialties Joint Initiative. Toolbox of Assessment Methods: a product of the joint initiative. 2000;1.1. Available from: https://www.partners.org/Assets/Documents/Graduate-Medical-Education/ToolTable.pdf

Chapter 6
Interpreter Services

Yu-Feng Yvonne Chan, Kumar Alagappan, Saadiyah Bilal, Jan Hargrave, Suzanne Bentley, and Marcus L. Martin

Introduction

The Institute of Medicine defines optimal primary care as including "an understanding of the cultural … systems of patients and communities that may assist or hinder effective health care delivery" [1]. With the swelling cultural, ethnic, and racial diversity of the USA, health care providers face increased challenges in achieving what has been termed "cultural competence" in their clinical practice. Cultural competence has been described as the skillful negotiation of cultural diversity in all its manifestations, an important aspect of which is adequate communication with patients regardless of the language barrier [2].

One in five Americans speak a language other than English at home and 8 % report that they speak English less than "very well" [3]. Unfortunately, miscommunication between patients and health care providers is a common occurrence in

---

Y.-F. Y. Chan, M.D., Ph.D. (✉)
Icahn Institute for Genomics and Multiscale Biology, Icahn School of Medicine at Mount Sinai, New York, NY, USA
e-mail: yu-fengyvonne.chan@mssm.edu

K. Alagappan, M.D.
Section of Emergency Medicine, Baylor College of Medicine, Houston, TX, USA

S. Bilal, M.D.
Division of Emergency Medicine, Ben Taub General Hospital, Baylor College of Medicine, Houston, TX, USA

J. Hargrave, B.S., M.S.
University of Louisiana, Lafayette, LA, USA

S. Bentley, M.D., M.P.H.
Emergency Department, Mount Sinai Medical Center, Elmhurst, NY, USA

M.L. Martin, M.D.
Department of Emergency Medicine, School of Medicine, University of Virginia, Charlottesville, VA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_6

emergency medicine (EM) and has been identified in over 70 % of malpractice depositions [4]. Although emergency physicians (EP) must be comfortable making critical decisions often based on incomplete information, the ability to communicate well with patients is nevertheless an important goal to achieve.

The services provided by interpreters are significant components of providing culturally competent care. Current evidence supports the importance and effectiveness of appropriately utilized interpreter services. Clearly, interpreter services are an important adjunct to care of the emergency patient and should be available in all EDs and health systems. Effective communication is critical in obtaining a reliable history and physical which is the cornerstone of appropriate medical care, in addition to addressing the emotional health of the patient. Effective use of interpreter services by EPs may improve patient outcomes in situations where language barriers exist [5, 6].

Methods used to overcome language barriers in the ED include ad hoc interpreters (such as family members or local staff), telephone interpreter services, professional interpreters, and computer assisted services, each with its own benefits and deficiencies. There is a paucity of data formally evaluating and validating these methods; existing evidence seems to be counterintuitive. Published results reveal that lack of uniform availability of interpretation options seems to be the biggest barrier to adequate translation. Therefore, establishing a standard for this aspect of patient care is timely and important. This paper will present a review of the various techniques used to overcome language barriers in the ED and a brief discussion of the advantages and drawbacks of each in an effort to determine the best method.

Discussion

Prevalence of Non-English-Speaking Patients and Demographics

National statistics gathered by the US Department of Education's National Adult Literacy Survey indicate that a significant minority (21–23 % or 40–44 million of the 191 million American adults) has limited English proficiency (LEP) [7]. Additionally, ethnic/racial populations often vary from area to area within a selected city, creating a need for different language skills from one ED to another. For example, within downtown New York City, one hospital cares for a large population of Spanish speakers while another cares for many Cantonese speakers. To further complicate matters, hospitals are subject to local population shifts so that the language interpretation needs within a given ED may also change over time.

Many studies demonstrate that language barriers decrease the quality of health care received by non-English speakers. Compared to their English-speaking counterparts, Non-English/LEP speakers are less likely to use primary and preventive services and are therefore more likely to utilize the ED as their primary care facility. A study done by Morrison et al. compared the care received by Somali immigrants versus their non-Somali counterparts, demonstrating that the completion of preventative health services such as rate of influenza vaccinations, colorectal cancer screenings, and mammography was lower for the immigrant patients than their non-Somali counterparts. The use of interpretation services was one of the factors associated with an increase in completion of these services [8].

Objective measures of medical urgency and triage scores, however, do not differ significantly between English-speaking patients and non-English speaking/LEP patients, thus demonstrating an equal need for accommodation and urgent emergency medical care between the two groups. It has also been shown that language barriers decrease patients' understanding of their disease processes, directly impacting their compliance and follow-up [9]. In addition, a 2013 retrospective study conducted by Gallagher et al. demonstrated that the rate of return visits resulting in admission was higher for non-English speaking/LEP patients than those who spoke English as their primary language, thus demonstrating that the communication barrier posed by non-English speaking/LEP patients may result in the disparity of care provided to them [10].

Negative Effects of an Existing Language Barrier

It is common to encounter medical personnel with some working knowledge of medical Spanish who may assist in communication with Spanish-speaking patients. Although this may seem beneficial, at least one study demonstrates its limited utility. For example, Price and Nelson studied the effectiveness of a 45-h medical Spanish training course for EM residents. After completion of the course, subsequent physician-patient interactions by those residents were audiotaped and analyzed by professional interpreters and native speakers for errors. Despite the formal training program, the investigators found that major errors (e.g., misunderstanding duration of symptoms or misuse of vocabulary) occurred in 14 % of encounters with Spanish-speaking patients. Minor errors (e.g., technically incorrect grammar) occurred in more than 50 % of encounters.

Although the medical Spanish training course was designed to supplement, not replace professional interpretation services, the residents requested interpreters in only 46 % of cases where a language barrier was deemed to exist, representing a decrease in interpreter use compared with before the course [11]. The overall decrease in performance may be due to a combination of overconfidence in newly acquired language skills and an incomplete instruction program that was necessarily limited by time. These factors, coupled with the many demands on residents' time, seem to indicate that this 45-h language instruction course is an impractical solution for caring for non-English-speaking/LEP patients [11].

When studying the adult population, Baker demonstrated that while patients were less satisfied and rated their understanding of their condition and treatment as worse in language barrier situations, the differences in understanding the diagnosis and treatment plan were not significantly different when a language barrier existed. Although the objective measures revealed little difference between patients in language barrier vs. no language barrier situations, the levels of understanding were quite poor overall [12–14]. Another study in a pediatric emergency department revealed that Spanish-speaking, limited-English-proficient parents who reported inaccuracies with the interpretation services were more likely to report problems with the education/information aspects of the care provided such as with understanding answers to questions or the cause of their child's illness [15].

Using Ad Hoc Interpreters vs. Professional Interpreters

Several studies suggest that, regardless of the resources available to EPs, one of the most common solutions to the challenge of non-English-speaking patients is the use of ad hoc interpreters [14]. In the interests of expediency, a wide variety of medical and non-medical personnel are recruited with considerable variation in their level of competence in medicine, language, and the art of interpretation. Ad hoc interpreters are commonly recruited from the friends and family of the patient, or from the ED staff, but can also include medical students, police officers, and other support staff.

Baker noted in a cross-sectional survey that an interpreter was used during 25 % of all Spanish-speaking patient encounters in the ED. Of these encounters, ad hoc interpreters were used 66 % of the time (nurses were used in 28 % of these cases while family members and others present were used during the remaining 72 % of cases). Doctors were used in 22 % of cases while professional interpreters were used only 12 % of the time [14]. Similarly, a study conducted by Leman noted that 51 % (28 of 55) of patients with limited English proficiency in an urban ED utilized family members to interpret and a different study by Kazzi reported use of ad hoc interpreters 42 % (55 of 131) of the time vs. 46 % (47 of 131) use of trained interpreters during the 131 encounters where a language barrier existed [16, 17].

There is also evidence that suggests that when interpreters are used, either ad hoc or professional, there is still a significant risk of miscommunication [12]. One study in the pediatric emergency setting demonstrated that communication errors were common even with the utilization of interpreters. Thirteen patient encounters yielded 474 pages of transcripts. Professional hospital interpreters were present for six encounters while ad hoc interpreters, including nurses, social workers, and family members, accounted for the remaining seven encounters. Overall, 396 errors were noted, with a mean of 31 errors per encounter. The most common types of errors were omission (52 %), false fluency (16 %), editorializing (10 %), and addition (8 %). Ad hoc interpreters were significantly more likely to make errors that had clinical significance than professional interpreters (73 % vs. 53 %) [12]. However, in 2012 in a similarly designed study conducted in two pediatric emergency departments, Flores et al. reported that among professional interpreters, hours of previous interpreter training were more significantly associated with types, numbers, and potential clinical consequences of errors than the interpreters' years of experience. These researchers found that interpreters with at least 100 h of training were less likely to commit errors of potential clinical consequence indicating that an investment by hospitals in the training of professional interpreter staff would be of benefit in reducing miscommunication among provider-patient interactions [13].

Professional medical interpretation, on the other hand, is a specialized skill and may be cost-prohibitive for certain institutions. Its use, however, has proven to be more effective than ad hoc interpretation and all other methods tested [18]. Even if the interpretation by non-professional interpreters is linguistically perfect, misleading information may still be transmitted due to the difficulty in obtaining a strict translation of medical problems, the tendency for over-simplification of complex cultural phenomena, and special problems dealing with translation by family members. In one study, patients who had family members interpret for them were less satisfied with the provider listening (62 % vs. 85 %), discussion of sensitive issues (60 % vs. 76 %), and manner (62 % vs. 89 %) compared to patients whose language was concordant with the provider [18]. Medical problems are often complicated to explain and frequently involve divulging very personal information. This often leads to complications such as patients leaving out important facts due to embarrassment and not wishing to share personal information when family members are translating. This is especially an issue when children are translating for parents and vice versa concerning topics that are sexually related or taboo in their specific culture.

Kuo, on the other hand, pointed out that patients and doctors have divergent views on the utilization of family members as interpreters. Physicians and patients agree that accuracy, accessibility, and respect for confidentiality are highly important characteristics of interpreters; however, patients are more concerned than physicians about the ability of the interpreter to assist them after the physician visit. Although both patients and physicians have a high level of satisfaction with the use of professional interpreters (92.4 % and 96.1 %, respectively), patients were also significantly satisfied with utilizing family members and friends to interpret (85.1 % vs. 60.8 %) because the family members and friends could continue to assist the patient at home after the physician encounter [19].

The decision of whether to use an ad hoc interpreter or a professional is often based on the perceived pros and cons thereof. Busy medical personnel may not justify the investment of time and effort to get a trained interpreter to a patient's bedside for a routine problem or procedure. In such cases, the question to be assessed is: what will be gained by using a professional interpreter instead of the family member already conveniently at the bedside?

Bilingual/Multilingual ED Staff

Bilingual/multilingual physicians may be proficient in communicating in the same language as a limited English-proficient (LEP) patient; however, it would be a mistake to assume language proficiency equates to cultural competency, or that an LEP patient would not face additional barriers in obtaining medical care. Several studies indicate that patients receive similar standards of care regardless of the language spoken, as long as the physician is truly fluent. However, such situations historically have been a fortuitous coincidence rather than a common ED solution to the problem in non-English-speaking/LEP patient populations [6, 20]. In fact, a study conducted by Chiu, Gold-Gomez, and Landry revealed that, out of 22 physicians who identified as self-translating in the ED and who were administered a telephonic exam by Interpreter Services, the number deemed competent in health care (32 %) and medical terminology (18 %) was substantially decreased compared to those deemed competent in conversational testing (55 %). This study demonstrates that even physicians who are conversational in a second language should maintain a lower threshold for utilizing translation services in the ED [21].

Bilingual nurses are possibly the most convenient and most commonly used ad hoc interpreters. Even with their medical training, however, there can still be pitfalls. Errors occur frequently in cross-language interpretations provided by nurses untrained in medical interpretation [22]. This leads to many non-English-speaking/LEP patients complaining of being misunderstood by their physicians. Interpretation errors include physicians failing to reconceptualize the problem when contradictory information was mentioned; nurses providing information congruent with clinical expectations but incongruent with patients' comments; nurses slanting the interpretation, reflecting unfavorably on patients and undermining patients' credibility; and patients explaining the symptoms using a cultural metaphor that was not compatible with Western clinical concepts [20].

The Importance of Utilizing Correct Nonverbal Communication

An important factor that needs exploration for clearer communication between interpreter and patient is the 90 % of communication which is nonverbal. Misunderstandings arise when an interpreter ineffectively and incorrectly uses gestures while communicating with patients [23]. Additionally, miscommunications occur when gestures are incongruent with the spoken word (saying "no" while nodding the head in an up and down "yes" motion).

Greetings, gestures, protocols, and forms of address are somewhat different in every culture; therefore, nonverbal multicultural awareness is a vital component of successful medical interpretation. Not all behavior is learned, nor is it all inherited; but there are actions that every human does that somehow communicate a meaning to all other humans regardless of race, color, creed or culture [24]. There is a universality of recognition of the facial displays of interest, joy, surprise, fear, anger, distress, disgust, contempt and shame. When the correct facial emotions are displayed, precise body language is incorporated, and proper wording is used, true interpretation communication exists.

Understanding the importance of body language during medical interpretations is vital to sending and receiving accurate data. Gestures are shortcuts; often much stronger than punctuation or the underscoring of words.

Before examining the array of body language gestures that might occur in medical interpretations, interpreters need to understand the meaning of gesture clusters and that a single gesture is similar to a single word within a sentence. Gesture clusters correctly placed together add clarity to spoken messages.

For successful medical interpretations to occur, five nonverbal channels need exploration: body angle, face, arms, hands and legs. To exhibit confidence and believability to his message, the interpreter needs to completely square his body and especially his shoulders toward the patient. Slightly leaning his body forward toward the patient will signal interest, openness and sincerity; leaning too far backward signals disinterest.

Direct eye contact signals honesty and interest; shifty-eyed people give the impression that they are hiding information from the patient or anxious to leave the ED. An interpreter can maintain control of his patient interaction if he gazes at his listener for approximately 80 % of the conversation. The smile, which has a reassuring effect, is the most positive facial expression. Genuine smiles involve the whole face; the corners of the mouth turn upward and the eye corners crinkle.

Open and relaxed hands, especially with the palms facing upward, allow the listener the assurance that the interpreter is part of the conversation. With his hands this way, it signals that he welcomes questions from the patient, whereas tightly clinched fists represent defensiveness. An interpreter who crosses his arms over his body while speaking to the patient is signaling defiance and disinterest [25]. Left-hand gestures to the face should be avoided as much as possible; these gestures represent deception and distrust. Since inventiveness and imagination are believed to originate in the right creative side of the brain (which also controls all left hand motions), an abundance of left-hand gestures to the face signals uneasiness and a lack of confidence [26]. An interpreter who places his right hand, with his fingers spread, to his upper chest area is displaying honesty. The best kind of handshake is firm and vertical.

Crossed legs or crossed ankles signal that there is hesitation or something preventing a completely open mind. Uncrossed legs and feet send a message of cooperation and friendly interest in the other person. Although it is best that the interpreter not cross his legs at all, a leg crossed toward the patient (signaling inclusiveness) is acceptable in the early phase of an interpretation.

In medical interpretations, direct eye contact, erect body posture, and open gestures signal power and confidence. Approximately 7 % of communication is verbal communication; gestures, voice inflection, posture, and facial expressions make up the remainder. To improve patient outcomes in situations where language barriers exist, a medical interpreter should constantly be aware of his body language and how his presence and gestures are read by the patient.

Telephone-Based Interpreter Systems

Telephone-based interpreter systems are an alternative to live interpreters and are widely used in the medical field. Telephone interpretation is useful since telephones are potentially more available than a live interpreter and because they offer the broadest range of possible languages.

Telephone interpretation also offers the more subtle advantage of offering remote (as opposed to on-site) because patients are often uncomfortable with having another person present during the history-taking and physical exam. The relatively impersonal nature of a telephone-based interpreter increases patient satisfaction when discussing sensitive issues. Patients also report that they are happier with their physician's skill level, attentiveness, manner, answers to questions, and explanations when a telephone-based interpreter was used when compared to a family member or ad hoc interpreter [27].

Despite these advantages, it seems that the special milieu of the ED continues to limit the use of this system. The first hurdle is the absence of bedside phones in the ED. Institutions are faced with providing bedside access to telephones and such concerns dilute one of the main advantages of telephone-based interpreters, namely their ease of introduction. Another factor to consider is that whether a specialized phone is needed or if the speakerphone of a normal phone may be used; however, this tends to result in raised voices, poor audio quality, and a certain lack of privacy. Another limit is that while using a phone during the initial history or during discharge is relatively straightforward, having a patient speak into a phone between each component of a neurological exam, for example, is rather cumbersome. The interpreter is also unable to see the patient's facial expressions and body language, which may further hinder the patient's ability to convey his or her history and concerns [27].

While telephone services can be a useful adjunct, they can rarely function as the primary or sole interpretation resource for an ED. In common practice at present, telephone-based interpretation appears to be limited to interpreting for unusual language speakers, dependent upon the setting [27]. The diversity of the local population will likely determine whether an ED treats enough uncommon language speakers capable of using a telephone interpretation service to provide justification for providing phone access in the ED and contracting an interpretation service, which can also be very costly. Regardless, it is clear that phone services cannot completely supplant live interpreters.

Interpretation for the Hearing-Impaired

The hearing-impaired patient deserves special mention when discussing the use of interpreters in a medical setting. There are over 30 million people in the USA who are classified as hearing-impaired. Of those, approximately 2.5 million are considered deaf. Hearing-impaired patients are often given substandard care, in part due to widely held misconceptions about the hearing-impaired and sign language [28].

Perhaps the most important consideration is that the terms "hearing-impaired" and "deaf" encompass a wide range of functional impairment ability, and that patients have varying degrees of comfort with spoken language, lip-reading, sign-language, and using writing to communicate. A physician therefore cannot assume that because a patient has some lip-reading ability, that they he or she would not prefer an American Sign Language (ASL) interpreter or that the patient's skills are sufficient for use in a medical setting [28].

ASL is a linguistically complete, natural language used by a community. It is unrelated to spoken English and has completely different rules governing its morphology and syntax. Although the most recent census did not include figures for the use of ASL, by most estimates, it is the third or fourth most common language in the USA. State-certified interpreters are available in every state, and the Americans with Disabilities Act (ADA) mandates their usage when needed [28].

The difficulty of interpretation in this unique type of patient encounter lies, perhaps, in the temptation to use ad hoc solutions. The most common solution is communication by writing. While some deaf patients prefer this modality, many others find it cumbersome. It is also important to realize that many deaf patients are pre-lingually deaf, and thus have poor reading comprehension. Finally, as noted above, ASL and English bear no relation to one another. Therefore, writing in English to an ASL speaker is probably slightly less effective than writing English notes to a Spanish speaker [28].

Another tempting solution is lip-reading. It must be understood that lip-reading is a skill, and while some patients have excellent comprehension, many others manage only partial recognition with normal conversation. The unusual language of medicine combined with the fast pace at which medicine is practiced in emergency situations often makes comprehension quite challenging for hearing-impaired patients. Not surprisingly, surveys of the deaf reveal an overwhelming preference for a signing interpreter [27, 29].

Ultimately, the hearing-impaired, deaf, or ASL-utilizing patient is no different from any other language barrier patient. As long as the medical staff is willing to inquire about the patient's preferred method of communication, the same considerations must be applied to deaf patients as to foreign language-speaking patients. In these cases, the use of ASL interpreters is clearly the superior solution to the communication barrier [28]. However, a study surveying physicians showed that while 63 % of physicians knew that signing should be the initial method of communication, only 22 % actually used an ASL interpreter in their common practice [27]. While the need for ASL interpreters might seem obvious, a growing body of successful litigation involves the hearing-impaired and failure by medical personnel to address their needs and indicates that perhaps the guidelines need to be more widely adopted. There is now a Language Video Interpreter that can be used on devices such as iPad, iPhone, Android, and allows an extremely convenient face-to-face interaction between the interpreter, ASL-speaking patient, and physician. This technology utilizes an Ethernet, cellular, or Wi-Fi connection and allows physicians the ability to move between rooms or to obtain translation services under difficult conditions. All communications occur on an encrypted network, ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance with patient privacy laws [30].

Patient Follow-Up and Compliance

Most ED patients require additional care and follow-up visits for their medical problems. There is a perception that non-English proficient patients are not only more likely to use the ED as a primary care facility, but that they are also less likely to comply with discharge instructions and follow up in a timely manner [2]. Presumably, failed referrals result in either repeat ED visits or loss of continuity. In one prospective, nonrandomized, descriptive analysis of ED patients referred to an established urban hospital follow-up network, the general follow-up rate for ED referrals was found to be approximately 28 % for all patients [5]. Although no significant differences were ostensibly found in the likelihood of follow up for non-English proficient LEP patients in this study, Sarver et al. did find that a language barrier resulted in a lower likelihood of receiving a referral in the first place [5]. This may be due to the fact that it may be more challenging to elicit a history sufficient to elucidate the need for further referral in LEP patients than it is to simply communicate a follow-up appointment time [31, 32].

Financial Impact of Interpreter Usage

Interpreters have several significant cost-lowering effects per visit. One study showed that non-English-speaking/LEP patients who lacked the use of an interpreter had a higher incidence and cost for testing, were more likely to be admitted, and were more likely to receive intravenous hydration, indicating excess care delivered as a precaution. Decision-making by the physician was more cautious and also more expensive when non-English-speaking/LEP patient cases were treated in the absence of a professional interpreter [6]. A retrospective study of nearly 4000 patients of an immigrant background presenting to an emergency department in Berlin, Germany with the chief complaint of headache demonstrated that these patients were more than twice as likely to receive imaging procedures and have invasive lumbar punctures performed than matched non-immigrant patients even though a serious secondary cause of headache was more often found in matched non-immigrant patients than the immigrant patients. The authors of this study concluded that this higher frequency of imaging and invasive testing in immigrant patients was symptomatic of the physicians' difficulty in establishing an etiology for the headache based on history and physical examination alone resulting in a more cautious clinical approach and they recommended the use of interpreters or headache questionnaires in various languages to help with reducing costs of this diagnostic work-up [33].

Emerging Technology

Various software systems are emerging that may strongly complement many of the interpretation solutions currently in practice. Mobile computerized technology is becoming available that affords point-of-care service and therefore makes service convenient and confidential for both patients and caregivers [34]. This technology offers an immediate response in an ED and may be incorporated as early as during triage. It allows for immediate assessment and may eliminate delays in care while waiting for an appropriate, live interpreter.

Using mobile computerized technology, the clinician selects the appropriate language and the patient is then automatically queried about his or her chief complaint. The patient answers via touching the appropriate response on the screen. This allows the clinician to communicate directly with non-English-speaking/LEP patients, as well as hard-of-hearing and deaf patients. A prerecorded voice communicating the words on the screen directly to the patient in their given language may make this technology useful to patients who cannot read or write. Although this development seems very promising, the technology still requires more study and validation in the ED. Another example of a translation device freely available to all health care professionals and to be used on mobile phones is the Canopy Medical Translator developed by the National Institutes of Health. The free mobile application is preprogrammed with 1500 medical phrases in 15 languages allowing physicians to communicate easily with patients regarding various stages of their care such as physical examination, results, and even greet patients in the appropriate language [35].

Summary

Interpreter services in emergency medicine will vary among EDs according to the prevalence of non-English-speaking patients and the different languages prevalent in the local patient population served. Solutions include utilization of professional interpreters, telephone interpretation services, bilingual/multilingual staff, and other ad hoc interpreter services; all have their own advantages and disadvantages. Health care providers in emergency medicine must be aware of the options for medical interpretation and the advantages and disadvantages of each method. Supporting data demonstrate that the utilization of professional medical translators is the superior and preferred choice whenever feasible. Professional medical translation should be the standard service recognized, accepted, and implemented in all medical facilities.

References

1. Tervalon N, Murray GJ. Cultural humility vs cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998;9(2):117–25.
2. Cross TL, Bazron BJ, Dennis, KW, Isaacs MR (National Institute of Mental Health, Rockville, MD. Child and Adolescent Service System Program). Towards a culturally competent system of care: a monograph on effective services for minority children who are severely emotionally disturbed. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center; 1989.
3. Shin HB, Bruno R. Language use and English-Speaking ability. Census 2000 Brief. 2003. Ed. U.S. Census Bureau. Washington, D.C: U.S. Census Bureau.

4. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor–patient relationship and malpractice. Arch Intern Med. 1994;154(12):1365–70.
5. Vukmir RB, Kremen R, Dehart DA, Menegazzi J. Compliance with emergency department patient referral. Am J Emerg Med. 1992;10(5):413–7.
6. Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization. Arch Pediatr Adolesc Med. 2002;156(11): 1108–13.
7. Kirsch IR, Jungeblut A, Jenkins L, Kolstad A. Executive summary of adult literacy in America: a first look at the results of the National Adult Literacy Survey. National Adult Literacy Survey, funded by the U.S. Department of Education's National Center for Education Statistics. NCES 1993-275. https://nces.ed.gov/naal/resources/execsumm.asp
8. Morrison TB, Wieland M, Cha SS, Rahman AS, Chaudhry R. Disparities in preventive health services among Somali immigrants and refugees. J Immigr Minor Health. 2012;14(6):968–74.
9. Hampers LC, Cha S, Gutglass DJ, Binns HJ, Krug SE. Language barriers and resource utilization in a pediatric emergency department. Pediatrics. 1999;103(6 Pt 1):1253–6.
10. Gallagher RA, Porter S, Monteaux MC, Stack A. Unscheduled return visits to the emergency department: the impact of language. Pediatr Emerg Care. 2013;29(5):579–83.
11. Prince D, Nelson M. Teaching Spanish to emergency medicine residents. Acad Emerg Med. 1995;2(1):32–6. discussion 36-7.
12. Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics. 2003;111(1):6–14.
13. Flores G, Abreu M, Barone CP, Bachur R, Lin H. Errors of medical interpretation and their potential clinical consequences: a comparison of professional versus ad hoc versus no interpreters. Ann Emerg Med. 2012;60(5):545–53. doi:10.1016/j.annemergmed.2012.01.025. Epub 2012 Mar 15.
14. Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K. Use and effectiveness of interpreters in an emergency department. JAMA. 1996;275(10):783–8.
15. Arthur KC, Mangione-Smith R, Meischke H, Zhou C, Strelitz B, Acosta Garcia M, et al. Impact of English proficiency on care experiences in a pediatric emergency department. Acad Pediatr. 2014; pii: S1876-2859(14)00240-X. doi: 10.1016/j.acap.2014.06.019.
16. Leman P. Interpreter use in an inner city accident and emergency department. J Accid Emerg Med. 1997;14(2):98–100.
17. Bonacruz KG, Cooper C. Barriers to the use of interpreters in emergency room pediatric consultations. J Pediatric Child Health. 2003;39(4):259–63.
18. Lee LJ, Batal HA, Maselli JH, Kutner JS. Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. J Gen Intern Med. 2002;17(8):641–5.
19. Kuo D, Fagan MJ. Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. J Gen Intern Med. 1999;14(9):547–50.
20. Manson A. Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. Med Care. 1988;26(12):1119–28.
21. Chiu D, Landry A. Evaluation of competency for physicians who self-translate for Limited English Proficiency patients in the emergency department. Abstract presented at: Annual New England SAEM Conference; 2013 April; Providence, RI.
22. Maltby HJ. Interpreters: a double-edged sword in nursing practice. J Transcult Nurs. 1999;10(3):248–54.
23. Gschwandtner G, Garnett P. The importance of nonverbal communication. In: Nonverbal selling power. Englewood Cliffs, NJ: Prentice Hall; 1985. p. 3–15.
24. Fast J. Body language: the essential secrets of non-verbal communication. New York, NY: MJF Books; 1970.
25. Morris D. BodyTalk: the meaning of human gestures. New York, NY: Crown Trade Paperbacks; 1994.
26. Springer SP, Deutsch G. Left brain, right brain: the concept of cerebral dominance. 3rd ed. New York, NY: WH Freeman and Company; 1989.

27. Iezzoni LI, O'Day BL, Killeen M, Harker H. Communicating about health care: observations from persons who are deaf or hard of hearing. Ann Intern Med. 2004;140(5):356–62.
28. Ebert DA, Heckerling PS. Communication with deaf patients. Knowledge, beliefs, and practices of physicians. JAMA. 1995;273(3):227–9.
29. Witte TN, Kuzel AJ. Elderly deaf patients' health care experiences. J Am Board Fam Pract. 2000;13(1):17–22.
30. Video Remote Interpreting- Language Uc, Inc. LanguageLine Solutions Software. Online (Available) https://www.languageline.com/solutions/video-interpretation/, 2013.
31. Sarver J, Baker DW. Effect of language barriers on follow-up appointments after an emergency department visit. J Gen Intern Med. 2000;15(4):256–64.
32. Enguidanos ER, Rosen P. Language as a factor affecting follow-up compliance from the emergency department. J Emerg Med. 1997;15(1):9–12.
33. Royl G, Ploner CJ, Leithner C. Headache in the emergency room: the role of immigrant background on the frequency of serious causes and diagnostic procedures. Neurol Sci. 2012;33(4):793–9. doi:10.1007/s10072-011-0830-y. Epub 2011 Nov 2.
34. Inocom, Inc. Medbridge Software. [Online] Available at: http://www.medbridge.net/, 2005.
35. Canopy Medical Translator, Inc. Canopy Innovations Software (Online) Available at: http://www.canopyapps.com/translator, 2014

Chapter 7
The Patient–Physician Clinical Encounter

Thea James

Introduction

In emergency medicine (EM), the clinical encounter between physician and patient is a vital "first impression." This is one of the greatest challenges in our clinical practice because we have a window of opportunity to optimize the physician–patient dyad. There is little time to establish a rapport, earn a patient's trust, make a correct diagnosis, and develop a treatment and discharge plan designed for *that* patient. The practice of EM provides physicians with a unique glimpse into human nature, the human condition, and all of what constitutes "life." Most patients in the emergency department are unknown to providers. Their visits are unplanned, traumatic, and include unexpected illness, tragic events, and emergent conditions that include psychiatric and psychosocial events. EM provides opportunities that can teach clinicians to listen and to learn what matters to people—because treatment plans created *with* patients and based on what *matters* to them have the greatest opportunity for success [1].

Patient's clinical experiences affect their health, shape their perspective on the health care system, and influence their health care outcomes [1–5]. The clinical experience begins when patients interface with and/or enter a medical facility. The experience occurs on telephones, in hallways, at front desks, at the point of triage, with ancillary health care staff, and ultimately in the examination room with providers. What occurs in the examination room weighs heavily on the patient's experience [6, 7]. Providers' mindfulness of the factors affecting the success and failure of clinical encounters makes a difference; culture, communication, patient centeredness, and unconscious bias are common factors addressed in the literature [1, 5, 8–17]. Medical education has begun to address the patient–physician encounter in medical schools and residency training to develop students and trainees into

---

T. James, M.D. (✉)
Emergency Department, Boston Medical Center, Boston, MA, USA
e-mail: thea.james@bmc.org; tljlcj@gmail.com; theaj@bu.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_7

providers who will become more aware of the factors affecting the success and failure of clinical encounters [18–29].

As previously mentioned in this book, in 2002 the Institute of Medicine (IOM) produced a report commissioned by the US Congress that analyzed more than 100 studies assessing the quality of care for racial and ethnic minorities [15]. The report found that minorities received fewer needed services and procedures than whites, even after controlling for insurance status, income, and other access factors. The authors of the report suggested that unconscious bias, prejudice, stereotyping, and physician uncertainty of disease severity may influence clinical decision-making and the allocation of services and procedures. Ultimately, the IOM report concluded that reasons for health care disparities were (1) the organization and operation of health care systems administratively, (2) "patients' attitudes and behaviors," and (3) "health care providers' biases, prejudices, and uncertainty when treating minorities." Nonetheless, these kinds of findings are discouraging, and they reinforce beliefs and distrust in some patient cultures. Recollection of historical injustices such as the Tuskegee study remains close to the surface in the memories of patients from minority communities [2, 4]. This has led to skepticism about the validity of medical research and the appropriateness of medical recommendations. Middle-class African-American patients often rate their physician interactions as less participatory when the doctor is of a different race as the patient. A lack of complete trust also affects patients' behaviors in health care systems, responses to recommendations, and ultimately their health outcomes [30–35].

Discussion

Factors Affecting the Patient–Physician Encounter

Culture

Both physicians and patients enter a clinical encounter bringing their personality and culture with them. Race, ethnicity, class, gender, economic conditions, spirituality, and sexual orientation represent some cultural components that accompany individuals into the examination room, and they can frame definitions of health, wellness, and the quality of the clinical encounter for patients *and* physicians [1–5, 7–17]. A lack of understanding regarding cultural factors can have an adverse effect on physician–patient communication, trust, treatment, and, most importantly, health care outcomes [30–35]. Perceptions, ideas, and beliefs held by members of the public accompany these individuals as they navigate through the world and during their daily activities. It is logical then that these opinions would also accompany them into the examination room.

For example, differences among cultures have a great impact on physician–patient encounters [13, 30–35]. However, because patients enter the examination room, which is the physician's area of expertise and comfort, it is important that physicians recognizeand understand that they, and not the patients, should try to bridge cultural gaps. This understanding is essential precisely because of the power dynamics present when a patient first enters into the examination room.

The effect of culture in clinical encounters is extensively noted in medical literature [1–36]. Studies about the impact of concordance on patients' perceptions of aspects of the clinical encounter suggest a cultural connection [32–36]. The effect of patient–physician concordance in clinical encounters was documented in a Commonwealth Fund study by Cooper [31]. The study examined the role of patient–provider racial, ethnic, and language concordance on disparities in patient experiences, health care processes, and outcomes. The study documented ongoing racial and ethnic disparities in health care and linked patient–physician race and ethnic concordance with higher patient satisfaction and better health care processes. Based on their findings, the authors made recommendations stressing medical education, increased workforce diversity, and further studies to better understand the concordance phenomenon.

Street et al. took the Commonwealth Fund study a step further to better understand concordance. The study suggested that the physician–patient relationship is strengthened when patients see themselves as similar to their physicians in personal beliefs, values, and communication style [33]. Perceived personal similarity is associated with higher ratings of trust, satisfaction, and intention to adhere to treatment plans. Race concordance is the primary predictor of a perceived ethnic similarity, although there are other factors involved. For example, physicians using patient-centered communication were a higher predictor of perceived personal similarity.

Communication

"It has long been recognized that difficulties in the effective delivery of health care can arise from problems in communication between patient and provider rather than from any failing in the technical aspects of medical care" [10, 11, 31, 35–37].

Improvements in provider–patient communication can have beneficial effects on health outcomes. For a successful and humanistic encounter at an office visit, one must ensure the patients' key concerns have been directly and specifically solicited and addressed. To be effective, the clinician must gain an understanding of the patients' perspectives on their illnesses.

Communication in the clinical encounter is a key factor in the success of the overall treatment plan and outcomes [10, 37, 38]. In a study by Kim, "patient-perceived physician empathy significantly influenced patient satisfaction and compliance via the mediating factors of information exchange, perceived expertise, interpersonal trust, and partnership. Improving physician empathic communication skills should increase patient satisfaction and compliance" [39].

The American Medical Association endorses patient-centered communication. "Effective, patient-centered communication is key to quality care. Good communication is both an ethical imperative, necessary for informed consent and effective patient engagement, and a means to avoid errors, improve quality, save money and achieve better health outcomes." [40]

Unconscious Bias

Unconscious or implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner [14, 41–56]. The 2002 IOM report documenting racial/ethnic disparities in health care frequently implicates physicians' unconscious biases. More recent studies suggest that there remains room for improvement in this regard. In 2007, Green et al. conducted a study to "measure physicians' unconscious racial bias to test whether this predicts physicians' clinical decisions" [54]. The study "tested whether physicians show implicit race bias and whether the magnitude of such bias predicted thrombolysis recommendations for black and white patients with acute coronary syndromes." To determine their results, the researchers used an Internet-based tool comprising a clinical vignette of a patient presenting to the Emergency Department with an acute coronary syndrome, followed by a questionnaire and three implicit association tests. Internal medicine and emergency medicine residents at four academic medical centers were randomized to either a black or white vignette patient. This study represents the first evidence of unconscious (implicit) race bias among physicians, its dissociation from conscious (explicit) bias, and its predictive validity. The results suggested that physicians' unconscious biases might contribute to racial/ethnic disparities in the use of medical procedures such as thrombolysis for myocardial infarction. Study results such as these translate into missed opportunities to connect with patients and worse, show that we could be unconsciously contributing to health care disparities. Enhanced medical education curriculums are crucial to addressing and raising levels of consciousness of students, residents and practicing providers [18–25, 27–29]. Medical education can make a difference in provider awareness and ultimately provider behavior.

Clinical Encounters Using Trauma-Informed Care

Many urban medical centers treat disproportionate numbers of young victims of intentional community violence. Physician encounters with patients who are victims of violent trauma require knowledge about manifestations of trauma and communication skills to avoid inadvertent re-traumatization of patients during the encounter. Clinical encounters with these vulnerable patients and their families can be sensitive and have high stakes involved because the ED can offer a unique opportunity for interventions geared specifically to reduce recidivism among vulnerable, violently injured youth.

Emergency physicians have the rare possibility to intervene and break the cycle of community violence by taking advantage of this teachable moment to engage young victims and mitigate thoughts of retaliation and hopelessness [57–70]. When victims of violence arrive in the emergency department and are in a vulnerable state, providers have an opportunity to engage with them and establish a rapport that is unbiased by the nature of their injury and assumptions of being perpetrators of bad behavior. Effective communication and engagement in these situations requires compassion from health care providers. Victims of intentional gun and knife violence are often labeled and deemed "bad kids" because they were shot or stabbed. For example, victims of violence's emotional responses to trauma can be misinterpreted as bad behavior. Trauma can cause neurobiological and psychosocial effects such as hyperarousability, hypervigilance, aggressive responses to fear and threat to safety, loss of empathy for others, withdrawal, anxiety, and depression [57, 61–69, 71–73]. Understanding and maintaining an awareness of this can help health care providers to comprehend post-trauma behavior and minimize re-victimization; symptoms are seen not as pathology but primarily as attempts to cope and survive. From providers, this requires care that is trauma-informed. Specifically, this requires respect, compassion, and familiarity with the manifestations of trauma.

In a study of victims of youth violence enrolled in a hospital-based violence intervention program, study subjects cited the following as challenges to healing: fear and safety, trust, isolation as a coping mechanism, bitterness, and symptoms of post-traumatic stress disorder [65]. These challenges are not unlike challenges to healing for all people who are victims of intentional trauma including domestic violence and mass traumas involving multiple victims in public places. There are opportunities in medical education to teach and inform all providers of health care the tenets and skills of trauma informed care. When providers understand manifestations of trauma, and employ trauma informed care they will ensure physical and emotional safety in the ED encounter and contribute to facilitating healthy recovery and empowerment. Several cities have established effective, peer-model based hospital based interventions that use "Trauma Informed Care" (TIC) in the ED setting [57–60, 63–65, 68, 70].

Interventions to Enhance Patient–Physician Encounters

Using Patient-Centered Care

Cultural competence and patient-centered care have evolved separately, yet there is overlap between them [39, 74–78]. Cultural competence is the ability to understand, appreciate, and interact with persons from cultures and/or belief systems other than one's own, based on various factors and on an individual basis. Patient-centered care means organizing the delivery of health care around the needs, values, and preferences of individual patients and their families; it is individualized care. The IOM defines patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." The IOM listed it as one of six aims to improve health care in the twenty-first century. Together, culturally competent care and patient-centered care are complementary, and they significantly enhance opportunities for successful clinical encounters. Like ideal clinical encounters, patient-centered care focuses on what matters to patients, and it can also involve systems and holistic care—for example creating a health care system that is convenient for patients and their families and designing appointment and clinic times that are flexible to accommodate individual patient schedules and needs. It is a patient-centered model versus the traditional physician-centered model. Providers can deliver patient-centered care in the clinical encounter by creating partnerships and a treatment/discharge plan that is unique to individual patients, one created to optimize opportunities for successful outcomes [1].

Patient-centered care has been associated with improved clinical outcomes, cost savings, and patient satisfaction. In a Health Affairs blog, Rikert discussed the fundamentals of patient-centered care and its impact on the clinical encounter [79]. Citing a study by Stewart et al. in 2000, Rikert supports the well-known fact that physicians do not always know when a failed clinical encounter has occurred, but patients always know [75]. In the study, audiotaped doctor–patient interactions were studied while patients also rated these same interactions. Expert opinion could not be correlated with positive results, but patient-perceived, patient-centered care correlated with “better recovery from their discomfort and concern, better emotional health 2 months later, and fewer diagnostic tests and referrals.” Rikert corroborated this finding with a study conducted by researchers at Thomas Jefferson University to test physician empathy, which led the researchers to develop the Jefferson Scale, a test for physician empathy [80]. Physicians also rated their own empathy, but the scale could not be correlated with improvements in patient care. However, researchers then changed it to the Jefferson Scale of Patient’s Perceptions of Physician Empathy and administered it to patients. The researchers found the tool useful for predicting patient outcomes.

Bertakis and Azari also conducted a study to look at the effect of patient-centered care on health care utilization [78]. In their study, 509 new adult patients were randomized to care by family physicians and general internists. An adaption of the Davis Observation Code was used to measure the patient-centered practice style. The main outcome measures were the use of medical services and related charges monitored over the course of a year. Patient-centered care was associated with decreased utilization of health care services and lower total annual charges. The authors concluded that reduced annual medical care charges might be an important outcome of medical visits that are patient-centered [39].

Systemic Changes and Accountability

Future changes are beginning to evolve systemically in medical education. In response to the identification of unacceptable differences in both health care provisions and health care outcomes, new standards of care are evolving [79]. State Medicaid regulations and Health Plan Employer Data and Information Set criteria now reflect the need to establish quality performance measures to ensure access to appropriate services for culturally diverse populations [80].

Education

Making thoughtful upgrades in medical education is the best opportunity to cause a permanent shift in the paradigm of the patient physician encounter [19–27]. Medical students are introduced to the patient–physician encounter early. They learn to interview patients with a focus on becoming comfortable talking with patients and using a *script* as a guide. The script is composed of a set of questions used to interview patients, and leads to diagnosing, treating and making discharge plans. Additional teaching is needed to focus on nuances of the interview and the complexity of the patient physician encounter. Enhanced medical education can raise student and resident self-awareness and consciousness of the multiple factors present in a patient physician encounter and how it can influence the outcome. A broad intervention integrating competency training into medical education and the professional development of health care professionals at all levels of training, including students, residents, and practicing providers is needed.

Cooper et al. recommended a curriculum where students and residents acquire knowledge, attitudes, and skills, and they advised that the AAMC, LCME, and AGGME work with medical educators and researchers to "develop and disseminate teaching strategies and curricular content" [81–83]. To ensure that practicing providers participate in competency training, Cooper et al. recommended competency training requirements for specialty board certification and recertification for practicing providers. The authors suggested making this training convenient by making it available at professional medical meetings.

Conclusion

The focus on patient–physician encounters has evolved. Its successes and failures have been correlated with health care outcomes, cost and profitability, and national measures of accountability and reimbursement. Continued progress will require ongoing research, enhanced medical education, required certification skills for practicing providers, and systemic implementation of creative interventions to achieve sustained and successful health care outcomes.

Our health care system shifts and frequently changes rules and standards of care. New changes can subsequently later become obsolete or inappropriate for changing cultures and times. Human nature, however, will never change. People will always respond to respect, consideration, efficiency, and quality health care. All patients want good health and a clinical experience that will provide them with it. Following the basic tenets of the successful patient–physician encounter will consistently lead to rewarding outcomes for patients and their providers.

Recommendations

- Maintain an awareness of the presence of bidirectional cultures during the patient physician encounter and how it can influence the outcome.
- Establish a partnership with patients for treatment and discharge plans. Create a plan together that patients are willing, able and have resources to accomplish.
- Educate: teach patients the diagnosis and test for comprehension.
  - Ask: "When someone asks you about your diagnosis today, what will you tell them?"

Create an Environment for High Yield Dialogue in the Examination Room

Dialogue during the clinical encounter should be open-ended, encourage any and all questions from patients. Providers should establish a treatment partnership with patients to assure a patient centered treatment model. Patients should participate in their treatment plan. The plan should be based on what matters to them. Labeling patients as noncompliant, irresponsible, careless, or unconcerned in lieu of inquiring about the exact causes for failed treatment plans or blaming them for lack of knowledge creates a barrier that affects physician *and* patient trust. It is extremely important to avoid making any patient feel unheard, ashamed, inept, blamed, or dismissed.

Important Questions to Ask Patients When Treatment Plans Are Not Going as Planned Include

1. I'm concerned about your blood pressure and blood sugar, they are high. Are you able to take your medication regularly? What would you say is the reason you were not able to take your medicine? What would make taking it easier for you? How can we help?
2. Should we have created a better plan for you? Can you suggest a better plan or how to implement your current plan better? What do you think you need to get better?
3. What would you suggest we do to create a plan that will successfully work for you?
4. Here are some suggested options for treatment. Do any of them sound like something you could do easily?
5. What do you think the problem is? Is it the medication, the schedule of care, the lack of communication, or another issue we can discuss?

6. What do you think is causing your current symptoms?
7. To patients with multiple complaints: “What is the one thing that made you say to yourself, I’m going to the hospital?”
8. Do you have any questions that I can answer for you today?

References

1. Task SAEM. Force on physician-patient communication: physician-patient communication in the emergency department. Part 2: communication strategies for specific situations. Acad Emerg Med. 1996;3:1146.
2. Miranda Jr D, Sanchez DJ. The Tuskegee experiment: an introduction in ethics for pre-healthcare professional students. J Microbiol Biol Educ. 2014;15:232–4.
3. Boulware LE, Cooper LA, Ratner LE, La Veist TA, Powe NR. Race and trust in the healthcare system. Public Health Rep. 2003;118:358–65.
4. Gamble VN. Under the shadow of Tuskegee: African Americans and health care. Am J Public Health. 1997;87:1773–8.
5. Mansh M, Garcia G, Lunn MR. From patients to providers: changing the culture in medicine toward sexual and gender minorities. Acad Med. 2015;90:574–80.
6. Cleary PD, Meterko M, Wright SM, Zaslavsky AM. Are comparisons of patient experiences across hospitals fair? A study in Veterans Health Administration hospitals. Med Care. 2014;52:619–25.
7. Merlino J, Rice S. Getting past the ‘tribal mentality’ to improve the patient experience. Mod Healthc. 2014;44:42–3.
8. Commonwealth Fund 2001 Health Care Quality Survey.
9. Xu KT, Borders TF, Arif AA. Ethnic differences in parents’ perception of participatory style of their children’s physicians. Med Care. 2004;42:328–35.
10. Johnson RL, Roter D, Powe NR, Cooper LA. Patient race/ethnicity and quality of patient–physician communication during medical visits. Am J Public Health. 2004;94:2084–90.
11. Roter DL, Hall JA. How physician gender shapes the communication and evaluation of medical care. Mayo Clin Proc. 2001;76:673–6.
12. Boulware LE, Ratner LE, Cooper LA, Sosa JA, LaVeist TA, Powe NA. Understanding disparities in donor behavior: race, and gender differences in willingness to donate blood and cadaveric organs. Med Care. 2002;40:85–95.
13. The Kaiser Family Foundation National Survey of Physicians. Part 1: doctors on disparities in medical care (2002).
14. Saha S, Arbelaez JJ, Cooper LA. Patient-physician relationships and racial disparities in the quality of healthcare. Am J Public Health. 2003;94:1713–9.
15. Smedley BD, Stith AY, Nelson AR. Unequal treatment: confronting racial and ethnic disparities in healthcare. Institute of Medicine. 2002.
16. Pacheco CM, Daley SM, Brown T, Filippi M, Greiner KA, Daley CM. Moving forward: breaking the cycle of mistrust between American Indians and researchers. Am J Public Health. 2013;103:2152–9.
17. Waseem M, Ryan M. “Doctor” or “doctora”: do patients care? Pediatr Emer Care. 2005;205: 515–7.
18. Park ER, Chun MB, Betancourt JR, Green AR, Weissman JS. Measuring residents’ perceived preparedness and skillfulness to deliver cross-cultural care. J Gen Intern Med. 2009;24: 1053–6.
19. Green AR, Betancourt JR, Park ER, Greer JA, Donahue EJ, Weissman JS. Providing culturally competent care: residents in HRSA Title VII funded residency programs feel better prepared. Acad Med. 2008;83:1071–9.

20. Green AR, Miller E, Krupat E, White A, Taylor WC, Hirsh DA, et al. Designing and implementing cultural competence OSCE: lessons learned from interviews with medical students. Ethn Dis. 2007;17:344–50.
21. Lopez L, Vranceanu AM, Cohen AP, Betancourt J, Weissman JS. Personal characteristics associated with resident physicians' self perceptions of preparedness to deliver cross-cultural care. J Gen Intern Med. 2008;23:1953–8.
22. Park ER, Betancourt JR, Miller E, Nathan M, MacDonald E, Ananeh-Firempong 2nd O, et al. Internal medicine residents' perceptions of cross-cultural training. Barriers, needs, and educational recommendations. J Gen Intern Med. 2006;21:476–80.
23. Kumagal AK, Lypson ML. Beyond cultural competence: critical consciousness, social justice and multicultural education. Acad Med. 2009;84:782–7.
24. Hamilton G, Marco CA. Emergency medicine education and health care disparities. Acad Emerg Med. 2003;10:1189.
25. Hobgood C, Sawning S, Bowen J, Savage K. Teaching culturally appropriate care: a review of educational models and methods. Acad Emerg Med. 2006;13:1288.
26. Flores G. Providing culturally competent pediatric care: integrating pediatricians, institutions, families, and communities into the process. J Pediatr. 2003;143:1.
27. Scott CJ, Martin M, Hamilton G. Training of medical professionals and the delivery of health care as related to cultural identity groups. Acad Emerg Med. 2003;10:1149.
28. Ko M, Heslin KC, Edelstein RA, Grumbach K. The role of medical education in reducing health care disparities: the first ten years of the UCLA/Drew Medical Education Program. J Gen Intern Med. 2007;22:625–31.
29. Dhaliwal JS, Crane LA, Valley MA, Lowenstein SR. Student perspectives on the diversity climate at a U.S. medical school: the need for a broader definition of diversity. BMC Res Notes. 2013;6:154.
30. Cooper LA, Beach MC, Johnson RL, Inui TS. Delving below the surface. Understanding how race and ethnicity influence relationships in Health Care. J Gen Intern Med. 2006;21 Suppl 1:S21–7. Review.
31. Powe NR, Cooper LA. Disparities in patient experiences, health care processes, and outcomes: The role of patient-provider racial, ethnic, and language concordance [Internet]. 2004. Available from: http://www.commonwealthfund.org/publications/fund-reports/2004/jul/disparities-in-patient-experiences--health-care-processes--and-outcomes--the-role-of-patient-provide
32. Lin X, Guan J. Patient satisfaction and referral intention: effect of patient-physician match on ethnic origin and cultural similarity. Health Mark Q. 2002;20:49–68.
33. Street Jr RL, O'Malley KJ, Cooper LA, Haidet P. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. Ann Fam Med. 2008;6(3):198–205.
34. Persky S, Kaphingst KA, Allen Jr VC, Senay I. Effects of patient-provider race concordance and smoking status on lung cancer risk perception accuracy among African-Americans. Ann Behav Med. 2013;45(3):308–17.
35. Johnson Thornton RL, Powe NR, Roter D, Cooper LA. Patient-physician social concordance, medical visit communication and patients' perceptions of health care quality. Patient Educ Couns. 2011;85(3):e201–8. doi:10.1016/j.pec.2011.07.015.
36. Cooper LA, Roter DL, Johnson RL, Ford DE, Steinwachs DM, Powe NR. Patient-centered communication, ratings of care, and concordance of patient and physician race. Ann Intern Med. 2003;11:907–15.
37. Arguete MS, Roberts CA. Participants' ratings of male physicians who vary in race and communication style. Psychol Rep. 2002;91:793–806.
38. Suarez-Almazor ME. Patient-physician communication. Curr Opin Rheumatol. 2004; 16:91–5.
39. Kim SS, Kaplowitz S, Johnston MV. The effects of physician empathy on patient satisfaction and compliance. Eval Health Prof. 2004;27:237–51.

40. American Medical Association. Patient-centered communication [cited 2015 February 2]. Chicago, IL: American Medical Association; c 1995-2015. Available from: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication.
41. Johnson RL, Saha S, Arbelaez JJ, Beach MC, Cooper LA. Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. J Gen Intern Med. 2004; 19(2):101–10.
42. Haider AH, Sexton J, Sriram N, Cooper LA, Efron DT, Swoboda S, et al. Association of unconscious race and social class bias with vignette-based clinical assessments by medical students. JAMA. 2011;306:942–51.
43. Cone DC, Richardson LD, Todd KH, Betancourt JR, Lowe RA. Health care disparities in emergency medicine. Acad Emerg Med. 2003;10:1176.
44. Cohen JJ. Disparities in health care: an overview. Acad Emerg Med. 2003;10:1155.
45. Todd KH, Samaroo N, Hoffman JR. The effect of ethnicity on physician estimates of pain severity in patients with isolated extremity trauma. JAMA. 1994;271:925.
46. Todd KH, Deaton C, D'Adamo AP, Goe L. Ethnicity and analgesic practice. Ann Emerg Med. 2000;35:11.
47. Bazarian JJ, Pope C, McClung J, Cheng YT, Flesher W. Ethnic and racial disparities in emergency department care for mild traumatic brain injury. Acad Emerg Med. 2003;10:1209.
48. Wall SP, Ha ES, Habicht ME, Wawda H, Merchant GL, Ettner SL, et al. Impact of patient race on receiving heat CT during blunt head injury evaluation. Acad Emerg Med. 2005;12:862.
49. Harris B, Hwang U, Richardson LD, Lee W. Disparities in computed tomography utilization for adult patients presenting to the emergency department with headache. Ann Emerg Med. 2007;50:S120.
50. Richardson LD, Irvin CB, Tamayo-Sarver JH. Racial and ethnic disparities in the practice of emergency medicine. Acad Emerg Med. 2003;10:1184.
51. James TL, Feldman J, Mehta SD. Physician variability in history taking when evaluating patients presenting with chest pain in the emergency department. Acad Emerg Med. 2006;13:147.
52. van Ryn M, Burke J. The effects of race and socioeconomic status on physicians' perceptions of patients. Soc Sci Med. 2000;50:813.
53. Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. J Gen Intern Med. 2013;28(11):1504–10.
54. Green AR, Carney DR, Pallin DJ, Ngo LH, Raymond KL, Iezzoni LI, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. J Gen Intern Med. 2007;22(9):1231–8.
55. Sewell JL, Velayos FS. Systematic review: the role of race and socioeconomic factors on IBD healthcare delivery and effectiveness. Inflamm Bowel Dis. 2013;19:627–43.
56. Mississippi Public Broadcasting Radio. Racial bias in health care: an interview with Dr. Claudia Fegan [Internet]. 2013. Chicago, IL: Physicians for National Health Program; c 2015. [cited 2015 February 6]. Available from: http://www.pnhp.org/news/2013/may/racial-bias-in-health-care-an-interview-with-dr-claudia-fegan .
57. Corbin TJ, Rich JA, Bloom SL, Delgado D, Rich LJ, Wilson AS. Developing a trauma-informed, emergency department-based intervention for victims of urban violence. J Trauma Dissociation. 2011;12:510–25.
58. Cunningham R, Knox L, Fein J, Harrison S, Frisch K, Walton M, et al. Before and after the trauma bay: the prevention of violent injury among youth. Ann Emerg Med. 2009;53:490–500.
59. Becker MG, Hall JS, Ursic CM, Jain S, Calhoun D. Caught in the crossfire: the effects of a peer-based intervention program for violently injured youth. J Adolesc Health. 2004;34: 177–83.
60. Cheng TL, Haynie D, Brenner R, Wright JL, Chung S, Simons-Morton B. Effectiveness of a mentor-implemented, violence prevention intervention for assault-injured youths presenting to the emergency department: Results of a randomized trial. Pediatrics. 2008;122:938–46.
61. Fein JA, Kassam-Adams N, Gavin M, Huang R, Blanchard D, Datner EM. Persistence of post-traumatic stress in violently injured youth seen in the emergency department. Arch Pediatr Adolesc Med. 2002;156:836–40.

62. Ketterlinus RD, editor. Youth violence: Interventions for health care providers. Washington, DC: The American Public Health Association; 2008.
63. Purtle J, Dicker R, Cooper C, Corbin T, Greene MB, Marks A, et al. Hospital-based violence intervention programs save lives and money. J Trauma Acute Care Surg. 2013;75:331–3.
64. Shibru D, Zahnd E, Becker M, Bekaert N, Calhoun D, Victorino GP. Benefits of a hospital-based peer intervention program for violently injured youth. J Am Coll Surg. 2007;205:684–9.
65. James TL, Bibi S, Langlois BK, Elizabeth Dugan E, Mitchell PM. Boston violence intervention advocacy program: a qualitative study of client experiences and perceived effect. Acad Emerg Med. 2014;21(7):742–51. doi:10.1111/acem.12409.
66. Thornton TN, Craft CA, Dahlberg LL, Lynch BS, Baer K (eds). Best practices of youth violence prevention: A sourcebook for community action. [Internet]. Atlanta, GA: CDC; 2002 [cited 2013 Aug 1]. Available from: http://www.cdc.gov/violenceprevention/pub/yv_bestpractices.html.
67. United States Department of Justice. Report of the Attorney General's national task force on children exposed to violence [Internet]. 2012 [cited 2013 Aug 1]. Available from: http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf.
68. Karraker N, Cunningham RM, Becker MG, Fein JA, Knox LM. Violence is preventable: A best practices guide for launching and sustaining a hospital-based program to break the cycle of violence. Replication Guide was produced by Youth ALIVE! under grant # 2009-SZ-B9-K004, awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. 2011 [cited 2013 Sept 23]. Available from: http://youthalive1.squarespace.com/storage/ViolenceisPreventableOnline.pdf.
69. Cheng TL, Schwarz D, Brenner RA, Wright JL, Fields CB, O'Donnell R, et al. Adolescent assault injury: risk and protective factors and locations of contact for intervention. Pediatrics. 2003;112:931–8.
70. Cooper C, Eslinger D, Nash D, al-Zawahri J, Stolley P. Repeat victims of violence: report of a large concurrent case-control study. Arch Surg. 2000;135:837–43.
71. National Center for Trauma Informed Care. Models for developing trauma-informed behavioral health systems and trauma-specific service [Internet]. 2008 [cited 2013 Dec 4]. Available from: www.uwgb.edu/bhtp/tools/developing_trauma.
72. National Center for Trauma Informed Care. Report of project activities over the past 18 months, history, and selected products [Internet]. 2012 Mar 26 [cited 2013 Dec 4] Available from: http://www.nasmhpd.org/docs/NCTIC/NCTIC_Final_Report_3-26-12.pdf.
73. Kilpatrick DG, Acierno R, Saunders B, Resnick HS, Best C, Schnurr PP. Risk factors for adolescent substance abuse and dependence: data from a national sample. J Consult Clin Psychol. 2000;68:19–30.
74. National Network of Hospital-Based Violence Intervention Programs. Available from: www.nnhvip.org
75. Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49:796–804.
76. Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. J Natl Med Assoc. 2008;100:1275–85.
77. Hearld LR, Alexander JA. Patient-centered care and emergency department utilization: a path analysis of the mediating effects of care coordination and delays in care. Med Care Res Rev. 2012;69(5):560–80.
78. Beach MC, Saha S, Cooper LA. The role and relationship of cultural competence and patient-centeredness in health care quality [Internet]. 2006 [cited 2015 Feb 5]. Washington, DC: The Commonwealth Fund; c 2015. Available from: www.commonwealthfund.org/usr_doc/Beach_rolerelationshipcultcomppatient-cent_960.pdf
79. Bertakis KD, Azari R. Patient-centered care is associated with decreased health care utilization. J Am Board Fam Med. 2011;24(3):229–3.
80. Rickert J. Patient centered-care: What it means and how to get there. 2012. Health Affairs blog [Internet]. Millwood, VA: Project HOPE; c 1995-2015. [cited 2015 January 12]. Available

from: http://healthaffairs.org/blog/2012/01/24/patient-centered-care-what-it-means-and-how-to-get-there/.
81. Kane GC, Gotto JL, Mangione S, West S, Hojat M. Jefferson scale of patient's perceptions of physician empathy: preliminary psychometric data. Croat Med J. 2007;48:81–6.
82. National Standards for Culturally and Linguistically Appropriate Services in Health Care. Final report. Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health; 2001. [cited 2015 February 2015]. Available from: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
83. Massachusetts Division of Medical Assistance: Appendix G: Cultural Competence QIP Reporting. Boston: Division of Medical Assistance; 1997.

Chapter 8
Spiritual Care Services in Emergency Medicine

Mildred M. Best, Swami Sarvaananda, Jamela M. Martin, Pamela Gayle White, and Marcus L. Martin

Introduction

Spiritual Differences Defined

Spirituality is broadly defined as that which gives a person's life ultimate meaning. For many, it might be a belief in God as expressed in a community of faith with others of like mind (i.e., church, synagogue, etc.). For some, it might be the belief in many gods as an expression of the divine. Still for others, it might be a personal relationship with God, or a connection with the universe and nature, or an understanding of a connection with a higher power or supernatural being. Spirituality can also be defined as that which an individual holds sacred. These beliefs and understandings are informed and influenced by race, ethnicity, religious status, culture, nationality, gender, and worldview. Spirituality is often what gives an individual hope to strive for wellness and wholeness during adversity and illness. Spiritual

---

M.M. Best, M.Div., M.S.S., B.C.C. (✉)
Department of Chaplaincy Services and Pastoral Education, University of Virginia Hospital, Charlottesville, VA, USA
e-mail: mb3aq@Virginia.EDU

S. Sarvaananda, Ph.D., B.C.C.
Department of Chaplaincy, University of Virginia, Charlottesville, VA, USA

J.M. Martin, M.S., B.S.N., Ph.D.
College of Health Sciences, Old Dominion University, Norfolk, VA, USA

P.G. White
Chaplaincy Department, University of Virginia Medical Center, Charlottesville, VA, USA

M.L. Martin, M.D.
Department of Emergency Medicine, School of Medicine, University of Virginia, Charlottesville, VA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_8

differences encompass the awareness that no two persons, regardless of similarities in faith or ethnicity, are the same as innately spiritual beings. Their life stories are unique, so their spiritual background and their understanding of life's situations will be different.

Spiritual differences are also informed by faith tradition and/or a system of beliefs, be it Christianity, Judaism, Islam, Hinduism, Buddhism, Paganism, Rastafarianism, or even Atheism. To understand spiritual differences in Emergency Medicine, one must first understand that world religions flourish in communities served by emergency departments throughout the USA [1].

Health-Related Beliefs and Cultural Values and Traditions

Health-related beliefs and assumptions are prevalent in many faith traditions. These beliefs become the lenses through which the patients' worldviews and understanding of their illness are seen. Some of these beliefs and practices are clearly articulated by the spiritual community and are well-known in the medical community. For example, many health care providers are aware that the Jehovah's Witnesses' faith prohibits the use of blood or blood products [2]. Some patients may view modern medical technology as a gift from God for healing. For others, beliefs may be unique to an individual's own understanding of his or her spiritual practices. Some beliefs and understandings may be articulated freely, but at other times may be unknown and not easily explained by the patient. These beliefs will affect whether a patient or family makes a decision about a Do-Not-Intubate order (DNI) or a Do-Not-Resuscitate order (DNR), or accepts or refuses a particular medical treatment or procedure. A basic spiritual awareness will help emergency physicians and health care teams understand the connections between spirituality and informed health care decision-making. This is an important element in providing cultural competency for the ED.

Health Care Provider Knowledge

Health care providers should have a basic understanding of the health-related belief systems of patients from varying faith traditions and an awareness of how these belief systems may inform the patient's health care decision-making process. There should also be an understanding of the ways in which religious beliefs and spiritual differences may enhance or detract from the doctor–patient relationship. For example, a patient who believes that all healing comes from God might decide that he wants to wait for a direct healing from God and might delay or outright reject medical intervention as illustrated by the following example:

An African American family … was resistant when the physician attempted to explain why a do not resuscitate (DNR) order was needed. A family member said that they would wait on God and that God would have the last word. At the time, the family felt that to agree on a DNR would be the same as giving their loved one a death sentence. The struggle for this family was whether to trust *man,* meaning the medical establishment as represented by the physician, or to trust in God [3].

Awareness of Practitioners in the Emergency Department

In emergency departments, it is especially important to recognize that, in the face of trauma and the unexpected onset of illness and disease, patients can be at significant spiritual risk. These individuals are considered at risk for poor health outcomes as a result of under-developed, conflicted, overwhelmed, or negative spirituality resulting in high spiritual needs and low spiritual resources to meet these needs [4].

It then becomes extremely important that practitioners in the ED recognize their limitations and determine when it is appropriate to refer to a chaplain or other spiritual care provider. This is not to say that the physician and health care providers need not be sensitive to various religious belief systems and their impact on illness. Instead, it is recognition that there are those who have dedicated their life and education to become credentialed in the area of pastoral/spiritual care/chaplaincy, just as the physician is educated and credentialed in providing medical care. An awareness of religious tradition and a basic understanding that some patients might be in a spiritual crisis are reasons for immediate referral to a chaplain or spiritual care provider/clergy.

Chaplain/Spiritual Care Provider Knowledge and Education

As pastoral and spiritual care providers, chaplains are educated to meet the spiritual, religious, and pastoral care needs of patients. Qualification and membership in the Association of Professional Chaplaincy require clinical supervision and training at least equal to qualifications to become a licensed clinical social worker. To be eligible for board certification, a chaplain is required at a minimum to have a 4 year undergraduate degree and 3 years of graduate theological education, leading to a Master of Divinity degree, along with 4 units of clinical pastoral education (CPE) which includes 1600 h of clinical supervision, and 2000 h of professional chaplaincy experience. Ecclesiastical endorsement by her/his religious body is also a requirement for board eligibility. The chaplaincy profession seeks to integrate mental health skills with religious training, inclusive of theological reflection, to prepare a chaplain to intervene effectively in a troubled person's life and during times of crisis and illness [5].

The 1600 h of clinical supervision are provided through Chaplaincy and Pastoral/Spiritual Care Departments in hospitals and other health care centers. These centers are accredited by the Association of Clinical Pastoral Education (ACPE) to provide clinical supervision for chaplain residents to earn the clinical hours needed for Board Certification eligibility. Chaplaincy residents are supervised and trained by Clinical Pastoral Supervisors/Educators who are certified by ACPE. The ACPE competencies include self-awareness, interpersonal awareness, conceptual ability, pastoral functioning, ministry management, and development. Each category includes competencies and outcomes. For example, interpersonal awareness requires that chaplain residents demonstrate competence in providing pastoral care to patients from various religious, racial, ethnic, and socioeconomic groups.

Spiritual Care Available

Pastoral/spiritual care has been traditionally rooted in enabling, encouraging, and facilitating the patient to access and make use of her/his own spirituality as a resource for sustaining her/him through crisis and illness. The chaplain's role has been to employ intervention tools like healing, sustaining, guiding, reconciling, and liberating, all in an empathetic spiritual relationship that is called the pastoral conversation [6]. Aspects of the pastoral conversation include responding empathetically, following the patient's lead, and discerning the patient's central theme with lost conversational fragments [7]. The pastoral conversation is but one aspect of pastoral/spiritual care used to address the spiritual care needs of patients. Harold G. Koenig of Duke University Medical Center describes the spiritual needs of patients as follows:

- *A need to make sense of the illness.* Patients need to understand why they have been singled out for illness, what it means for them, their future, and their families' future. They need to know how they are going to cope with, and bear the burden of, a changed life that may involve long-term physical discomfort.
- *A need for purpose and meaning in the midst of illness.* Patients need renewed purpose and meaning in order to continue to fight illness. They need to know that they can still contribute, despite their illness. Religious and spiritual beliefs often lie at the core of what gives life purpose and meaning in these circumstances.
- *A need for spiritual beliefs to be acknowledged, respected, and supported.* Religious or spiritual beliefs become increasingly important to patients who are sick and hospitalized. Patients need their health professionals to acknowledge, respect, and support those beliefs.
- *A need to transcend the illness and the self.* Patients need to get their minds off of their current status to counteract the obsessive preoccupation with self that almost always accompanies serious illness. Focusing on spiritual matters often helps patients put their own concerns into perspective.
- *A need to feel connected to others.* Hospitalization and illness makes patients feel isolated from others. Spiritual beliefs, visits from their pastor or a member of their congregation or a hospital chaplain, or knowing that members of the faith community are praying for them, all help to reestablish connection with others.

Feeling connected to, cared for, and loved by God also helps to relieve loneliness.

- *A need to acknowledge and cope with the notion of dying and death.* Having illness serious enough to warrant hospitalization sends a terrifying message to many patients—that they cannot live forever. Many fear death less than they fear the process of dying, and the discomfort, isolation and loss of control associated with it. Spiritual beliefs provide a world-view that makes sense of life, death, and suffering—and gives answers that medicine and science cannot provide. On the other hand, patients may not feel spiritually ready to die. They may fear punishment after they die, or worry about their relationship with God.
- *A need to forgive and be forgiven.* Because illness can sometimes be perceived as punishment and because it forces us to confront our ultimate mortality, the need to give and receive forgiveness is greatly enhanced. Religious and spiritual rituals exist that help patients to forgive others and accept forgiveness themselves, releasing them from the emotional turmoil that guilt and bitterness produce.
- *A need to be thankful in the midst of illness.* Being thankful and grateful for the health and relationships they still have helps patients to adapt more quickly to illness and maintain a positive outlook. Religious beliefs and stories both encourage an attitude-of-gratitude, and provide role models to help accomplish them.
- *A need for hope.* Hope is the engine of motivation. Without hope, patients give up, neglect themselves, and strike out at others trying to help them. Spiritual beliefs are a powerful source of hope for many patients [8].

Discussion

In 2007, the majority of Americans (71 %) in the USA believed in God. Of this number, 78.5 % practiced some form of Christianity (51.3 % Protestant, 23.9 % Roman Catholic, <2 % Mormon, Orthodox, Jehovah's Witness, and other Christians). The population of people in the USA who practice religions other than Christianity include 1.7 % Jewish, 0.6 % Islam, Hindus 0.4 %, and Buddhists 0.7 % [9–12]. Medical points about these population and other faith traditions in the USA are shown in Table 8.1, which may be used for a quick patient reference, a comparison between religions, or even as a concise synthesis of some of the major points.

Health and Spirituality

Buddhism

In the West, most Buddhist patients will either belong to traditionally Buddhist families from Asian countries such as Vietnam, Mongolia, and Japan, or will themselves have converted to Buddhism. While many different schools of Buddhist

Table 8.1 Summary of major religious/medical points

Religion	Facilitating practices and lifestyle	Food and diet	Illness	Healing	End of life
Buddhism	Practices focus on developing wisdom, meditation and morality with Liberation as the goal	May be vegetarian	May result from karma, unwholesome lifestyle, strong emotions, an imbalance of the "humors," or other factors	Variable depending on Buddhist school; prayers may be carried out by pt, clergy or community	State of mind at death is of utmost importance as it helps determine where the pt's mind/spirit will transition
Baptist	Strong prohibition against homosexuality and alcohol in some denominations	No outlined restrictions other than alcohol intake	Variable with individual	May request prayer support from congregation	Belief in life after death makes prayer for the terminally ill important
Pentecostal	Prayer and scripture readings daily	No outlined restrictions	Variable with individual	Strong emphasis on faith healing	Belief in life after death and emphasis on faith healing makes prayer for the terminally ill important
Roman Catholic	Restriction on all birth control other than the Rhythm method	May avoid meat other than fish on Fridays and during the season of Lent	May result from predestined fate or be the result of punishment for wrongdoings	No restrictions on most modern medical practice as long as it does not violate Natural Law	Believe in life after death therefore, Sacrament of the Sick is important
Islam	Increased importance of modesty and potential gender segregation	No pork or alcohol with other variable restrictions including shellfish	May serve religious roles and therefore treatment may be refused	Medications containing forbidden dietary products are strictly forbidden	Multiple rituals and needs must be met, including confession of sins, proper body placement, and a reciting of the Islamic Creed

Judaism	Increased emphasis on sexual relations beyond the duty to procreate	Determined by Kosher law	Variety of theodicies	Unless absolutely necessary, surgical procedures to be avoided on Sabbath	Increased value on prolonging life, which raises a multitude of ethical issues
Hinduism	Goal: Clear, peaceful mind, clean and healthy body Practices: use of prayer, meditation, contemplation; one God, many forms Special ceremonies and music (bajans) Will want holy objects, music, and family in room Families will prefer patient to be at home, not left in institutions	Many vegetarian, observe fast days for healthy life Right hand for eating, left hand is for cleansing May wish to bring food from home to facility	Result of past and present karma of patient; all illness have biological, psychological and spiritual element Cleanliness especially important Use complementary medicine (ayurvedic, yoga, other) in addition to western medicine Will not use medicines that have animal products	Believe that healing takes place on physical, mental, and spiritual levels Many prayers and ceremonies can be done in room by family, priest, guru, or swami Decision making made by eldest male	Goal: a conscious and clear minded exit Death a part of circle of life Person will be reborn to purge all karma, eventually leading to union with the Divine May give organs Suicide and euthanasia forbidden Treatment to prolong life likely to be refused
Rastafari	Disapprove contraception Tend to smoke ganja to feel at peace with the world and to help spiritual perception	Ital is a specific diet whose name stems from the word vital Natural foods, fruits vegetables, can include fish Refuse processed meats	Healing is an art Illness is an unnatural interference with the course of nature For every sickness there is an herb that can heal it	Prefer herbal and related natural ingredients over pills Danger of vaccines outweigh benefits Breast feeding provides protection against a range of diseases	Believe in physical immortality Reincarnation follows death and life is eternal or “ever-living life”

philosophy and practice have evolved over the centuries, certain core beliefs common to all branches may influence the therapeutic dynamic.

For Buddhists, “salvation” translates as “enlightenment” or “liberation.” The Buddha achieved Enlightenment in India around the sixth century BCE and spent decades teaching others how to proceed towards the same goal. The practice and development of morality, wisdom, and meditation as presented in the Buddha’s Eightfold Noble Path are the means to this end.

The notion of an interventional Creator is foreign to Buddhism. Buddhists do not view suffering as divine punishment, but rather as something to be expected: “From birth as a requisite condition, then aging & death, sorrow, lamentation, pain, distress, & despair come into play. Such is the origination of this entire mass of stress & suffering” [13]. Health, sickness, healing, and death result from interwoven causes and conditions. Illness may result from the karmic ripening of past actions, a lifestyle that is not in harmony with wholesome principles, a predominance of negative emotions, an imbalance of the “humors,” or any of a number of other sources.

Medicine is a traditional field of Buddhist knowledge. “Buddhist medicine” is holistic and has developed to include elements of the healing arts of many lands; it may include diet, yoga, acupuncture, herbals, etc., in addition to the traditional Ayurvedic medicine of India. Some Buddhists are vegetarian, some are not. Certain patients may practice “Medicine Buddha,” a healing practice that combines meditation and recitations. In general, modern Western treatment options are also welcome. Indeed, it has been stated that, “The principles governing Buddhism and the practice of medicine have much in common,” as both seek to alleviate suffering and its causes [14].

Most Buddhist patients will be as comfortable as anyone else in a medical setting with male and female caregivers. However, Buddhist monks and nuns will generally prefer receiving intimate care from a caregiver of the same gender as they. All Buddhist cultures treat monastics with deference; Asian monastics in particular may be unprepared for the loss of intimacy and, in a certain sense, respect that go along with illness.

Buddhist patients may enjoy the presence of religious icons—representations, statues, etc.—and/or recordings of music or rituals. These serve as reminders that help one remain present and connect with merit and liberation. In addition to visual representations, which should be treated with respect, light (an electric tea light, for example) has strong symbolic import.

It is important to understand that some Buddhists may choose to remain aware up to the time of death, preferring a clear mind to pain relief that clouds the consciousness. Buddhists believe that the moment of death is crucial to determining what happens next. Whether the next phase will be complete liberation from rebirth, an eventual rebirth in the pure realms, or reincarnation (as a human or in another sphere of existence) depends on a combination of factors, such as the dying person’s aspirations, habits, beliefs, merit, and state of mind at the moment of transition. Rituals and wishing prayers directing the patient’s mind-stream toward a positive rebirth may also be carried out by Buddhist clergy or members of their community.

The state of mind at the time of death will also impact a patient's decisions about organ donation and funeral arrangements. Some Buddhists believe that the body should ideally remain undisturbed for a period up to 3 days in order to ensure the safe passage of the mind or spirit. The dying process is described as a progressive dissolution of the grosser elements or constituents of the body into ever subtler ones, until finally there is separation of body and spirit. This may take place at the time of clinical death, or it may happen a bit later, within 3 days.

Christianity

Baptists

Baptists views affecting sexualities other than heterosexual are most often recognized and newsworthy. The most conservative and noteworthy of these denominations are the Southern Baptists. Prohibition of alcohol and tobacco are important to many Baptists. Although there is some division within the church about abstinence from tobacco, at least from a religious perspective, it still deserves to be addressed. Alcohol has been attacked by Baptists on three fronts—religious, medical, and social. To many Baptists, alcohol is a negative influence on bodily and psychological health, society, and family life [1]. According to Proverbs 20:1, "Wine is a mocker, strong drink is raging: and whosoever is deceived thereby is not wise." Thus, the Baptist views alcohol as a path to spiritual death [15].

Furthermore, the ultimate solution to a drinking problem has always been spiritual. Only the grace of Jesus Christ can save people from drink. It must be noted that many Southern Baptists do not take this outlook, but for those who do, the consequences could be emotionally and mentally troubling if alcoholic drinks are consumed. A Baptist alcoholic, who belongs to a church holding this belief, would be expected to recover through prayer and the spiritual guidance support of other Baptists. Likewise, because a spiritual recovery seems best to a Baptist, he may or may not have to face feelings of guilt in front of his congregation for an ailment which he may not be able to cure through his faith. In this light, such a strong and steadfast abstinence from something unhealthy may have detrimental consequences for those who suffer from the illness of alcoholism.

It has been no secret that this Christian group has taken a firm stance against same-sex attraction. The Southern Baptist Convention's Position Statement on Sexuality and the Baptist Faith and Message show what Southern Baptists generally believe: that the Biblical passages condemning homosexuality are still valid today (Gen 19 [cf. Jude 7; 2 Pet 2:6–10]; Lev 18:22; 20:13; Rom 1:24–27; 1 Cor 6:9–11; 1 Tim 1:8–11). It must also be noted, however, that although same-sex attraction is regarded as a sin, it is not unpardonable, and therefore Southern Baptists recognize that "the same redemption available to all sinners is available to homosexuals" [16, 17]. The medical concern is not their stance on same-sex attraction, but rather how that stance may affect an adolescent boy or girl as they mature and discover their sexuality, especially if it is towards their same gender. Mental, emotional, and spiritual damage could be lasting and severe with expected repression of their desires and who they are. It is once again this indirect effect of a religious belief that physicians must be aware of with their Baptist patients. Still, not all Baptist patients may have the same beliefs on homosexuality. The Alliance of Baptists, for example, supports same-sex marriages and ordains clergy who are openly gay [18, 19].

Pentecostal

The following quote, taken from the United Pentecostal Church International, gives a concise summary of the healing beliefs of this Christian denomination. "God is the Great Physician. His knowledge of the human mind and body is complete. He can do more for the sick and the diseased than can all earthly doctors and surgeons combined. He created us; is it not reasonable, then, to believe that He can heal us when we are sick?" [20]. Deep belief in faith or divine healing is the central focus of a number of Pentecostal traditions concerning health and illness. Pentecostal interpretation of the Bible is literal, and the complete truth of the gospel is held as a vital element. Although Pentecostals still believe that modern medicine has benefits (although only because it was God who created doctors and medicine), it is through prayer, faith, and the church that one is truly healed.

The modernization of many Pentecostal traditions has brought about a greater willingness to accept modern medicine and its treatments [21]. The Assemblies of God, the largest Pentecostal denomination in the USA, states: "Through the skill and training of physicians recoveries and restorations do occur, a truth that neither refutes nor diminishes the belief in divine healing [22]. We rejoice should God, who is the source of all healing, work through the doctors, give thanks to them for their dedication, and offer continual praise to God. With all their learning, training, and skill, doctors are still not the last word to be uttered in diagnosing human maladies. We continually look to God who is more than able to bring healing even in situations deemed to be hopeless" [23]. However, as a physician, it is very important to be aware of the patient's level of commitment to his or her religion. This may give clues as to delayed medical treatment or even resistance to treatment. By showing an understanding of the patient's beliefs and encouraging the use of faith healing *with* modern care, the physician can maximize the patient encounters and eliminate total dependency on the church.

Roman Catholic

Although Roman Catholics are generally very accepting of most aspects of modern medical practice, areas where they differ have been subject to much debate and have been put at the forefront of one of the most controversial medical topics in the USA. Their outlooks on conception, pregnancy, and beginning-of-life issues have linked Catholicism to legal and political topics—a popular realm for religion in today's society.

Catholics have historically been well-known for prohibiting nearly all forms of contraception. Instead, they suggest natural family planning or the rhythm method which consists of only engaging in sexual intercourse when the woman is not fertile (just before, during, and just after ovulation). The basis for this belief lies in the Catholic concept of natural law. In its most basic form, natural law reasoning assumes that every human act has a natural goal attributed to it by God. Any attempt to frustrate that goal is unnatural and therefore wrong. In this instance, sexual intercourse is designed to produce offspring. Any method of contraception other than taking advantage of a woman's "natural rhythms" interrupts the natural goal and is thus considered unacceptable [24].

Likewise, Catholics may refute some birth control methods with additional moral arguments. As will be discussed, many Catholics view life as beginning with fertilization [25]. Therefore, any device that allows fertilization, but not implantations (RU- 486, copper IUDs, etc.) is viewed as essentially causing the murder of a developing life, which would clearly be morally wrong in their belief system.

Because the Catholic religion gives the fertilized egg the dignity of human life, ending a pregnancy at any stage is considered murder. Initially the prohibition against abortion stood for any circumstance, even if it meant death for the mother and the baby. Today, however, the belief has evolved for most Catholics. Medical intervention in pregnancy, while doing the utmost to save two lives, will focus on saving one life instead of allowing both mother and fetus to perish [25]. In basically all other circumstances where the mother's life is not in danger, abortions are still considered murder. However, the medical profession should watch for further directional alterations of this concept in Catholicism. For example, Father Richard McCormick cites a study by Susan Teft Nicholson who suggested that abortion may be reconceptualized from a killing intervention to the withdrawal of maternal assistance. This raises a new question whether a woman would be expected to give maternal assistance when her pregnancy was caused by rape [25]. Physicians must be aware that although a religion may be thousands of years old, its beliefs are not.

The final point to examine about the Roman Catholic faith is their outlook on illness and suffering. With the monotheistic background and the emphasis in the afterlife of heaven and hell, the "Sacrament of the Sick" becomes very important [24]. The Catholic patient may wish to pray or confess his or her sins to a Catholic priest in the hospital before departing to the afterlife, and their ability to do so may be seen as promoting their entry into heaven. It is therefore imperative to many Catholic patients that the appropriate clergy be notified in advance of death.

Also linked to the monotheistic idea of an omnipotent, all-powerful God is the belief by some that illness and suffering may either be predestined fate or punishment for wrongdoings [24]. The latter is an example of free will theodicy. From a Bible that speaks of God striking down rebellious people with illnesses such as scurvy, blindness, and boils, it is an easy transition to think that one's illness may be a punishment from God. For some, this may bring feelings of guilt or misunderstanding. For others, it may bring a type of resigned penance to their illness, or a feeling that they must endure God's punishment. Some may see it as a test of faith or a type of educative theodicy, but others may have none of these thoughts.

Evaluation of the patient's religious commitment and involvement is the key to understanding in this situation. Without this understanding, the doctor may not comprehend or even be aware that such hardships exist for these patients.

Islam

Of great importance to people in the Islamic religion is the concept of modesty, which stems from a deeper belief in sex segregation. This belief is central to the medical care of Islamic patients in many ways. For instance, women may insist on wearing the traditional garments that completely cover their body when in the hospital rather than the customary and sometimes revealing hospital gowns [26]. They may also wish to have an all-female staff to provide their care. Furthermore, a Muslim woman would likely not want be left alone with a man who is not her husband [27]. Men may wish to remain clothed from the waist down even in front of other men [28]. Some customs may even prevent handshakes or contact between genders.

The Muslim diet is another very important aspect of the Islamic lifestyle that affects health care. Food has a central role in the lives of Muslim families, and dietary restrictions may vary between countries depending on how the members follow tradition. The diet of the Muslim patient should not contain pork, pork products, or alcohol. Most Muslims will not eat shellfish, and some believe meat must be halal, from animals slaughtered in the prescribed manner. Some patients desire a Kosher or vegetarian diet. During Ramadan, the ninth month of the Muslim year, faithful Muslims fast from dawn to sunset for 28 days. This fast includes abstinence from food, drink, smoking, and sexual intercourse. It is believed that fasting teaches obedience to God and is required only by adults who are physically capable and mentally competent. Elderly people, ill people, travelers, pregnant women, lactating mothers, menstruating women, women with postpartum discharge, and women who have experienced a miscarriage are exempt from fasting. Children are exempt, but at the age of 12 or 13, adolescents are urged to attempt to fast in preparation for adulthood [27].

Some Muslims, especially the older and more conservative ones, may refuse to eat hospital food altogether and insist on having their food brought to them by friends or relatives of the Islamic faith [28]. A related aspect of dietary restrictions arises when faced with the controversy between restrictions of the diet and medical necessity. Can a Muslim consume, as medicine, what has been prohibited by religious law? "On the eating of the pig, wherever the Qur'an mentions a prohibition, it always makes an exception for 'cases where it may be necessary, without willful transgression of the Law'" [29]. However, in the case of alcohol, the Qur'an severely denounces its use without giving an outright and explicit prohibition. Lastly, some Muslims may not accept medicines prepared by non-Muslims for fear they may have used ingredients whose consumption is not allowed by Islamic law. Because of these restrictions and other variations within Islamic groups, it is imperative that the Muslim patient be questioned about dietary preferences while in the hospital.

The attitudes of Muslim patients may pose serious problems in the treatment plan. Many Muslims may refuse treatment of any kind, especially if brought into the hospital against their will. The reason for this lies in the etiology of illness according to Islamic teachings. As health is the greatest blessing of God, illness serves three important functions: (1) it is regarded as a purgative role; (2) it may be a punishment for sins; and (3) it may entail positive reward. In all three situations, illness is regarded as a blessing. Furthermore, some traditions emphasize not seeking medical treatment for an illness until it becomes unbearable [30]. Obviously, this could pose great challenges to the physician attempting to treat certain members of the Muslim faith. However, as a useful tool for the health care provider, the Qur'an states that saving and preserving life are among the most highly regarded tasks within the religion [31].

Death itself is a taboo subject for many Muslims. Although members must face death as part of Allah's will and acknowledge submission to Allah's plan for their life, it is also believed that one should never give up hope, because to do so would be to deny the will of Allah [1]. When caring for the dying Muslim patient, the physician must be aware that the patient may be quite passive for one of three reasons: (1) a resigned acceptance of their fate; (2) a disguising of fear, since fear would indicate a lack of trust in Allah's judgment and mercy; or (3) guilt over inadequate submission prior to illness [28]. These reflect both the free will and eschatological theodicies associated with the Islamic religion. Also, because life is viewed as preparation for eternal life after death, a dying Muslim may have specific needs to prepare for passage. First, a Muslim may desire to sit or lie facing Mecca. Secondly, a Muslim may wish to confess sins and beg forgiveness in the presence of family before death. Lastly, a believer may want the Islamic Creed recited as the moment of death approaches. Because of these needs, the physician might need to make patient visitation more flexible and take great care in attempting to estimate the final remaining days or hours of life.

Judaism

Judaism in its most traditional form, Orthodox Judaism, prescribes a life conducted according to the laws contained within the Torah (the Five books of Moses). Members of the religion use these laws as justification for every aspect of life, from diet to sexuality and death. As one moves from Orthodox to Conservative to the Reform Jewish communities, some of the laws are adjusted to a more modern era. There are, however, very important threads that bind them all and in some way affect the medical care they may receive.

The first of these common threads lies in dietary laws, or the provision of kosher foods. Kosher laws refer not only to the preparation of foods, but also to which items may be consumed. For example, meat must undergo special slaughtering, milk and meat must be separated, and some items, like pork, are forbidden from the Jewish diet [28]. These laws can be complicated depending on the personal adherence of the patient in question, which makes questioning dietary preferences all the more important. A Jewish minister or Rabbi can often assist in food issues for Jewish patients. Health care staff should also be prepared for the request to bring food from home into the hospital. The origination of these laws was considered by many Jews and non-Jews to be for health maintenance reasons. In fact, "some modern Jews use this explanation in order to justify their abandonment of those rules, reasoning that the work of the United States Food and Drug Administration makes the health measures involved in Jewish dietary laws unnecessary" [32]. In fact, "the Bible specifically indicated several times that the rationale for restricting the number of animals that could be eaten was to make the people of Israel holy (Lv. 11:43–45; Dt. 14:1–3, 21)" [32].

Interestingly, Jewish views on sexuality are more direct and explicit than many other religious traditions. This may prove useful for the family practitioner or counselor of Jewish couples. Two separate commandments, one to multiply and the other not to withhold conjugal rights from one's wife, exist in the scripture [32]. This means that a man has a sexual duty to fulfill his wife's sexual needs even after they have had children. In fact, the book of Exodus speaks of how often a man should have "sexual relations with his wife in order to fulfill the commandment," which depended upon the husband's occupation [32]. A physician will be more capable of assisting a patient with sexual issues if he understands the religious implications.

The Jewish views on end-of-life issues are unique and significant from an ethical standpoint. Stemming from the Jewish code stating "One should aim to maintain physical health and vigor in order that his soul may be upright, in order to know God…. Whoever follows this course will be continually serving God …," springs the basic tenet of Judaism: that nothing must stand in the way of preserving or prolonging life [33]. The role of the physician in the Jewish religion is held in the highest regard, because a physician is the healing agent of God. Thus, a doctor's duty is to prolong life and undertake no actions which may in any way hasten the time of death. In fact, the Jewish faith asserts that all life support and active treatment be maintained until death insofar that the life can be saved and meaningfully prolonged. Questions then arise: What defines death? If life support may maintain a person's life indefinitely, is it ethically just to do so? For a patient in extreme pain at the end of life, is it ethical to maintain their life at all costs? It has been written that no active or passive hastening of death is permitted, but removing a natural hindrance of death is permitted [33]. Obvious difficulties arise when trying to decide what would constitute removing a natural hindrance versus hastening death. It would benefit the physician to understand the patient's and patient's family's belief system as soon as possible before one of the above situations arises.

The great respect for the patient's body continues after death and is reflected in the Jewish views on handling the deceased body, as well as outlooks on autopsy. In most instances, death is presumed when breathing has stopped. When this has been established, the eyes and mouth are closed (preferably by a relative), arms and hands are extended at the side of the body, lower jaw is bound up, and the body is placed on the floor with the feet toward the door and is covered with a sheet. A lit candle is also placed close to the head. In addition, if death occurs on the Sabbath (Friday evening sunset to Saturday evening sunset), the body is not to be moved until after Saturday evening sunset plus 30 min [28]. Furthermore, if no fellow Jews are available, it is often asked that the hospital staff carry out these requests. Lastly, the Jewish association Chevra Kadisha should be notified immediately, because it functions as the Jewish burial society and will take charge of all arrangements after the time of death.

The issue of autopsy must also be discussed since Jewish law forbids autopsies unless ordered by law, when three separate doctors cannot ascertain the cause of death, or if it will help save the lives of others or prevent their suffering [32, 33]. The latter also serves as justification for dissection of the deceased in organ transplants. The reasoning for autopsy denial lies in the belief that dissection of the body after death shows great dishonor of the human body. Understanding the key issues of the Jewish tradition can benefit the physician, medical student, and health care team.

Hinduism

The laws of karma and reincarnation are the path to finding spiritual enlightenment, to go back to being one with the Divine. The patient's lifestyle and his family, his culture, are the means to one's health and well-being. Questions of belief should center on how one puts ones beliefs into daily life: how one deals with family, children, education, business, and how one prepares one's physical, mental, spiritual self for this life and beyond.

When seeking medical information, one must ask about complementary and traditional methods from the East as well as Western medicine. Many Hindus also use astrological charts when discussing their health and well-being. A Hindu is a combination of east and west in culture, family, beliefs, and lifestyle practices in all areas. The spiritual assessment should address all these areas when gathering the history. Please note that traditional culture would mean that the oldest male in the family will answer all questions, not necessarily the patient.

Rastafari

The Rastafari is a predominantly male-oriented religion whose members worship the Emperor Haile Selassie. The name derives from Ras Tafari, the Emperor's name before he was crowned in 1930 [34].

The Rastafari movement is a religion with deep political convictions which began in the slums of Jamaica in the 1920s and 1930s. There is no formal organized leadership in Rastafarianism, creating wide variety of spiritual and moral variation within the religion. Some Rastafarians see Rasta more as a way of life and others see it more as a religion. There are about 1 million adherents worldwide. Rastafari believe in the Judeo-Christian God whom they call Jah. In general Rastafari beliefs are based in Judaism and Christianity, with an emphasis on Old Testament Laws and Prophecies in the Book of Revelation [35].

The Rastafarian religion is unique in having few set beliefs to follow or doctrines to live by. Its African origins teach unity and love among all. There is no unified Rasta church but it does, however, hold certain philosophies sacred and a number of principles true. Rastas are united in believing that Haile Selassie was divine. They believe he was the living God returned [36].

Rastas disapprove strongly of contraception because to them birth control means sterilization. Ganja is used to feel at peace with the world and helps their spiritual perception. Ganja is also used as medicine, primarily as an expectorant and an aphrodisiac. Rastas stress, to them, ganja is not a drug of addiction. Rastas avoid clinic and orthodox medicine and prefer herbal and related natural ingredients over pills or medicine out of bottles [34].

Rastas tend to be in approval of X-rays, particularly in ruling out the possibilities of tuberculosis, broken bones, etc., but in general avoid use of the hospital. Children are delivered at home. Utilization of bush teas and herbs are typically used to treat ailments before consultation with clinics and physicians. In addition to herbs including ganja and teas, prayer and divine inspiration from healers and drum therapy are common practices [37].

Rastas believe the dangers of vaccines outweigh the benefits and are typically opposed to any policy that demands immunization as a condition for their children's education [38]. Rastafarians do not object to immunization in principle. Instead, they believe more emphasis should be placed on natural means of disease prevention. They argue that there is good evidence to support the claim that breast feeding provides protection against a range of diseases such as meningitis, whooping cough, tetanus and polio [39].

Recommendations

- A chaplain or chaplain resident should be responsible for providing pastoral and spiritual care coverage in the ED;
- The department for spiritual/pastoral care should provide education and resources to physicians and residents on religious beliefs from various religious groups and their impact on health care decision-making;
- Physicians should be familiar with research and literature on the connection between religious faith and practice (i.e., prayer) and health and healing;
- ED physicians and staff should have a basic understanding of spiritual risk assessment in terms of simple, nonintrusive ways to determine if a patient is experiencing spiritual injury and is at spiritual risk in order to make an appropriate referral to a chaplain.

Conclusion

Medicine is based on eliciting information, understanding that information, and then knowing how to apply it to the treatment of one's patient. Use of the presented information is no different. Eliciting spiritual history, understanding the implications of the patient's religion, and then being able to apply that to a tailored treatment plan designed to heal and comfort the patient spiritually and medically is important. Provision of culturally competent spiritual care depends upon the collaborative efforts of physicians, chaplains, social workers, nurses, and others. The practice of medicine is more than mere scientific diagnostics and problem-solving; rather, medicine is about science *and* emotion, religion, and spirituality.

References

1. Neusner J. World religions in America: an introduction. 2nd ed. Louisville: Westminster John Knox Press; 2000.
2. Zieg PM, Cohn SM, Beardsley DS. Nonoperative management of a splenic tear in a Jehovah's Witness with hemophilia. J Trauma. 1996;40(2):299–301.
3. Best MM. A spiritual perspective: why do African Americans resist end-of-life decisions? Chaplaincy Today. 2003 Autumn/Winter;19(2):7–9.
4. Fitchett G. Screening for spiritual risk. Chaplaincy Today. 1999;15(1):2–12.
5. Weaver AJ, Flannelly LT, Flannelly KJ, VandeCreek L, Koenig HG, Handzo G. A 10-year review of research on chaplains and community-based clergy in 3 primary oncology nursing journals: 1990–1999. Cancer Nurs. 2001;24(5):335–40.
6. Lester AD. Hope in pastoral care and counseling. Louisville: Westminster John Knox Press; 1995.
7. Gibbons G, Retsas A, Pinikahana J. Describing what chaplains do in hospitals. J Pastoral Care. 1999;53(2):201–7.
8. Koenig HG. Meeting the spiritual needs of patients. Satisfaction Monitor. 2003; 1–4. Available from: http://www.pressganey.com/research/resources/satmon/text/bin/178.shtm
9. Pew Research religious and public life project. U.S. religious landscape survey [Internet]. 2007 [cited 2014 Oct 28]. Available from: http://religions.pewforum.org/comparisons#
10. Matlins SM, Magida AJ. How to be a perfect stranger: the essential religious etiquette handbook. 3rd ed. Woodstock: Skylight Paths; 2003.
11. Queensland Health. A health-care providers' handbook on Hindu patients. Hindu Today 2013;35(1):26–31.
12. Editors of Hinduism Today. How Hindu dharma addresses 25 controversial medical issues frequently encountered by physicians. Hindu Today 2013;35(1):18-25.
13. Access to insight: readings in Theravada Buddhism [Internet]. Thanissaro Bhikku; c1997 [updated 2013 Nov 30; cited 2015 Feb 9]. Paticca-samuppada-vibhanga Sutta: Analysis of dependent co-arising; [about 2 p.]. Available from: www.accesstoinsight.org/tipitaka/sn/
14. Duncan AS, Dunstan GR, Welbourn RB. Dictionary of medical ethics. 2nd ed. London: Daron, Longman and Todd; 1981.
15. Weber TP. The Baptist tradition. In: Numbers RL, Amundsen DW, editors. Caring and curing: health and medicine in the Western religious traditions. Baltimore: John Hopkins University Press; 1986.
16. Southern Baptist Convention. [Internet] c2015 [cited 2015 Jan 16]. The Baptist faith and message; [about 9 p.] Available from: http://www.sbc.net/bfm2000/bfm2000.asp
17. Southern Baptist Convention. [Internet] c2015 [cited 2015 Jan 16]. Position statements; [about 3 p.]. Available from: http://www.sbc.net/aboutus/positionstatements.asp

18. Alliance of Baptists. [Internet]. Atlanta: Alliance of Baptists; c2012 [cited 2015 Feb 12]. The alliance of Baptists statement on same sex marriage; [about 1 p.]. Available from: http://allianceofbaptists.org/documents/SameSexMarriage2004.pdf
19. Alliance of Baptists. [Internet]. Atlanta: Alliance of Baptists; c2012 [cited 2015 Feb 12]. A statement on lifelong sexual education, sexual & reproductive rights, and opposing sexual injustice and violence: the gathering of the alliance of Baptists in Austin, Texas on April 14, 2012; [about 2 p.]. Available from: http://allianceofbaptists.org/documents/LifelongSexualEducation2012.pdf
20. United Pentecostal Church International [Internet]. Hazelwood (MO): United Pentecostal Church International; c2015 [updated 2011 May 18; cited 2015 Jan 16]. Divine Healing; [about 5 p.]. Available from: http://www.upci.org/about-us/about-us/83-beliefs/87-divine-healing
21. Wacker G. The Pentecostal tradition. In: Numbers RL, Amundsen DW, editors. Caring and curing: health and medicine in the Western religious traditions. Baltimore: Johns Hopkins University Press; 1986.
22. Pew Research religion & public life project. U.S. religious landscapsurvey: affiliations [Internet]. 2007 [cited 2014 Oct 24]. Available from: http://religions.pewforum.org/affiliations
23. The General Council of the Assemblies of God. Divine healing position paper. [Internet]. 2010 Aug 9-11 [cited 2014 Oct 24]. Available from: http://ag.org/top/Beliefs/Position_Papers/pp_downloads/PP_Divine_Healing.pdf
24. O'Connell MR. The Roman Catholic tradition since 1545. In: Numbers RL, Amundsen DW, editors. Caring and curing: health and medicine in the Western religious traditions. Baltimore: Johns Hopkins University Press; 1986.
25. McCormick RA. Health and medicine in the Catholic tradition: Tradition in transition. New York: Crossroad; 1987.
26. Wintz S, Cooper E. A quick guide to cultures and spiritual traditions: unit resource packet. St. Joseph's Hospital and Medical Center; 2001.
27. McKennis AT. Caring for the Islamic patient. AORN J. 1999;69(6):1187–96.
28. Kirkwood NA. A hospital handbook on multiculturalism and religion: practical guidelines for health care workers. Morehouse: Harrisburg, PA; 1993.
29. Rahman F. Health and medicine in the Islamic tradition: change and identity. New York: Crossroad; 1989.
30. Rahman F. Islam and health/medicine: a historical perspective. In: Sullivan LE, editor. Healing and restoring: health and medicine in the world's religious traditions. New York: Macmillan; 1989.
31. Antes P. Medicine and the living tradition of Islam. In: Sullivan LE, editor. Healing and restoring: health and medicine in the world's religious traditions. New York: Macmillan; 1989.
32. Dorff EN. The Jewish tradition. In: Numbers RL, Amundsen DW, editors. Caring and curing: health and medicine in the Western religious traditions. Baltimore: Johns Hopkins University Press; 1986.
33. Feldman DM. Health and medicine in the Jewish tradition: L'hayyim--to life. New York: Crossroad; 1986.
34. Kitzinger S. Protest and mysticism: the Rastafari cult of Jamaica. J Sci Study Relig. 1969;8(2):240–62.
35. ReligionFacts [Internet]. c2004-2014 [updated 2013 Dec 13; cited 2014 Dec 8] Rastafari; [about 6 pages]. Available from: http://religionfacts.com/a-z-religion-index/rastafarianism.htm
36. Katz M. The Dread Library [Internet]. [cited 2014 Dec 8]. Fundamentals: the Rastafarian lifestyle; [about 8 pages]. Available from: http://debate.uvm.edu/dreadlibrary/katzm.html
37. Sanborn M. Natural medicine and healing. 2012 Apr 23 [cited 2014 Dec 2]. In: Rastafari & the Environment [Internet]. [place unknown]: Hesler K, McGurrin L, Sanborn M, and Gray M. [about 4 pages]. Available from: https://caribbeanreligionuvm.wordpress.com/2012/04/23/morgan/
38. Denny J. Rastas protest vaccinations. St. Kitts–Nevis The Observer. 2008 Sep 5. Available from: http://thestkittsnevisobserver.com
39. Cooper C. Pricks of conscience. Jamaica Gleaner. 2010 Oct 3;Leisure 3.

Chapter 9
Lesbian, Gay, or Bisexual (LGB): Caring with Quality and Compassion

Joel Moll and Paul Krieger

Introduction

Demographics

There is a wide range of societal opinions on the prevalence of lesbians, gay men, and bisexuals (LGB) in the USA. This reflects in part societal bias, lack of research, and barriers to disclosing or collecting data on an individual's sexuality. Many health care data banks and government health care organizations have not traditionally collected data on sexual orientation. The often cited Kinsey data from the 1940s suggested that 10 % of the men and 5–6 % of women are exclusively or predominately gay and lesbian [1, 2]. More recent estimates are that 1.6–3.5 % of adults in the USA identify as lesbian or gay, 0.7 % bisexual, and 8.2 % have had same-sex sexual behavior; and 11 % have some sexual attraction to the same sex [3, 4]. Since sexual orientation does not always reflect sexual acts, finding patients who would benefit from counseling and screening based on disparities for MSM and WSW can be challenging. A significant number of LGB patients do not disclose their sexual orientation to their physician [5]. A mix of societal, patient, and provider factors may account for this nondisclosure. The majority of LGB people are in relationships [6].

J. Moll, M.D.
Department of Emergency Medicine, Virginia Commonwealth University,
Richmond, VA, USA

P. Krieger, M.D. (✉)
Emergency Department, Mount Sinai Beth Israel Medical Center, New York, NY, USA
e-mail: pkrieger@chpnet.org

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_9

Terminology

In creating a welcome and inclusive environment for LGB patients, health care providers should be familiar with culturally competent terminology to better communicate and avoid unintentional offense. Important among this is the use of terms free from bias or prejudice. Terms like "homosexual" or "sexual preference" may be common in the vernacular, but have stigma when used in the LGB community. The word "homosexual" is associated with past societal bias, and thus MSM should be referred to as gay, and WSW referred to as lesbian or gay. Many LGB people will go through a process of coming to terms with being LGB termed "coming out." Although gay men or lesbians may identify as bisexual at some point in their coming out process, it should be noted that bisexuality is a distinct sexual orientation. Similarly, since there is no legitimate evidence that sexual orientation is a choice, "sexual preference" should not be used. Patients should be asked about their significant other in gender neutral terms, and asking open-ended questions will signal being receptive to patients not in traditional heterosexual relationships. When in doubt, ask the patient for their preferred term, or allow them to define their relationships.

History

Same-sex relationships are referenced in early ancient recorded history. Societal acceptance and tolerance have varied, but in the USA, being lesbian, gay, or bisexual has been traditionally less accepted. Laws forbidding homosexual behavior were commonplace for centuries, which adversely influenced attitudes of health care providers, and isolated gay and lesbians from society and medical care. Homosexual behavior was risky, discreet, and repressed.

The arrival of the 1960s, along with more progressive thoughts on sex, began to see opinions on homosexuality change. In 1961, Illinois became the first state to decriminalize homosexuality, although it would take years for others to follow. On June 28, 1969, the Stonewall Inn, a gay bar in the Greenwich Village neighborhood of New York City was raided by police. Angered by police harassment, patrons fought back. The Stonewall riots are commonly considered the spark for the modern gay rights movement.

The following decades had important progress for LGB rights. In 1973, the Board of Directors of the American Psychiatric Association removed homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as a psychiatric illness. After progress in the 1970s, the early 1980s revealed a new and sinister threat. The first case of Acquired Immune Deficiency Syndrome (AIDS) was described in 1981. AIDS had a devastating effect on the LGB community, with a generation of activists and community leaders affected. Health care providers and the general public were frightened of the new and mysterious disease, initially termed GRID (gay-related immunodeficiency syndrome), leading to ostracism of LGB patients and discrimination in care. Subsequently through the identification of the virus, education, and research, safer sex and infection control precautions were identified. In the 1980s and early 90s, rights and inclusiveness in health care of LGB individuals, especially gay men, could not be separated from the AIDS epidemic. With advancements in HIV care over the last 20 years, political activism and health care concerns could focus on other issues beside simple survival.

In the 1990s and 2000s, the USA also began to know more LGB people if not in their lives, on their television. In 2003, in the landmark Lawrence vs. Texas ruling, the Supreme Court struck down sodomy laws used to criminalize homosexuality. In 2004, Massachusetts became the first state to legalize same-sex marriage, and in 2013, the Supreme Court declared the 1996 Defense of Marriage Act, which forbade federal recognition of same-sex relationships, unconstitutional. The federal government repealed the ban on gays serving openly in the military, enacted protections for hospital visitation, and recognized gay marriages for income tax filings. In June 2015, the United States Supreme Court ruled in favor of marriage equality, making same-sex marriage now legal in all of the United States. Polls show the majority of Americans (55 %) support same-sex marriage, overwhelmingly so by younger Americans [7].

Health Care Disparities

The health and health care of LGB individuals are multifactorial. LGB people have the same health care needs as others, but also have specific health risks intrinsic to their sexual orientation and behavior. Obstacles to quality health care include legal barriers, stigma, discrimination, and lack of provider education. Patient's prior negative interactions with the health care system often lead to avoidance of medical care and delays in diagnosis. Since sexual orientation demographic is not routinely identified in surveys or health care settings, additional disparities may exist or not be understood. LGB people can be an invisible minority.

The "Minority stress model," described by Meyer, explains that like other minority groups, LGB individuals experience chronic high levels of stress from stigmatization. Higher levels of anxiety, depression, and substance abuse result from increased stress caused by discrimination and violence (enacted stigma), fear of discrimination, and rejection that lead to a hypervigilance (perceived stigma) and the adoption of societies' negative attitudes on oneself (internalized homophobia). Psychological illness and substance abuse disparities result from the increased stresses from nonconformity rather than homosexuality itself [8–10]. A recent study suggests that sexual minorities who live in areas with high prejudice had a 12-year shorter life expectancy compared to those in tolerant areas. Suicide, homicide/violence, and cardiovascular disease were significantly higher in sexual minorities in these areas [11].

Lesbian, gay, and bisexual patients may have reason to fear substandard care. In a Lambda Legal study 56 % of LGB respondents reported harsh or abusive language from a health professional, and 8 % reported being denied care outright [12]. A needs assessment by New York State found 27 % of LGB respondents feared poor treatment by providers, and 40 % reported lack of provider education as a barrier to care [13]. In order to provide LGB people with appropriate high quality health care, the health care system must be inclusive so LGB patients are comfortable confiding in providers, and barriers to care can be addressed.

Legal Barriers

Lack of access to quality health care is not only tied to stigma and discrimination, but also the result of discriminatory laws. There are over 1000 rights and benefits in the USA attached to marriage by the federal government. Although the federal government has recognized same-sex marriage since 2013, it has only been recognized in every state as of June 2015 [14]. Prior to the recent supreme court ruling, significant differences existed in rights and access to healthcare in states with and without marriage equality. Marriage allows access to employer sponsored insurance for both same-sex spouse and children. When companies provided domestic partners benefits, and it was not prohibited by law, same-sex couples were subject to additional taxes on employer health plans in non-marriage equality states. Marriage also provides access to the benefits of the Family Medical Leave Act, social security survivor benefits, and certain tax and probate protections. Perhaps the most important legal right conferred by marriage is medical decision making for a spouse. In states without marriage equality, the state default surrogate laws may not have allowed for domestic partners to make decisions. Without marriage equality, it was vital LGB patients have advance directives to assure medical decision rights for their significant others. Lastly, marriage itself likely provides certain health benefits. In Massachusetts and California, same-sex married couples have decreased psychological distress and less utilization of medical and mental health care [14, 15].

In 2010, after numerous cases of partners were denied access to their loved ones at their most vulnerable moments, Medicare and Medicaid participating hospitals were prohibited from denying visitation based on sexual orientation or gender identity. However, nonparticipating hospitals are only subject to state visitation laws [16]. As a result of marriage equality nationwide, hospitals should no longer be able to deny married same sex couples visitation rights. However, patients in unmarried same-sex relationships, and providers who care for them, should consult with an attorney to understand evolving federal and state laws before they are needed. Adoption laws may impede the nonbiological parent of a same-sex couple from being able to make medical decisions for children raised with their partner. Only 24 states allow second parent adoption, eight states have active obstacles, and two states prohibit gay people from adopting. The remaining states determine adoption cases on an individual and inconsistent basis [14].

Access to insurance is further impeded by the lack of a national employment nondiscrimination law. Over 60 % of Americans receive medical insurance through their employer [17, 18]. Lack of job protection based on sexual orientation leads to nondisclosure, further limiting insurance coverage for partners and their dependents. It also contributes to lower income and more LGB living below the poverty line compared to heterosexuals. LGB employees who have not disclosed their sexual orientation to others (sometimes referred to as "closeted"), as well as those with actual or perceived discrimination, have increased rates of anxiety and depression and worse health [19].

Medical Disparities

Documented health disparities for LGB patients adversely affect physical and mental health (Table 9.1). Isolated research on bisexual individuals is limited, due to rare collection of sexual orientation as a demographic data point. Mental health disparities exist amongst LGB people, but the vast majority of LGB people are psychologically healthy. Increased substance abuse is not intrinsic to being LGB and more likely secondary to coping with minority stress, discrimination, victimization, and lack of support from friends and family. Same-sex couples are at risk for domestic violence like heterosexuals, and should be questioned on the matter, not overlooked or minimized [8, 16, 20].

Table 9.1 LGB health disparities

Gay men (MSM)	Lesbians (WSW)
Higher rates of eating disorder	Increased rate of obesity
Higher STD rates, HIV, gonorrhea, chlamydia, herpes[a]	Increased risk of postpartum depression
Increased anxiety, depression, suicide	Increased anxiety, depression, suicide
Increased risk of HPV, 17× more risk of anal cancer	More likely to use illicit drugs
Increased smoking rates	Increased smoking
Alcohol abuse and binge drinking	Alcohol abuse and binge drinking
Increased risk of asthma	Increased risk of asthma
Syphilis (75 % new cases in MDM)	Possible higher rates of breast and cervical cancer
Increased risk of hepatitis A, B	
Increased risk of oral–fecal bacteria infection including Giardia	

STD sexually transmitted disease, *HIV* human immunodeficiency virus

[a] Medical providers should screen for STD in the genital, oral, and anal regions

MSM comprise half of all people living with and having died from HIV. Two-thirds of new cases each year are MSM, with 20 % in young men ages 13–24. Twenty percent of MSM who are HIV positive are unaware of their HIV status. Patients who are aware that they are HIV positive are more likely to take precautions to reduce transmission to their partners. Sexually active MSM should be tested for HIV every 3–6 months. Additionally treatment is paramount since an undetectable viral load markedly decreases the risk of transmission to seronegative partners. Only 49.5 % of HIV positive MSM are on antiretroviral treatment (ART), and only 42 % have achieved viral suppression at levels that decrease transmission. Offering pre- and post-exposure prophylaxis can provide further risk reduction. Providers should be trained and prepared to prescribe these treatments for at risk individuals [8, 21]. Because of increased risk, hepatitis A, hepatitis B, and HPV vaccinations should be offered to all MSM [21].

Special Populations

Youth

LGB youth are particularly vulnerable. Among adolescents 7–8.7 % report having at least one same-sex partner or romantic interest, although fewer identify as being LGB (1–3 %). Only 16 % of LGB youth share their sexual orientation with their physician [8, 22–25]. On average gay males identify their same-sex attraction at age 9 and lesbians at age 10, with self-awareness of their sexual orientation at age 16.7 and 16, respectively [8, 26]. They are developing in an evolving political time, as well as an era of expanding access to information via the Internet and social media. Like adults, they are subject to the minority stress described above, but may not have formed adequate family or peer support. LGB youth are more likely to be victimized, likely contributing to health care disparities [8, 25].

The vast majority of LGB youth are healthy and well adjusted, but disparities exist similar to their adult counterparts. LGB youth have twice the risk of suicide, more experimentation with drugs and alcohol, increased risk of abuse (physical, sexual, and verbal), higher rates of STDs including HIV, and are more vulnerable to eating disorders [8, 25]. It is estimated that 20–40 % of all homeless youth are LGB or transgender, and 25 % of gay males are kicked out of their homes. Homeless youth are more likely to engage in risky sexual behavior, substance abuse, and have higher rates of mental disorders. They are 7 times more likely to be the victim of a crime [8, 24]. LGB youth may find it difficult to find adults in which they can confide. Although 70% receive positive messages from friends about their sexual orientation, more (90 %) report negative messages. Twenty-five percent of LGB students miss school due to feeling unsafe and bullying [25, 26]. Only 17 states have laws prohibiting bullying based on sexual orientation, and fewer have laws protecting students from discrimination [14]. This combination puts LGB youth at risk for poor academic achievement and negatively impacts health [27].

Sexual minority youth have gender-specific eating disorder and body image disparities. Lesbian and bisexual girls are more content than heterosexuals with their bodies, and are less likely to try to look like women in media. Conversely, gay and bisexual boys are more likely to want to look like images in media. Those who described themselves as gay, bisexual, or “mostly heterosexual” had increased rates of binging and purging behavior. There may be an association with lesbian and bisexuals of both sexes with an increased risk of obesity [8, 23].

Gay and bisexual adolescents are at an increased risk for all STDs. According to the CDC, 1 in 5 new HIV cases are gay and bisexual men between the ages of 13 and 24, and almost 60 % are unaware. African-American boys of this age are disproportionately affected. They represent 10 % of all new annual cases of HIV and increased 22 % between 2008 and 2010. Significant barriers to prevention in adolescence include low perception of risk, decreased testing, less condom use (40 %), older sexual partners that may be more likely to have HIV, homelessness, and substance abuse. Physicians must educate LGB youth on HIV safer sex practices, and pre- and post-exposure prophylaxis [21].

Little data also exist for lesbian youth, but female-to-female transmission of HIV, HPV, syphilis, HSV, gonorrhea, chlamydia, and bacterial vaginosis has been documented. Many lesbian youth will engage in penile–vaginal intercourse, and compared to heterosexuals, lesbians report having sex with men at a younger age, are less likely to use hormonal contraception, and have higher rates of teenage pregnancy. As a result, physicians need to counsel on safer sex practices, consider contraception, perform STD and pregnancy screening, and not underestimate the risk [8, 22, 27].

Advanced Age

There are an estimated 1.5 million LGB Americans over the age of 65 [28]. Although LGB individuals and couples are increasingly parents through adoption, surrogacy, or other means, many do not have children who may assist them in advanced age compared to heterosexuals. An estimated 37 % of LGB-identified adults have had a child at some time in their lives, compared to 74 % of all Americans [29]. Elder LGB individuals are twice as likely to live alone and be single, and may be estranged from what biological family they have [28]. LGB individuals often rely more on friends and community, but may find themselves separated from social support necessitated by declining independence and health. In a survey of LGBT extended-care facility residents, only 22 % felt comfortable being open about their sexuality and 43 % reported mistreatment based on their sexuality [30].

Significant health disparities disproportionately affect elder LGB patients including both physical and mental illness. Physical disparities relate to care and rates of hypertension, hyperlipidemia, diabetes, heart disease, and HIV [28]. Mental health concerns are staggering. Over half of LGB people over age 65 are depressed, 39 % have contemplated suicide, and 53 % feel isolated [28]. They, like other LGB Americans, are less likely to have medical insurance, and more likely to live in poverty [28].

Because of lack of protective laws, couples may be separated into different extended care facilities, and denied financial protections and benefits afforded an opposite sex spouse. The probate process may not respect their relationship outside of marriage, or not recognize an out-of-state marriage, and cause financial ruin for the surviving partner unable to inherit joint assets. In addition, at the time of illness or death, estranged family is always a threat to come forward to contest the wishes of the ill or deceased individual. Probate judges hostile to the LGB community have, without protection of marriage, overruled wills and other legal documents.

LGB People of Color

Although LGB individuals face many barriers in the equitable obtainment of health care and in society, those of color have additional hurdles. Being LGB and an underrepresented minority due to race, creed, ethnicity, or religion can potentially cause direct conflict with strongly held opposing values in their community. Some will choose to live the lifestyle imposed by cultural beliefs, repressing their sexual orientation, or having same-sex relationships in a parallel or hidden life. This is often referred to as being “on the down low” [31]. Minority LGB individuals are less likely to be open with their provider about their sexual behavior [5]. Providers should be aware of how different cultural expectations that form their identity can conflict and have negative effects on their overall mental and physical health. This can magnify preexisting disparities in the LGB community. African-Americans bear a heavy burden for HIV compared to other racial groups, but even more so for LGB African-Americans. African-Americans account for 44 % of new HIV infections among MSM but only represent 12 % of the US population, and Hispanics are 21 % of new cases while only 16 % of the population [21]. Same-sex couples of color are 2.2 times more likely to partner with individuals of another race/ethnicity compared to heterosexuals. Racial/ethnic minority same-sex couples are more likely to have children compared to white heterosexuals. About 1 out of every 3 individuals of same-sex couples raising children are people of color [32].

Conclusion

Lesbian, gay, and bisexual people are ubiquitous in society and deserve high quality, equitable, patient-centered care. They have had a complex and discriminatory history in the USA resulting in a less visible, closeted population subject to legal barriers, stigmatization, and lack of research and education on health care needs. We are witnessing a rapid transformation with new and overdue societal acceptance, and improving legal and living conditions for LGB Americans.

Despite improving conditions, many health care disparities still exist and collective work is needed to close those gaps. LBG people have increased risk of physical and mental health disorders, substance abuse, STDs, eating disorders, certain cancers, less access to insurance and quality health care, and lower overall health status. LGB youth, seniors, and those of color have unique and specific needs. Health care providers need to understand the barriers that exist and how they impact patients. Broad sweeping legal reform would remove many legal barriers that contribute to poor access to care. Some societal and education barriers are likely to remain, which deserve attention if we are to give LGB people the quality, compassionate care they deserve.

Recommendations

Communication

- Providers should communicate with LGB patients in an open and inclusive manner. Direct conversations, using culturally competent and patient-centered terminology, are essential.
- Patients should be directly asked details on sexual practices that can affect health, even if such questions are uncomfortable for the providers. Gay men and lesbians should receive education on sexual health and health care disparities relating to their sexuality and identity.
- All patients should be specifically asked who they wish to be involved as decision makers, and who should have access to their health care information.
- Providers should refer to significant others in gender-neutral terms.

Education

- Health professionals should receive LGB health education in medical school, residency, and CME. Currently medical schools and residency training do a limited and inadequate job instructing on LGB health [8, 33].
- Because of limited knowledge and research on health care disparities and barriers, a greater effort for inquiry and knowledge distribution should be undertaken. This is in line with calls from UN, Institute of Medicine, Department of Health and Human Services, American Medical Association (AMA), and the Joint Commission on the Accreditation of Healthcare Organizations [8, 16, 20].

Hospital Policies

- Hospital administrators and medical leadership should review the Joint Commissions publication “Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community.” This is a comprehensive guide for hospitals on how to provide equitable, patient-centered care to LGBT patients and offers recommendations for LGBT-inclusive policies [33].

- All hospital policies, including visitation and nondiscrimination, should be reviewed to assure they are inclusive of LBG people, and should be in visible sight to create a more inclusive environment.
- Common areas should be inclusive of LGBT patients and families by displaying LGBT friendly symbols (rainbow flag, pink triangle, safe zone) and having resources on LGBT topics available.

Law and Health Care

- Health care providers and patients should be aware of the laws that impact health and access to care; legal advice should be obtained when needed.
- Providers should advise same-sex couples to have advanced directives in order to assure that surrogate decision making preferences are respected.

Research

- Sexual orientation should be collected as part of demographic data, allowing for identification of patients in research databases.
- When feasible, research studies should include LGB patients and outcomes in their studies just as they would with any other demographic.

References

1. Kinsey AC, Pomeroy WB, Martin CE. Sexual behavior in the human male. Philadelphia, PA: W.B. Saunders; 1948.
2. Kinsey AC, Pomeroy WB, Martin CE, Gebhard P. Sexual behavior in the human female. Philadelphia, PA: W.B. Saunders; 1953.
3. Gates GJ. How many people are lesbian, gay, bisexual, and transgender? [Internet] Los Angeles, CA: The Williams Institute, UCLA School of Law; April 2011. [cited 2014 September 24, Available from: http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/how-many-people-are-lesbian-gay-bisexual-and-transgender/
4. Ward BW, Dahlhamer JM, Galinsky AM, Joestl SS. Sexual orientation and health among US adults: National Health Interview Survey, 2013. Natl Health Statistics Rep. 2014 77:1-12 [cited 2014 September 24].
5. Bernstein KT, Liu KL, Begier EM, Koblin B, Karpati A, Murrill C. Same-sex attraction disclosure to health care providers among New York City men who have sex with men: implications for HIV testing approaches. Arch Intern Med. 2008;168(13):1458–64.
6. Klinger RL, Cabaj RP. Characteristics of gay and lesbian relationship. In: Oldham JM, Riba MB, Tasman A, editors. American psychiatric press review of psychiatry. Washington, DC: American Psychiatric Press, Inc; 1993. p. 101–25.
7. McCarthy J. Same-sex marriage support reaches new high at 55% [Internet]. Gallop Politics. 2014 May 21. [cited 2014 September 24]. Available from: http://www.gallup.com/poll/169640/sex-marriage-support-reaches-new-high.aspx

8. Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. The health of lesbian, gay, bisexual and transgender people: building a foundation for better understanding. Washington, DC: The National Academies Press, 2011.
9. Meyer IH. Minority stress and mental health in gay men. J Health Soc Behav. 1995;36(1):38–56.
10. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003;129(5):674–97. doi:10.1037/0033-2909.129.5.674.
11. Hatzenbuehler ML, Bellatorre A, Lee Y, Finch BK, Muennig P, Fiscella K. Structural stigma and all-cause mortality in sexual minority populations. Soc Sci Med. 2014;103:33–41.
12. Lambda Legal. When health care isn’t caring: Lambda Legal’s survey of discrimination against LGBT people and people with HIV [Internet]. New York: Lambda Legal; 2010 [cited 2014 Sept 15]. Available at: www.lambdalegal.org/health-care-report.
13. Frazer S. NYS-wide survey on LGBT health and human services needs in New York State. Albany, NY: Empire State Pride Agenda Foundation; 2009.
14. Human Rights Campaign [cited 15 Oct 2014]. Available at: http://www.hrc.org.
15. Gonzales G. Same-sex marriage—a prescription for better health. N Engl J Med. 2014;370:1373–6.
16. Assistant secretary for Health, US Department of Health and Human Services. Recommended actions to improve the health and well-being of lesbian, gay, bisexual, and transgender communities [Internet]. Washington, DC: Department of Health and Human Services; 2012 [cited 2014 Sept 15]. Available from: http://www.hhs.gov/secretary/about/lgbthealth.html.
17. Gay and Lesbian Medical Association [website]. Washington, DC: GLMA, 2015 [cited 2014 Oct 15]. Available from: www.glma.org.
18. Sonier J, Freid B, Au-Yeung C, Auringer B. State-level trends in employer-sponsored health insurance [Internet]. Princeton, NJ: Robert Wood Johnson Foundation; 2013. Available from: http://www.rwjf.org/en/library/research/2013/04/state-level-trends-in-employer-sponsored-health-insurance.html
19. Sears B, Mallory C. Documented evidence of employment discrimination & its effects on LGBT people [Internet]. Los Angeles, CA: The Williams Institute, UCLA School of Law; c 2011. Available from: http://williamsinstitute.law.ucla.edu/research/workplace/documented-evidence-of-employment-discrimination-its-effects-on-lgbt-people/
20. The Joint Commission. Advancing effective communication, cultural competence, and patient and family centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: a field guide. Oak Brook, IL: Joint Commission; 2011.
21. Center for Disease Control and Prevention [website]. Atlanta, GA [cited 2014 Oct 15]. Available at: www.cdc.gov.
22. DuRant RH, Krowchuk DP, Sinal SH. Victimization, use of violence, and drug use at school among male adolescents who engage in same-sex sexual behavior. J Pediatr. 1998;133(1):113–8.
23. Austin SB, Ziyadeh N, Kahn JA, Camargo Jr CA, Colditz GA, Field AE. Sexual orientation, weight concerns, and eating-disordered behaviors in adolescent girls and boys. J Am Acad Child Adolesc Psychiatry. 2004;43(9):1115–23.
24. Russell ST, Joyner K. Adolescent sexual orientation and suicide risk: evidence from a national study. Am J Pub Health. 2001;91(8):1276–81.
25. The Human Rights Campaign. Growing up LGBT in America [Internet]. 2012 [cited 2014 Sept 26]. Washington, DC: Human Rights Campaign; c 2011-2015. Available from: http://www.hrc.org/youth/about-the-survey-report
26. Herdt G, Boxer A. Children of horizons: how gay and lesbian teens are leading a new way out of the closet. Boston, MA: Beacon; 1993.
27. Steevers J, Frances J, Gordon LP, Lee J. Sexual minority youth. Prim Care. 2014;41(3):651–69.

28. Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE). Discrimination [cited 2014 September 24]. New York, NY: SAGE; c 2012-2015. Available from: http://www.sageusa.org/issues/general.cfm
29. Gates GJ. LGBT parenting in the United States [Internet]. 2013 Feb [cited on 2014 Sept 24]. Los Angeles, CA: The Williams Institute, UCLA School of Law; c 2011. Available from: http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-parenting-in-the-united-states/
30. National Senior Citizens Law Center. LGBT older adults in long-term care facilities: stories from the field [Internet]. April 2011 [cited 2014 September 24]. New York, NY: National Resource Center on LGBT Aging; c 2011-2015. Available from: http://www.lgbtagingcenter.org/resources/resource.cfm?r=54
31. Green J. Cassell's dictionary of slang. New York, NY: Sterling Publishing; 2006. p. 893.
32. Kastanis A, Wilson BDM. Race/ethnicity, gender and socioeconomic wellbeing of individuals in same-sex couples [Internet]. Los Angeles, CA: The Williams Institute, UCLA School of Law; c 2011. Available from: http://williamsinstitute.law.ucla.edu/wp-content/uploads/Census-Compare-Feb-2014.pdf
33. Moll J, Krieger P, Moreno-Walton L, Lee B, Slaven E, James T, et al. The prevalence of lesbian, gay, bisexual, and transgender health education and training in emergency medicine residency programs: what do we know? Acad Emerg Med. 2014;21(5):608–11. doi:10.1111/acem.12368.

Chapter 10
Culturally Competent Care of the Transgender Patient

Brandy Panunti

Introduction

Terminology and Concepts

The frequent tendency to add transgender individuals' identities into the larger LGBT group contributes to misunderstanding and confusion. It is critical that clinicians become familiar with both the medical and vernacular terminology used (and often debated) within LGBT, and specifically transgender, populations. While the LGBT community has loosely been referred to as a *sexual minority*, many emphasize the distinction between *sexual* and *gender* minority. *Sexual minority* is defined by sexual orientation and is generally used to describe lesbian, gay, and bisexual individuals. Those who define themselves as part of a *gender minority* identify discordance between their anatomic gender (birth gender or sex) and their gender identity. The term minority in itself proves controversial, with some objecting to its use and others arguing that the term is necessary to protect the right to unique medical care and legal protections.

Sexual orientation is a physical and/or emotional attraction to a specific gender or genders. *Gender identity* is a person's sense of his or her own gender. *Transgender* includes people that have been assigned either male or female at birth yet self-identify as opposite of, neither, or somewhere along, the male–female spectrum. Transgender can also be referred to as *gender nonconforming*, for example, a transgender man who was assigned a female gender at birth and now identifies as male or a transgender woman who was assigned a male gender at birth and now identifies as female [1]. Identifying as transgender is a self-identification and does not require a certain dress, hormone therapy, or surgery.

B. Panunti, M.D. (✉)
Department of Endocrinology, Ochsner Medical Center, New Orleans, LA, USA
e-mail: Bpanunti@ochsner.org

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_10

Being transgender does not predict sexual orientation—a person who is transgender can be heterosexual, gay, lesbian, or bisexual [2]. For example, a person assigned as male at birth, later identifies as female and is sexually attracted to women is a homosexual transgender woman. A person assigned female at birth who later identifies as male and is attracted to both men and women is a bisexual transgender man.

Cross-dressing, which was previously called *transvestism*, is not the same as being transgender. Individuals who cross-dress, including *drag queens* and *drag kings,* are comfortable with their gender but choose to express themselves through behaviors that are generally associated with the opposite gender (*gender expression*) for entertainment or personal/sexual satisfaction.

Gender identity development is multifaceted and likely reflects a complex interplay of genetic, hormonal, environmental, and cultural factors. *Gender variant behavior*, such as a girl being considered a "tomboy," can either be attributed to typical childhood development or may be symptomatic of being transgender. Gender-variant behavior in childhood does not inevitability continue into adulthood. Longitudinal studies have demonstrated that most gender-variant prepubertal youth will no longer meet the mental health criteria for transgender at the onset of puberty [3].

In the presence of significant psychological distress, a combination of medication-based puberty suppression (GnRH agonists) and mental health counseling is advised for children in early puberty, as distress often worsens at the development of secondary sexual characteristics [1]. Puberty blockade treatment is fully reversible and can provide more time with a therapist. Once the physical changes of puberty occur (beard, deep voice, breasts), they are not easily reversed. The Endocrine Society guidelines suggest that cross-sex hormones (testosterone and estrogen) can be initiated around the age of 16 (the legal age for medical decision-making in some countries), whereas surgical procedures (with the exception of mastectomy) should be deferred until at least 18 [4].

Being transgender is not considered a disorder of sexual differentiation (DSD). *Disorders of sexual differentiation* are a group of disorders that, in rare cases, can lead to a delayed ability to assign a gender to a newborn due to ambiguous genitalia. These cases (which are beyond the scope of this chapter) are complicated and often require gender assignment decisions directed by a team of specialists aided by chromosomal analysis, imaging, and hormonal studies.

Being transgender is not a mental illness. It can, however, cause distress, known as *gender dysphoria* [5]. Prior to May 2013, the American Psychiatric Association classified transgender individuals as having gender identity disorder—a psychiatric diagnosis. This was changed to *gender dysphoria* in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V). Prior to this change, the focus was on *identity*, or the incongruity between birth gender and identified gender. Now the focus is on *dysphoria*, or psychological distress caused by a birth gender that is incongruent with gender identity (see Table 10.1). This revision eliminates the stigma of gender nonconformity being classified as a mental disorder, recognizing that the psychological distress and symptoms of depression and anxiety are socially caused, and

Table 10.1 Sexual orientation, gender identity, gender dysphoria

Sexual orientation	Physical and/or emotional attraction to a specific gender or genders
Gender identity	Person's sense of his or her own gender
Gender dysphoria	Psychological *distress* caused by a birth gender that is incongruent with gender identity

not a result of being gender variant or gender nonconforming. The change is part of current advocacy work, which may ultimately result in the removal of gender dysphoria as a psychiatric diagnosis from DSM, as was done with homosexuality in 1973. Alternately, some members of the transgender community reason that gender dysphoria should remain a medical diagnosis in order to secure insurance coverage of expensive, and often lifelong, therapy costs.

Demographics

A lack of national surveys has resulted in limited data regarding the percentage of the population identifying as transgender. Early studies underestimated the numbers by only including subgroups, such as HIV-positive or surgical patients. According to *DSM-V,* the prevalence of gender dysphoria is 1:7000 to 1:20,000 for adult natal males (transgender women) and 1:33,000 to 1:50,000 for adult natal females (transgender men) [5]. A 2011 study by Gates found 0.3 % of US adults, or close to one million people, identify as transgender [6]. The Institute of Medicine (IOM), in its March 2011 report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding,* emphasized the need for collection of gender identity and sexual orientation data on federally supported surveys [7]. The Affordable Care Act requires The Department of Health and Human Services (HHS), through its programs and surveys, to collect a range of demographic data related to understanding health disparities [8]. As part of implementing this provision, HHS has instituted an "LGBT Data Progression Plan" to add sexual orientation and gender identity questions to federal population health surveys.

Health Care Disparities and Barriers

Transgender individuals experience negative healthcare outcomes for a variety of reasons. According to the Transgender Discrimination survey, 19 % were refused care due to their transgender status, 28 % postponed necessary medical care due to discrimination or inability to pay, 33 % delayed or did not seek preventative care, and 50 % reported having to teach their providers about transgender care [2].

Overcoming healthcare disparity begins with education. The need for LGBT undergraduate and graduate medical education has been recognized and acted upon by many institutions across the country. When exposed to LGBT education, students perform more comprehensive histories, hold more positive attitudes toward LGBT patients, and possess greater knowledge of LGBT healthcare concerns than students with little or no clinical exposure [9].

Maintaining a nonjudgmental attitude is a critical first step in obtaining a thorough and accurate history with transgender individuals. Strategies for improving open communication include asking patients if they have a preferred name other than the one listed in their medical record and using the pronoun that matches their gender identity rather than their sex (if there is uncertainty—ask). A sexual history is essential to comprehensive health assessment; however, providers often fail to initiate such discussions due to personal discomfort or perceived lack of skill. Although this may be the case, studies validate that patients prefer their providers to ask about their sexual health [10]. Providers can provide a respectful and empathetic environment by reassuring their patients that these are routine and confidential parts of the clinical encounter. Open-ended questions can include:

- Whether the patient is sexually active.
- Whether the patient has sex with men, women, or both.
- Whether the patient is using protection against sexually transmitted diseases.
- [If the patient has a vagina] whether the patient engages in vaginal and/or anal sex.

Certain health concerns impact the transgender population at a higher rate and should be specifically addressed. Some of these include tobacco use, substance abuse, HIV, self-harm, violence, and victimization [2]. According to a National Transgender Discrimination Survey, 57 % of transsexual individuals reported experiencing family rejection, 53 % were verbally harassed or disrespected in a place of public accommodation, 40 % were harassed when presenting ID, 26 % lost a job, and 19 % were refused medical care [2]. The lifetime suicide attempt rate in the transgender community is 41 %, compared to 1.6 % in the general population and anxiety and depression rates are reported as higher than that of the general community [2, 11, 12]. Proposed contributors to anxiety and depression include lack of social support, stigma, discrimination, and minority stress. Minority stress is a concept proposed by Meyer:

> [B]ased on the premise that gay people in a heterosexist society are subjected to chronic stress related to their stigmatization. Minority stressors were conceptualized as: internalized homophobia, which relates to gay men's direction of societal negative attitudes toward the self; stigma, which relates to expectations of rejection and discrimination; and actual experiences of discrimination and violence. The mental health effects of the three minority stressors were tested in a community sample of 741 New York City gay men. The results supported minority stress hypotheses: each of the stressors had a significant independent association with a variety of mental health measures. Odds ratios suggested that men who had high levels of minority stress were twice to three times as likely to suffer also from high levels of distress [13].

The model has since been tested in the transgender community. Respondents had a high prevalence of clinical depression (44.1 %), anxiety (33.2 %), and somatization (27.5 %). Social stigma was positively associated with psychological distress, supporting the relationship between "minority stress" and mental health and confirming psychological illness resulting from a non-accepting culture rather than the gender conformity itself [14].

Therapy

For a variety of reasons, many transgender individuals forego hormonal and surgical therapies, which are neither medically required nor expected [2, 4]. If therapy is opted for, specific medical health care concerns are twofold: those effects resulting from transgender-specific therapy (hormones and surgery) and those relating to the anatomy present. The anatomy present, or *birth anatomy*, can lead to a sensitive medical discussion.

Medical therapy options for transgender men include hormonal and surgical interventions. Hormonal interventions include endogenous hormonal suppression (blocking female sex hormone production) and exogenous testosterone use. Surgical options are more complex and include mastectomy, hysterectomy, oophorectomy, and genital reconstruction (phalloplasty). Medical history should include menstrual history, desired and undesired effects of hormonal therapy. Sexual history should include vaginal sex and contraception, with the physical exam that may include a breast or pelvic exam. A penile exam may be included if the individual has had sexual reassignment surgeries (SRS).

Medical therapy options for transgender women include hormonal and surgical interventions. Hormonal interventions may include endogenous hormonal suppression (blocking male sex hormone production), exogenous estrogen and occasional progesterone use, and antiandrogen use to block androgen receptors (spironolactone to prevent terminal hair growth and finasteride to prevent scalp hair loss). Surgical options are more complex and include breast augmentation, orchiectomy, vaginoplasty, and other feminizing surgeries. Medical history may include prostate as well as urinary symptoms, and desired and undesired effects of hormonal and antiandrogen therapy. Sexual history should include libido and the ability to get and maintain erections. Exam can include a breast or a prostate exam and may include the female anatomy as urological and vaginal complications can occur after sexual reassignment surgeries.

Because medication use and surgical information may not be volunteered, prompted questions may be necessary. Specific questions should include prescription use (including whether purchased online or from a nonmedical source) and non-prescription hormones, which may not be listed on the intake form. Unique to the transgender female population is the use of injectable silicone into breasts, hips, and buttocks in an attempt to shape or change body contours [15]. This practice can involve needle sharing, the use of industrial-grade silicone or contaminated biological-grade silicone, and failure to use proper or aseptic injection techniques. All such practices can have adverse health consequences, including tissue necrosis, infection, inflammatory granulomas and may not be disclosed during the clinical encounter without specific questioning by the provider [16].

Legal Issues

Despite some laws protecting individual healthcare rights, transgender individuals face many complex legal issues. The Affordable Care Act of 2010 prohibits sex discrimination in federally funded health care facilities, and in 2012 the federal Department of Health and Human Services clarified that this includes discrimination based on transgender status. The Act also forbids insurance providers from refusing coverage based on a preexisting conditions, including being transgender [17].

Other issues include the acquisition of identity documents, marriage rights, bathroom rights, and healthcare access. Name changes are generally straightforward, but many agencies require surgery to change a birth certificate and driver's license. In 2010, the US State Department stopped requiring surgery for issuing passports to transgender people and began asking instead for proof of "appropriate clinical treatment for gender transition to the new gender" [18]. Marriage and spousal rights also pose legal challenges. There are the nuances of transgender people bathroom rights—many establishments do not provide unisex or family restrooms. Lambda Legal states:

> The medical community (and increasingly, employers, schools and courts) now recognize that it is essential to the health and well-being of transgender people for them to be able to live in accordance with their internal gender identity in all aspects of life—and that restroom usage is a necessary part of that experience [19].

Conclusion

Transgender individuals, like all individuals, deserve access to high quality healthcare. Taking complete transgender medical and surgical histories, performing appropriate transgender guided physical exams, and providing the best medical therapies with appropriate monitoring is necessary for this group as it is for all groups. It is the responsibility of the healthcare community to become educated in all of these important areas of transgender health.

Recommendations

Education

- Providers should have a thorough understanding of the differences among groups within the LGBT community and familiarize themselves with both the medical and vernacular terminology used within the transgender population.
- Patients should determine the name and gender pronoun by which they and their significant others are referred.

- Healthcare workers should serve as their patients' advocates, dispelling misinformation among colleagues and students and correcting and/or reporting offensive language and behavior.
- Clinicians should stay abreast of developments in their fields that will help address transgender-specific concerns.

Clinical Decision-Making

- Providers should perform a comprehensive health assessment by obtaining a full sexual history using open-ended questions.
- Providers should provide a respectful and empathetic environment by reassuring patients that these assessments are a routine and confidential part of the clinical encounter.
- Clinicians should be aware of and address concerns that impact transgender patients at higher rates, including tobacco use, substance abuse, HIV, self-harm violence, and victimization.
- Providers should be aware of and attempt to mitigate barriers to care, including minimal social support, financial struggles, and lack of education.

Facility Environment

- Health professionals should document and internally report on a range of demographic data from their transgender patients in order to obtain a clear picture of their patient population and specific resources needed.
- Clinic and hospital areas should provide unisex restrooms in all patient areas.

References

1. World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender-nonconforming people. Minneapolis, MN: World Professional Association for Transgender Health; 2012.
2. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. Injustice at every turn: a report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011.
3. Wallien MSC, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. J Am Acad Child Adolesc Psychiatry. 2008;47(12):1413–23.
4. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ, Spack NP, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2009;94(9):3132–54.
5. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013.

6. Gates G. How many people are lesbian, gay, bisexual and transgender? The Williams Institute at UCLA School of Law; 2011.
7. Institute of Medicine (US), editor. The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. Washington, DC: National Academies Press; 2011. 347 p.
8. Improving data collection for the LGBT community [Internet]. Washington, DC: US Department of Health and Human Services, Office of Minority Health; c 2013. Available from: http://minorityhealth.hhs.gov/assets/pdf/checked/1/Fact_Sheet_LGBT.pdf.
9. Sanchez NF, Rabatin J, Sanchez JP, Hubbard S, Kalet A. Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. Fam Med. 2006;38(1):21–7.
10. Marwick C. Survey says patients expect little physician help on sex. JAMA [Internet]. 1999;281(23) [cited 2015 Mar 29]. Available from: http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.281.23.2171c
11. Budge SL, Adelson JL, Howard KAS. Anxiety and depression in transgender individuals: the roles of transition status, loss, social support, and coping. J Consult Clin Psychol. 2013;81(3): 545–57.
12. Hoffman B. An overview of depression among transgender women. Depress Res Treat. 2014;2014:394283. doi:10.1155/2014/394283.
13. Meyer IH. Minority stress and mental health in gay men. J Health Soc Behav. 1995; 36(1):38–56.
14. Bockting WO, Miner MH, Swinburne Romine RE, Hamilton A, Coleman E. Stigma, mental health, and resilience in an online sample of the US transgender population. Am J Public Health. 2013;103(5):943–51.
15. Wilson E, Rapues J, Jin H, Raymond HF. The use and correlates of illicit silicone or "fillers" in a population-based sample of transwomen, San Francisco, 2013: TEACH2 Fillers. J Sex Med. 2014;11(7):1717–24.
16. Styperek A, Bayers S, Beer M, Beer K. Nonmedical-grade injections of permanent fillers: medical and medicolegal considerations. J Clin Aesthetic Dermatol. 2013;6(4):22–9.
17. Cray A, Baker K. The Affordable Care Act: Progress towards eliminating insurance discrimination against LGBT people [Internet]. 2013 May 2.Washington, DC: Center for American Progress; c 2015. Available from: https://www.americanprogress.org/wp-content/uploads/2013/05/CrayNonDiscrimIns-facts.pdf
18. Lambda Legal. FAQ about identity documents [Internet]. New York, NY: Lambda Legal. Available from: http://www.lambdalegal.org/know-your-rights/transgender/identity-document-faq
19. Lambda Legal. FAQ about restrooms & what to do if you're hassled [Internet]. New York, NY: Lambda Legal. [cited 2015 Mar 29]. Available from: http://www.lambdalegal.org/know-your-rights/transgender/restroom-faq

Chapter 11
Looking Past Labels: Effective Care of the Psychiatric Patient

Leslie S. Zun and John S. Rozel

Introduction

A is a 42-year-old male, well known to the ED with a history of paranoid schizophrenia, who presented via Emergency Medical Services (EMS) for altered mental status. He was found lying on a sidewalk. A cursory physical exam was unremarkable. Mild bradycardia was noted but vitals were otherwise unremarkable. He was minimally responsive on interview and was felt to be catatonic and was transferred to the psychiatric emergency service (PES) in an adjoining part of the hospital. After transfer to the psychiatric inpatient service, a small amount of fresh blood was noted trickling down his neck prompting closer physical examination. A fresh, small puncture wound just above the hairline behind the ear was noted and he was promptly transferred back to the ED for management of a gunshot wound.

B is a 46-year-old female transferred from the ED to the PES. The transfer occurred at shift change with the triage nurse reporting that the patient was anxious, tachycardic, and had just walked over from the outpatient anxiety clinic. The nurse explained she had not done the triage and "all I know is we're busy and she's from the anxiety clinic so she's yours." On arrival, B was immediately recognized by the psychiatric inpatient service staff as a psychiatric nurse who worked at the anxiety clinic. She was returned to the ED for further management of her myocardial infarction.

C is a 26-year-old male with severe intellectual disability and communication is limited to a pidgin sign language. He is brought in by a community crisis team after

---

L.S. Zun, M.D., M.B.A. (✉)
Department of Emergency Medicine, Chicago Medical School/Sinai Health System,
Chicago, IL, USA
e-mail: leslie.zun@sinai.org

J.S. Rozel, M.D., M.S.L.
Western Psychiatric Institute and Clinic of University of Pittsburgh Medical Center, re:solve
Crisis Network, Pittsburgh, PA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_11

a neighbor called and complained that he was wandering around the neighborhood. A full physical examination is done and he is noted to be emaciated, disheveled, and has patterned bruises, scars, and cigarette burn marks on his body of varying ages. He tells the physician and social worker that he is afraid to go back home because his uncle hurts him. The social worker calls the local adult protective services office who state they can start an investigation “in a few days” as long as a police report has been started. The police are called and the responding officer dismisses the concerns “I know C, he’s not right in the head. He probably did it himself; don’t you know that’s what those crazies do?”

These examples highlight a variety of pitfalls in the care of people with mental health issues in ED settings. They are, in many ways, the tip of the iceberg. Patients awaiting psychiatric admission being boarded for hours, days, even months in emergency departments can be highly disruptive to operations at a major cost [1–3]. Demands by psychiatric services or hospitals for excessive, unnecessary diagnostic tests for “medical clearance” can escalate costs [4, 5]. Most concerning, the presence of a psychiatric diagnosis becomes, in and of itself, a risk factor for worse medical outcomes [6].

People with mental health issues including those with psychiatric and substance use disorders, dementias, and intellectual and developmental disorders commonly face special challenges because of their mental health conditions. These challenges arise from systematic issues and from stigma [7]. These factors impact emergency, inpatient and outpatient medical settings [8–10]. The impact of these barriers includes poor outcomes with elevated morbidity and mortality due to preventable causes, elevated costs of care due to overuse and underuse errors, and disruption of ED operations due to inadequate internal and external resources. Several examples of these barriers are discussed and evidence based interventions are identified.

Discussion

The reduction in inpatient psychiatric beds and lack of community mental health resources has had a significant effect on the ED. Studies have demonstrated that the emergency department has become the treatment facility for person with mental illness. Larkin’s 2005 study of ED usage reported 53 million mental health related visits to US ED’s annually. This number represented an increase from 4.9 to 6.3 % of all ED visits from 1992 to 2001. The most frequent diagnoses were substance-use disorders 22 %, mood disorders 17 % and anxiety related 16 %. More recent statewide analysis found that there was an increase of 5.1 % from 2008 to 2010, for a rise of mental health related chief complaints to 9.3 % of all ED visits. These patients are admitted at a rate of 31.1 %, which is 2.3 times greater than other types of admissions [11]. There is a similar pattern of high use in the pediatric population. One study found that 1.6 % of all ED patients in this age group presented with mental illness. The most frequent complaints were substance use disorder (24.2 %) and anxiety disorder (16.6 %) [12].

Stigma and Diagnostic Overshadowing

Stigma is a pattern of unfair and inaccurate beliefs about a class of persons. One of the cardinal dangers of stigma is diagnostic overshadowing: the misattribution of symptoms of physical illness to mental illness [13]. This may happen because a person is known to have a mental illness or because they are perceived to have a mental illness. Stigma in health care settings is driven by providers, including, vexingly, mental health professionals themselves [14]. Stigma from health professionals varies with the type of mental illness; overdose, alcohol and drug dependency and anorexia rate high on the list of stigmatized conditions [15]. One study found that psychiatrists had more negative attitudes and stereotypes than the general population for patients with schizophrenia and major depression [16]. Although there is a lack of studies that directly examine the attitudes of emergency providers to chronically mentally ill, it is reasonable to extrapolate from the psychiatric literature. Indirect studies of ED staff do identify stigma as a cause of diagnostic overshadowing within the emergency setting [13]. This stigma, in turn, adversely affects the providers and health system and even the patients themselves, in a phenomenon called self stigma. People with mental illness face perceptions of the need for secrecy, lower self-esteem, and shame and external fears of social exclusion, prejudice and discrimination [15].

Recent studies looking at stigma and diagnostic overshadowing in EDs have identified it as a significant issue. Freidman reviewed the negative and derogatory attitude of ED staff towards patients with mental illness. The author found unfavorable attitudes towards patients with substance use and overdose as well as a dislike for anorexic and borderline personality patients. Another study in the emergency setting found that the ED staff had unhelpful attitudes about patients with self-harm. Almost 80 % of the staff viewed these patients as attention seeking [17]. Emergency medicine professionals identify lack of knowledge and expertise in dealing with mental health issues as well as their personal attitudes as a factor. Patients also identified poor rapport and interaction with mental health services as an issue [18].

Diagnostic overshadowing in emergency departments is also identified as a major concern of patients and their families, along with wait times and attitudes of staff [19]. The attitude of staff can lead to worse outcomes. Suicidal behavior can elicit mostly negative feelings among staff members. In some studies, this attitude was a key determinate to whether the patient commits suicide. If these attitudes are not acknowledged and properly managed, they may lead to premature discharge [20].

Systematic Disparity

Disparity of care for the mental health patients is also a systems issue. It is thought that psychiatric patients are not treated "on par" with other patients seen in the ED [21]. This difference is reflected in how the patients are triaged, assessed, treated, and referred. Triage systems frequently do not properly assess the severity of patients with mental illness. Patients in psychiatric crisis are not given the same resources as are those who present with acute myocardial infarcts or cerebrovascular accidents. Psychiatric patients are rarely given medications that treat their underlying illness, especially when they board in the ED. In some locales, psychiatric patients are sent out of the ED without proper mental health referrals [22].

Inadequate Resources outside of the Medical Emergency Department

The present problem of overflow of psychiatric patients into the ED results from the "perfect storm" of the lack of inpatient beds, reduced outpatients services, limited number of mental health professionals and lesser number of crisis services. The lack of public funding and large number of underfunded and unfunded patients has intensified the problem. Diminished resources have led to a boarding problem in many EDs across the USA. More than 70 % of ED administrators report boarding of psychiatric patients for more than 24 h, with 10 % reporting that patients waited more than 1 week for an inpatient bed [23]. This has also produced situations in which patients are sent home without ever getting an appropriate mental health evaluation. A study from California found that 23 % of the ED patients were sent home without seeing a mental health professional due to a lack of resources [24]. The Joint Commission set a standard to address the problem of boarding with a focus on behavioral health patients, LD.04.03.11. The hospital manages the flow of patients with a particular focus on patients at risk for boarding due to behavioral health. The problem of boarding psychiatric patients in the ED led the Washington State Supreme Court to rule that this practice is illegal. However, they did not provide any resolution to this problem.

Medical Clearance

The medical clearance process is designed to determine if the patient has a medical problem that is causing or exacerbating the patient's presentation. An appropriate history, physical exam, mental status testing, and clinically indicated testing can differentiate medical from psychiatric illness. Unfortunately, the testing performed by emergency physicians may not meet the requirements of the psychiatrists. Studies have demonstrated that emergency physicians test based on clinical indications and psychiatrists tend to test based on routines. This creates a conflict between the physicians that may increase health care costs. The medical clearance process has been made more difficult by high rates of concurrent medical illness and substance use disorders amongst people with mental illness which also need appropriate assessment by emergency physicians.

Conclusions

Mental health patients commonly use emergency services. Their use of emergency services is impacted by limited clinical resources, overcrowding and boarding, stigma and disparity in care. There are a number of evidence based interventions that can reduce this impact and improve the quality of care of people with psychiatric illnesses.

Recommendations

Specialized Treatment Providers

When possible, specialized psychiatric emergency services should be utilized and, if possible, be located within or near the ED. When this is not possible, even a designated psychiatric clinician, nurse or other mental health professional integrated into the medical emergency department may be helpful [8]. One urban ED facing a surge in mental health volume with a psychiatric emergency service took the added step of embedding additional staff from a local crisis center in the ED with significant success [25].

Improved Physical Plant Design

While added space is always valuable, physical crowding in and of itself is a significant risk factor for escalation and violence that should be avoided when possible [16]. Separate areas for people with active mental health concerns that allow privacy and which maintain a calmer, less stimulating environment may be helpful [26]. Care should be taken to assure those areas have adequate staffing for observation of patients and should be reserved for those patients where the sole or primary concern is mental health without significant medical comorbidity.

Evidence Based Interventions for Agitation

Physical intervention for agitation, also known as "takedowns," constitutes one of the most dangerous events for patients and health care providers [27]. Project BETA, "Best Practices for the Evaluation and Treatment of Agitation," constitutes a set of guidelines for care of agitated people in emergency settings. These consensus guidelines, developed by the American Association of Emergency Psychiatry, cover assessment, verbal de-escalation, and medical management of agitation [28].

Evidence Based Assessment

Suicide attempts and completions following medical ED visits are frequent and may follow presentations for non-psychiatric concerns [29, 30]. Especially noteworthy is the finding that a large number of people evaluated for non-psychiatric issues will reveal significant suicidality, ideation in 8–11 % and intent in up to 2 %, if they are screened [31, 32]. There are a variety of evidence-based suicide screening tools useful for adults and adolescents in ED settings [31]. The Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) model has been developed by Substance Abuse and Mental Health Services Administration as a simple tool for screening for suicide risk [33–35].

Knowledge and Skill Development

Lack of knowledge and skills are identified by emergency medicine professionals as a source of frustration and cause of stigma and diagnostic overshadowing [13]. Educational interventions about mental health have been shown to be effective at decreasing stigma in multiple health care settings including emergency departments [36–38]. Training can encompass broad understanding of mental health issues, systems issues, stigma itself, and the use of person-first language in verbal and written communication [39]. This knowledge and training gap is even more significant as it relates to pediatric mental health [12].

Service User Involvement

The use of patient navigators, people who have undergone medical treatment for similar conditions, is increasingly common in medical settings; the analogy in mental health is the use of peer supports. Peer supports are people who are in recovery from a mental health or substance use disorder and use their experiences to help others. They are increasingly common in a variety of mental health settings including crisis centers and EDs [40]. Peers and patient advisors can also provide valuable insight in program development and physical plant design [40, 41]. Involving peers and family members in treatment delivery and program design can provide invaluable momentum in achieving person and family centered care [42]. Consumers, peers and family members are eager to collaborate with hospitals and emergency departments in the design and delivery of care [14, 43].

Public Policy Advocacy

Ultimately, many of the factors that impact the care of people with mental health issues in emergency settings are not under the control of the emergency department, the hospital, or the patients and their families. Public policy advocacy including collaboration with community stakeholders and efforts to influence state and federal policy, regulation, and legislation may be the only way to address many of these issues [44].

References

1. Slade PD, Dixon E, Semmel L, Sarah BA. Trends in the duration of emergency department visits, 2001–2006. Psychiatr Serv. 2010;61(9):878–84.
2. Chang G, Weiss AP, Orav EJ, et al. Hospital variability in emergency department length of stay for adult patients receiving psychiatric consultation: a prospective study. Ann Emerg Med. 2011;58(2):127–36.
3. Weiss AP, Chang G, Rauch SL, et al. Patient and practice-related determinants of emergency department length of stay for patients with psychiatric illness. Ann Emerg Med. 2012;60(2):162–71.e5.
4. Henneman PL, Mendoza R, Lewis RJ. Prospective evaluation of emergency department medical clearance. Ann Emerg Med. 1994;24(4):672–7.
5. Korn CS, Currier GW. Henderson SO: "medical clearance" of psychiatric patients without medical complaints in the Emergency Department. J Emerg Med. 2000;18(2):173–6.
6. Parks J, Svendsen D, Singer P, Foti ME, Mauer B. Morbidity and mortality in people with serious mental illness [Internet]. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council Alexandria, VA, USA; 2006. http://theempowermentcenter.net/Articles/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf. Accessed 25 Aug 2014.
7. Happell B, Scott D, Platania-Phung C. Perceptions of barriers to physical health care for people with serious mental illness: a review of the international literature. Issues Ment Health Nurs. 2012;33(11):752–61.
8. Emergency Nurses Association: Care of the psychiatric patient in the Emergency Department (White Paper) [Internet]. Emergency Nurses Association; 2013. http://www.ena.org/practice-research/research/Documents/WhitePaperCareofPsych.pdf. Accessed 25 Aug 2014.
9. Farley-Toombs C. The stigma of a psychiatric diagnosis: prevalence, implications and nursing interventions in clinical care settings. Crit Care Nurs Clin North Am. 2012;24(1):149–56.
10. Corrigan PW, Mittal D, Reaves CM, et al. Mental health stigma and primary health care decisions. Psychiatry Res. 2014;218(1–2):35–8.
11. Larkin GL, et al. US usage of ED for psychiatric illness. Psychiatr Serv. 2005;56:671–7.
12. Sills MR, Bland SD. Summary statistics for pediatric psychiatric visits to US emergency departments, 1993-1999. Pediatrics. 2002;110:1–5.
13. Jones S, Howard L, Thornicroft G. "Diagnostic overshadowing": worse physical health care for people with mental illness. Acta Psychiatr Scand. 2008;118(3):169–71.
14. Sartorius N. Iatrogenic stigma of mental illness. BMJ. 2002;324(7352):1470–1.
15. Byrne PL. Psychiatric stigma. Br J Psychiatry. 2001;178:281–4.
16. Nordt C, Rossler W, Lauber C. Attitudes of mental health professionals towards people with schizophrenia and major depression. Schizophr Bull. 2006;32:709–14.

17. Friedman T, et al. Predictors of A&E staff attitudes to self-harm patients who use self-laceration. Influence of previous training and experience. J Psychosom Res. 2006;60:273–7.
18. Van Nieuwenhuizen A, Henderson C, Kassam A, et al. Emergency department staff views and experiences on diagnostic overshadowing related to people with mental illness. Epidemiol Psychiatr Sci. 2013;22(03):255–62.
19. Clarke DE, Dusome D, Hughes L. Emergency department from the mental health client's perspective. Int J Ment Health Nurs. 2007;16(2):126–31.
20. Rossberg JI, Frills S. Staff members emotional reactions to aggressive and suicidal behavior of inpatients. Psychiatr Serv. 2003;54:1388–94.
21. Zun, Leslie S. An Issue of Equity of Care: Psychiatric Patients Must Be Treated 'on Par' with Medical Patients. American Journal of Psychiatry. (2014(7):716–1.
22. Zun LS. An issue of equity of care: psychiatric patients must be treated "On Par" with medical patients. Am J Psychiatry. 2014;171:716–9.
23. Schumaker Group: ED Administrators Schumaker Group: 2010 Survey Hospital Emergency Department Administrators. http://schumachergroup.com/_uploads/news/pdfs/ED%20Challenges%20and%20Trends%2012.14.10.pdf. Accessed 25 Sep 2014.
24. Baraff LJ, Janowicz N, Asarnow JR. Survey of California emergency departments about practices for management of suicidal patients and resources available for their care. Ann Emerg Med. 2006;48(4):452–8. Accessed 21 Aug 2014.
25. Management ED. Embedded crisis workers help to decompress ED, connect mental health and addiction medicine patients with needed resources. ED Manag. 2014;26(2):13–7.
26. Schneider SM, Gallery ME, Schafermeyer R, Zwemer FL. Emergency department crowding: a point in time. Ann Emerg Med. 2003;42(2):167–72.
27. Harris G, Rice M. Staff injuries sustained during altercations with psychiatric patients. J Interpers Violence. 1986;1:198–211.
28. Knox DK, Holloman GH. Use and avoidance of seclusion and restraint: consensus statement of the American association for emergency psychiatry project BETA seclusion and restraint workgroup. West J Emerg Med. 2012;13:35–40.
29. Gairin I, House A, Owens D. Attendance at the accident and emergency department in the year before suicide: retrospective study. Br J Psychiatry. 2003;183(1):28–33.
30. Crandall C, Fullerton-Gleason L, Aguero R, LaValley J. Subsequent suicide mortality among emergency department patients seen for suicidal behavior. Acad Emerg Med. 2006;13(4):435–42.
31. Claassen CA, Larkin GL. Occult suicidality in an emergency department population. Br J Psychiatry. 2005;186(4):352–3.
32. Ilgen MA, Walton MA, Cunningham RM, et al. Recent suicidal ideation among patients in an inner city emergency department. Suicide Life Threat Behav. 2009;39(5):508–17.
33. Horowitz L, Ballard E, Teach SJ. Feasibility of screening patients with nonpsychiatric complaints for suicide risk in a pediatric emergency department. Pediatr Emerg Care. 2010;26(11):787–92.
34. Berman AL, Silverman MM. Suicide risk assessment and risk formulation part II: suicide risk formulation and the determination of levels of risk. Suicide Life Threat Behav. 2014;44(4):432–43.
35. Corps HM. Combat and operational stress first aid: caregiver training manual. 2010. Available from: http://www.researchgate.net/publication/232735117_Combat_Operational_Stress_First_Aid_Manual/file/9fcfd5092a9a4b654a.pdf. Accessed 27 Aug 2014.
36. Kassam A, Glozier N, Leese M, Loughran J, Thornicroft G. A controlled trial of mental illness related stigma training for medical students. BMC Med Educ. 2011;11(1):51.
37. Magliano L, Read J, Sagliocchi A et al. "Social dangerousness and incurability in schizophrenia": results of an educational intervention for medical and psychology students. Psychiatry Res. http://www.sciencedirect.com/science/article/pii/S0165178114004818. Accessed 25 Aug 2014.

38. Stuhlmiller CM, Tolchard B, Thomas LJ, et al. Increasing confidence of emergency department staff in responding to mental health issues: an educational initiative. Australas Emerg Nurs J. 2004;7(1):9–17.
39. Blaska J. The power of language: speak and write using ‘person first’. In: Nagler M, editor. Perspectives on disability: text and readings on disability. vol. 2. Palo Alto, CA: Health Markets Research; 1993. p. 25–32.
40. Rozel J, Parham K. Peer Professionals benefit psychiatric care. Psych Advisor. 2014. http://www.psychiatryadvisor.com/peer-professionals-benefit-psychiatric-care/article/368458/. Accessed 21 Oct 2014.
41. Weinstein J. Mental health service user involvement and recovery. 1st ed. London: Jessica Kingsley Pub; 2009. 224 p.
42. Berwick DM. What “Patient-Centered” should mean: confessions of an extremist. Health Aff (Millwood). 2009;28(4):w555–65.
43. Iezzoni LI, Long-Bellil LM. Training physicians about caring for persons with disabilities: “nothing about us without us!”. Disabil Health J. 2012;5(3):136–9.
44. Stefan S. Emergency Department treatment of the psychiatric patient: policy issues and legal requirements. 1st ed. Oxford: Oxford University Press; 2006. 232 p.

Chapter 12
Disability and Access

Anne Beth Smith

Introduction

The term "disability" refers to difficulties encountered in any area of human function: impairments of specific body functions, challenges in executing particular movements that result in limitations to activity, and restrictions of participation in routine daily activities [1]. This chapter will focus specifically on the provision of quality care to the physically disabled. Physical disabilities are a broad group, and it is difficult to write recommendations that are appropriate for all types of disability. Furthermore, patients' experiences of having a disability and the severity of that disability vary widely [1].

Physical disability may be caused by medical illness (infectious diseases, or chronic non- communicable disease) or trauma. Worldwide, it is estimated that approximately 15 % of the population lives with some form of disability [1]. This number varies across countries and economic regions, and reporting a single disability prevalence rate worldwide is very difficult [2]. Different definitions, survey methodologies and grading systems affect the results reported from individual countries. Most questionnaires or grading systems use measures of individual impairments, e.g., sight, mobility, hearing. This simplifies the concept of disability, which is a complex interaction of physical condition, social environment, and psychological response to people and events [1]. Globally, those made vulnerable by disabilities are at higher risk for poor education, unemployment, abuse and discrimination. Infectious diseases are a significant cause for disability in low and middle income countries—HIV/AIDS, malaria and trachoma causing the most disability and physical impairment [3]. Rare diseases like polio and leprosy still occur in some low-income countries and may cause significant physical disability.

A.B. Smith, M.B.Ch.B., F.C.E.M.(S.A.) (✉)
Emergency Centre, George Regional Hospital, George, South Africa
e-mail: annebsmith@gmail.com

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_12

Non-communicable chronic diseases, including diabetes, cardiovascular disease and cancer, account for an increasing proportion of disability worldwide. An aging global population and changes in lifestyle related to diet, alcohol, and physical activity have contributed to this change [3]. Road traffic accidents, occupational injury, interpersonal violence and humanitarian crises and wars constitute the remainder of causes of physical disability [3].

Those with disabilities face challenges both with their healthcare needs and their activities of daily living. Poverty is a known risk factor for disability and those in developing countries face an added burden of environmental factors, where lack of sanitation or access to immunisations independently increases the risk [3]. Healthcare expenses are higher for those with disabilities, placing strain on already scarce resources [3]. Building and home infrastructure may be unsuitable for access for disabled people, even if they do have assistive mobility devices [4]. There is a lack of accurate, quantitative research on those with disabilities in low and middle income countries. Those in developed countries face other challenges—while they may have health services that support their needs, they are more likely to stop working or have lower incomes than their non-disabled colleagues [3]. Discrimination and negative attitudes towards the disabled are universal, both from medical personnel and the general public.

Mobility and access are challenges for both developing and developed countries. In low or middle income countries, there may not be resources to fund assistive devices like wheelchairs or walking frames. Only an estimated 5–15 % of disabled people in developing nations have access to assistive mobility devices. The infrastructure of residential and commercial buildings in many developing nations is not conducive to access for disabled people, particularly those living in poverty or informal housing [4]. In developed countries where these devices are more likely to be available, if wheelchair ramps or wide door entrances are not in place, the disabled may be left without access.

Physical disability brings with it unique medical and psychosocial healthcare needs. Quality care involves effectiveness, safety, timeliness, equity, patient centredness, and efficiency [5]. In the context of these principles, this chapter will define quality care for patients with physical disability.

Discussion

The physically disabled may present to emergency departments for a number of reasons: their visit may involve an injury or medical condition that is the cause for their newly diagnosed disability; they may have a new medical problem related or unrelated to the disability; or they may have a problem which requires a primary care practitioner but do not have a “regular” doctor. In any event, the emergency department (ED) staff need the necessary skill set to assess and treat the physically disabled person with appropriate dignity and medical skill.

Infrastructure and equipment should be suitable for those with impaired mobility or using assistive devices. Doors and bathrooms should be wheelchair accessible, and additional hand railings and large flush handles and taps should be available [6]. Staff should be available to assist the physically disabled to mobilize when they need to, and to assist with specific tasks if help is required. Those who are hard-of-hearing should be offered written alternatives of information or questions, and signage should be clear and in large print with good colour contrast, to enable the partially sighted to find their way around. Brightly coloured or contrasting coloured floor tiles or coverings should be employed to clearly demarcate areas for the partially sighted [6]. Floors should be non-slip and have no raised joins or seams [6]. If required, an escort or family member who may assist with translation and movement around the department should accompany the patient. Those with indwelling catheters or stoma bags should have access to the appropriate care for these items.

The internationally accepted symbol of accessibility (usually a line drawing of a person in a wheelchair within a square) should be clearly displayed at all entrances/ramps/toilets specifically designed for wheelchair or other device accessibility. Corridors, bathrooms and rooms should be wide enough to allow wheelchairs to pass through and to turn around. Ramps at entrances should be clearly marked for wheelchair access and should have adequate hand railings for grip [6].

In acute illness or injury that may cause disability, appropriate emergency management and early referral to the appropriate inpatient specialty are essential. In the case of medical illness causing disability (for example stroke or acute myocardial infarction), early and aggressive supportive and resuscitative management should be instituted to prevent morbidity and mortality [7, 8]. Simple "ABC" measures like appropriate fluid administration, airway management and invasive/non invasive ventilator support will prevent further deterioration before admission. In the case of injuries, whether from large road traffic accidents, or smaller interpersonal violence incidents, a structured approach of a primary survey, followed by a comprehensive secondary survey is required. Early wound closure, sufficient fluid management, aseptic technique and appropriate use of blood products, along with early operative interventions if required will prevent complications that may cause or worsen disability [9, 10]. Neurovascular examinations should be meticulous and documented clearly, particularly if any local anaesthetic or sedative agents are to be given. The patient and/or family should be counselled honestly regarding the illness or injury, and the potential outcomes and prognosis. The acute phase of the disease marks the beginning of a massive transition from "normal" to "disabled" for many people, and a compassionate and informative approach at this stage may help ease the transition. Early involvement of a multidisciplinary team, and the individualised rehabilitation plans should be employed [11].

Patients with a known disability may present with a medical condition as a result of their disabled state. Poorly mobile patients or immobile patients are at increased risk for pneumonia, thrombo-embolic disease and decubitus ulcers [12]. Indwelling lines and catheters are an infection risk, and those patients who are living in care institutions are at risk for nosocomial infections [13]. Many patients (or their families), particularly after years of living with a disability, will have a good understanding of the functional baseline and should be able to give a good history of their medical illnesses. As with any patient, a thorough history and examination are essential, but particular attention should be paid to the long term care and psychosocial aspects of the disabled patient [14].

The professional caregivers and family members of physically disabled patients, particularly those with a severe disability who are care dependent, should also be consulted as carer compassion fatigue is a very real concern and may negatively affect the patients' care. Compassion fatigue may negatively affect the relationship between the carer and the patient, and cause feelings of depression, hopelessness and anger in the carer. Healthcare providers should be particularly vigilant with carers or family members of the severely disabled (require full nursing care), and those who have an associated mental disability or behavioural disturbance. These patients and their carers should be referred to social services to ensure that sufficient social support is in place for them. Respite care may be offered in the form of planned short term admissions into care facilities [15, 16].

Long term care plans and primary health provision should be reassessed at every contact with healthcare, including in the ED. Those with disabilities express greater dissatisfaction with healthcare, particularly those without independent medical insurance. There is also reduced use of preventative healthcare provisions in those with a physical disability [17]. In low or middle income countries, or developing nations, creative plans will have to be made to better accommodate the physically disabled, especially if assistive devices such as mobility scooters or even wheelchairs are not available. Realistic treatment goals and the disease progression and prognosis should be addressed at every contact with healthcare providers. Treatment goals and decision making should be patient centred. The benefits of diet, appropriate weight loss and exercise programmes should be emphasised to the disabled patient, as all of these will improve mobility and overall outcome, as well as having the additional mortality benefits [18].

A multidisciplinary team approach is required for the long term quality care of patients with physical disabilities. A primary care physician or general practitioner will act as the first contact point in the healthcare system, as well as a referral point for further specialist care. A good relationship between the primary care physician and the disabled patient will increase overall health seeking behaviour and patient satisfaction.

Conclusion

Physically disabled people are prevalent in every society in every nation. The cause of the disability may vary according to disease patterns and standard of living; however, the challenges faced by those with a physical disability are similar challenges worldwide. Emergency departments are often the first point of contact with the healthcare system, either as a first presentation with the disease causing the disability, or with a complication arising from it. Quality care in the ED involves both treatment and counselling for acute illness or injury that may result in disability, as well as recognition of the concomitant complications. The infrastructure and equipment in EDs should accommodate those with a physical disability. The psychosocial aspects of disability should not be ignored, but rather ought to be a priority at every visit. Physically disabled people should, as far as possible, be encouraged to function in mainstream work, school and living settings. Assistive devices, working animals and technology are all options to improve function and assist with activities of daily living.

Recommendations

- To ensure quality care in the emergency department, staff should be trained and able to not only manage the physical or medical complaints of disabled people, but to address psychosocial and support systems too.
- Emergency departments should be designed to have barrier free access for the physical disabled, ensuring the infrastructure is both safe and accessible for those with physical disabilities.
- Patients who present with acute injuries or illnesses that may lead to disability in the long term should have appropriate emergency care in the ED. Early referral and admission to the relevant inpatient team are required. Honest and clear communication regarding the potential disability and prognosis should be given to the patient.
- Medical staff should be aware of specific medical risks that present with long term physical disability, particularly for patients who live in a care facility or those with indwelling catheters and feeding tubes.
- Long term care should be reassessed at every visit and multidisciplinary teams involved throughout the care process to ensure that the patient receives an individualised approach to their rehabilitation and reintegration in to “normal” life.

References

1. World report on disability. Geneva: World Health Organization; 2011. Chapter 1. Available at: http://www.who.int/disabilities/world_report/2011/en/
2. Mont D. Measuring disability prevalence. World Bank; 2007. Available at www.siteresources.worldbank.org/DISABILITY/Resources/Data/MontPrevalence.pdf
3. World report on disability. Geneva: World Health Organization; 2011. Chapter 2. Available at http://www.who.int/disabilities/world_report/2011/en/
4. Joint position paper of mobility devices in less resourced settings. Geneva: World Health organization; 2011. Available at: http://www.who.int/disabilities/technology/en/
5. Institute of Medicine. Medicare: a strategy for quality assurance, vol. 1. Washington, DC: National Academy Press; 1990.
6. Accessibility for the disabled: a design manual for a barrier free environment. United Nations Economic and Social Commission for West Asia. Department of economic and Social Affairs. Available at: http://www.un.org/esa/socdev/enable/designm/AD3-01.htm

7. Adams Jr HP, de Zoppo G, Alberts MJ, Bhatt DL, Brass L, Furlan A, et al. Guidelines for the early management of adults with ischemic stroke: a guideline from the American Heart Association/American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research interdisciplinary working groups: The American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists. Circulation. 2007;115(20):e478–534.
8. Rodriguez R, Gene HH. An approach to critically ill patients. West J Med. 2011;175:392–5.
9. American College of Surgeons. Advanced trauma life support program of physicians. 9th ed. Chicago: American College of Surgeons; 2012.
10. Murphy TSVP, Bhatia P, Sandhu K, Prabhakar T, Gogna RL. Secondary brain injury: prevention and intensive care management. Indian J Neurotrauma. 2005;2:7–12.
11. Clarke DJ. The role of multidisciplinary team care in stroke rehabilitation. Prog Neurol Psychiatry. 2013;17:5–9.
12. Marx JA, editor. Rosen's emergency medicine: concepts and clinical practice. 7th ed. Philadelphia: Mosby Elsevier; 2010. Chapters 74, 86.
13. Hughes RG, editor. Patient safety and quality: an evidence-based handbook for nurses. (Prepared with support from the Robert Wood Johnson Foundation). Chapter 42. AHRQ Publication No. 08–0043. Rockville, MD: Agency for Healthcare Research and Quality; 2008.
14. Hannah SD. Psychosocial issues after a traumatic hand injury: facilitating adjustment. J Hand Ther. 2011;24(2):95–103.
15. Bendroth M. Overview and summary: compassion fatigue: caregivers at risk. Online J Issues Nurs. 2011;16(1): Overview and Summary.
16. Mahoney MS, Hyland CM, Twomey C. Regular planned respite admissions to a geriatric unit. Ir Med J. 1990;83(3):102–4.
17. Hoffman JM, Shumway-Cook A, Yorkston KM, Ciol MA, Dudgeon BJ, Chan L. Association of mobility limitations with health care satisfaction and use of preventative care: a survey of medicare beneficiaries. Arch Phys Med Rehabil. 2007;88:583–8.
18. Cooper RA, Quatrano LA, Axelson PW, Harlan W, Stineman M, Franklin B, et al. Research on physical activity and health among people with disabilities: a consensus statement. J Rehabil Res Dev. 1999;35(1):142–54.

Chapter 13
Racial and Ethnic Disparities in the Emergency Department: A Public Health Perspective

Edward Stettner, Leon L. Haley Jr., and Sheryl L. Heron

Introduction

The state of health care delivery seems to be filled with challenges, ranging from concerns about rising health care costs, to medical errors and patient safety and the numbers of uninsured and underinsured Americans. While the recently introduced Affordable Care Act (ACA) seeks to address many of these concerns, its impact on reducing the number of uninsured is just now being seen, while its impact on quality and patient safety remains unknown. To further complicate matters, the issue of racial and ethnic disparities in health care not only continues to exist in our delivery models, but in many domains also has seemingly worsened. According to the Institute of Medicine (IOM), despite years of attention to these disparities and improvements in overall health care, the racial gap in American's health remains, and in some areas continues to widen [1].

Both the general medical literature as well as literature specific to emergency medicine is replete with examples of racial and ethnic disparities showing differential utilization in areas of cardiology, disease prevention, pain management and "gatekeeping" activities; many of these will be discussed in detail throughout this chapter. African-Americans die from nearly every major disease or cause at rates higher than whites; the top three causes of death in the USA are the same for blacks and whites, but the rates of death for black people are strikingly higher: heart disease (20 %), cancer (16 %), and stroke (47 %) [2, 3].

Further, minorities and non-English speakers have greater difficulties accessing health care services. Minorities are disproportionately more likely than the general population to be uninsured, and are overrepresented among those in

---

E. Stettner, M.D. • L.L. Haley Jr., M.D., M.H.S.A., C.P.E. • S.L. Heron, M.D., M.P.H. (✉)
Department of Emergency Medicine, Emory University School of Medicine and Grady Memorial Hospital, Atlanta, GA, USA
e-mail: sheron@emory.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_13

publically funded health systems; even when individuals have the same health insurance and similar access to providers as non-minorities, research shows that racial and ethnic minorities tend to receive a lower quality of health care than white patients [4].

This chapter will discuss these disparities from a public health perspective; specifically why these racial and ethnic disparities threaten to impede the efforts to improve the nation's health. We will: (1) provide background information, including a review of the Institute Of Medicine (IOM) report on health care disparities and public health implications; (2) describe the racial and ethnic compositions of individuals in the ED setting from the perspective of both the patient and health care provider; (3) discuss the most prevalent disease presentations to the ED that are likely to have racial and ethnic disparities; and (4) give conclusions and general recommendations on how to address disparities in emergency health care.

The Evidence: The IOM Report

In 2002, in response to a mandate from Congress, the IOM published a landmark analysis of health disparities in the USA. Focusing on disparities rather than health outcomes, the IOM reviewed over 600 papers on health disparity, and even when controlling for confounders including insurance status, access to care and disease severity, found overwhelming evidence that minorities were less likely than whites to receive needed services, including clinically necessary procedures [5]. In general, this research showed the following:

- African-Americans and Hispanics tend to receive a lower quality of care across a range of disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, mental health and other chronic and infectious diseases.
- African-Americans are more likely than whites to receive less desirable services such as amputation of all or part of a limb.
- Disparities are found across a range of clinical settings including public and private hospitals, teaching and non-teaching hospitals.
- Disparities are associated with higher mortality among minorities who do not receive the same services as whites (e.g., surgical treatment for small-cell lung cancer) [6].
- Specific coverage of emergency medicine (EM), as reported by Cone et al., is minimal [7]. There is brief discussion of the Emergency Medical Treatment and Active Labor Act (EMTALA) in a chapter on patient and system-level factors that contribute to racial and ethnic disparities. Discussion on the study by Lowe et al. has found that, after controlling for age, gender, time of day, type of managed care organization and triage score, African-Americans were approximately 1.5 times more likely than whites to be denied insurance authorization for their ED visit [8].

Potential Sources of Racial and Ethnic Disparities

The IOM report notes that many sources—including those related to characteristics of patients, health systems and the clinical encounter—may contribute to racial and ethnic disparities in care [5].

Some researchers speculate that there may be subtle differences in the way that members in different racial and ethnic groups respond to treatment, particularly with regard to some pharmaceutical interventions. For example, when taking warfarin for anticoagulation, blacks tend to require higher dosing than other ethnic groups, with Asians requiring the lowest dose [9]. Others have theorized that minority patients may receive a lower quality of care because of differences in health-seeking behaviors. As such, minority patients are more likely to refuse recommended services and delay seeking health care. These behaviors can develop as a result of a poor cultural match between patient and provider that in turn may lead to mistrust, misunderstanding of provider instructions, poor interactions with the health care system and inadequate access. A small group of studies have found that African-Americans are slightly more likely (approximately 3–6 %) to reject medical recommendations, but these small refusal rates do not explain the differences [5]. More research is needed to understand the reasons behind these refusals and, if explained, the different strategies for helping patients to make informed decisions.

The IOM study considered other causation factors that may be associated with health care disparities. Limitations in the operation of the health care system as well as legal and regulatory challenges may contribute. These include [5]:

- Cultural and/or linguistic barriers (e.g., the lack of interpretation services).
- Fragmentation of the health care system.
- Factors related to minorities being disproportionately enrolled in lower-cost health plans where the demands on service utilization are controlled.
- Where minorities receive care (less likely to seek access in a private physician's office even when insured at the same level as whites).

The other additional factor is related to the clinical encounter itself. According to the IOM, three mechanisms might be operative in health care disparities from the provider's side of the exchange [5]:

- Bias or prejudice against minorities.
- Greater clinical uncertainty when interacting with minority patients.
- Beliefs or stereotypes held by the provider about the behavior or health of minorities.

As we will discuss, there is ample evidence that ethnic differences result in disparate care, but studies examining the reasons for this difference are scant and still developing. As of yet, there is no direct evidence how and why prejudice, stereotypes and bias influence care. There is a large body of social psychology research that demonstrates that stereotyping is an almost universal human cognitive function and, conscious or not, impacts the perception, interpretation and retrieval of information [10].

With these factors in mind, the role of the Emergency Medicine health care professional is significant as racial and ethnic communities seek health care in the ED. There is literature to suggest that an increase in the size of vulnerable populations served by EDs, such as ethnic minorities, the poor and the working poor, is an important contributor to increases in ED visits [11, 12]. As a result, emergency department patients are especially vulnerable to the impact of disparities in care. Evidence of disparate emergency medical care has been well documented in the literature, and we will discuss several of these areas below.

The IOM report clearly notes patient, provider and system level factors, beyond access-related issues, which may contribute to racial and ethnic health care disparities. This section of the report highlights ways in which health disparities can occur among various demographic groups in the USA, particularly as they relate to the aforementioned individual patient risk factors, such as lower socioeconomic status, environmental risks in minority communities and health-related cultural beliefs of the patient and the health care provider [13]. In the following section of this chapter, we will also examine the recommended strategy of workforce diversity, particularly as it relates to physician characteristics and related factors within the patient–physician dyad. The public health model of defining the problem, identifying the risk and protective factors, creating interventions and evaluating the effect of these interventions will be examined in the context of what the literature notes on health care disparities stated above.

Individual Factors: Lower Socioeconomic Factors

Health disparities have been linked to socioeconomic status (SES). Lillie-Blanton and colleagues noted that minority patients were less likely than white patients to receive medical care from private physicians and less likely to have a primary care provider [11]. In the Emergency Medicine Patients Access to Healthcare Study (EMPATH), investigators noted that minority patients were more likely to access the ED for their general health care than white patients, and reported financial reasons for seeking care in EDs [12]. This behavior was also noted in a study of acute asthma among adults presenting to the ED, where ED management were similar for all racial groups but SES accounted for most of the observed acute asthma differences [14].

SES is also linked to insurance status. Racial and ethnic minorities are less likely than white Americans to have health insurance, which is the most significant barrier to health care. African-Americans are less likely to have private or employment-based health insurance compared to white Americans and are more likely to have Medicaid or other publicly funded insurance. Native Americans, Alaska natives, Asian Americans, and Pacific Islanders also have a disproportionately high rate of uninsurance [15]. It is clear that lower SES and lack of insurance in ethnically diverse communities are a significant barrier to health care access. As a result, many of these disadvantaged groups turn to the ED for health care. Despite these findings and the need for African-Americans to seek care in the ED, Lowe et al. noted that African-American patients enrolled in managed care organizations (MCOs) were more likely than whites to be denied authorization for emergency department (ED) care [8].

Health-Related Beliefs of the Health Professional and the Patient

Health care professionals are held to the highest professional standards and ethics, which ideally should prevent disparities in how health care is rendered in the physician–patient encounter. Van Ryn's work supports the idea that physicians' perceptions of patients were influenced by patients' sociodemographic characteristics; specifically, physicians in her study tended to perceive African-Americans and members of low SES groups more negatively on a number of dimensions than they perceived whites or members of the middle and highest third of SES. Among her findings, SES correlated with physicians' perceptions of patients' personality, abilities, behavioral tendencies, and role demands, while race was found to impact assessment of patient intelligence, feelings of affiliation toward the patient, and beliefs about patient's likelihood of complying with medical advice [16]. Clinical uncertainty, provider beliefs and stereotypes, and patient mistrust of the health care system are cited in the literature as important factors contributing to disparate treatment. The theory of uncertainty implies that a physician's vagueness in understanding and interpreting information from patients may contribute to disparities in care and can lead to minority patients getting either more or less care than white patients [5, 17].

Workforce Environment and Diversity

The physician–patient dyad has been based on the common belief of trusting one's doctor, yet many workforce factors may play a role in differences in the delivery of medical care. Burgess et al. stated that stereotyping and bias is not simply a product of the individual provider but is caused by features of the health care setting that decrease cognitive capacity, features such as fatigue, overload, and time pressure. Moreover, these conditions have been shown to be more prevalent in settings that predominantly treat minority patients [18]. This is particularly noteworthy given the ED setting where fatigue, overload and time pressure are natural parts of the work.

Also impacting the physician–patient relationship is the demographics of both parties. A number of studies have demonstrated increased patient trust and more appropriate medical recommendations in race concordant rather than discordant encounters, where patients felt more satisfied with their health care when treated by a physician of the same race [19, 20]. In cases of language differences, this is even more evident. Language barriers and lack of interpreter services impede health care delivery in the ED setting. Bernstein and colleagues noted that use of trained interpreters can increase clinic utilization, decrease 30-day total and ED return charges, and reduce disparities between English-speaking patients and non-English non-interpreted patients in a number of services at the index ED visit [21].

The Evidence: Literature Related to Care in the ED

The IOM report was a landmark publication in that it was the first large-scale government-sponsored examination of racial and ethnic disparity in health care. As mentioned earlier, however, coverage of emergency medicine in this report is scant. While this was due in part to the relative paucity of academic research in this area at the time of the report's publication, more recent literature focusing on emergency care sheds light on this issue. While a complete review of the breadth of literature on health care disparities is beyond the scope of this chapter, we will address some of the most significant research in areas relevant to emergency medicine.

General Medical Care

The impetus to examine disparity in the ED stems from the overwhelming evidence on inequality in health care in general, where studies examining the provision of general medical care have identified dramatic differences. A 1994 comparison of care provided to nearly 10,000 Medicare beneficiaries (including ordering of diagnostic studies such as serum chemistries and chest x-rays as well as the provision of therapies including diuretics and antibiotics) demonstrated significant deficiencies in the treatment of black patients [22]. An even larger study published in 1997 compared the provision of major therapeutic and diagnostic procedures in 77 disease categories among 1.7 million hospital encounters. African-American patients were significantly less likely than whites to receive a major therapeutic procedure in nearly half of these categories [22]. Other researchers have demonstrated similar disparities with Hispanic patients. These studies provide a glimpse into the widespread and deeply ingrained problem of health care disparity.

Chest Pain and Acute Coronary Syndrome

The past 15 years has seen a marked increase in the number of papers examining disparity in cardiac care. Recent studies of patient presenting to the ED with chest pain have demonstrated both significantly lower utilization of diagnostic tests including EKGs and chest x-rays as well as cardiac enzymes and telemetry monitors in addition to delays in obtaining these studies for non-white patients [23–25]. These differences in care persist in patients suspected of, or diagnosed with, acute coronary syndromes (ACS) and acute myocardial infarction (AMI). Studies have shown that non-white patients are significantly less likely to undergo cardiac stress testing, receive reperfusion therapies including cardiac catheterizations, and be treated with newer evidence-based medications [26–28]. In patients who do receive thrombolytics or percutaneous coronary intervention, door-to-therapy times are significantly longer for African-American, Hispanic, and Asian patients [28].

There is some evidence to suggest that these treatment disparities can be partially attributed to care variation between participating hospitals, rather than within each of the individual sites. However, even with multivariate analysis to factor out this effect, the study still reported that minority groups received substandard care [28]. It is vital to recognize that this inter-hospital variability itself is an example of race-related disparity, as hospitals with poorer performance tended to treat a preponderance of African-Americans, Hispanics, and Asians. This type of systematic race disparity occurs throughout society, and is emblematic of the inherent class differences in American society.

Interestingly, there is evidence that this racial inequality can be overcome. An examination of nearly 1500 AMI patients within the equal-access, government-subsidized Department of Defense health care system demonstrated no race-based variability in the rate of immediate revascularization procedures [29]. This single-payer system provides guaranteed care to active and retired military, as well as their family members. The fact that a closed system that ensures equal access to care is able to overcome disparities seen in almost every other health care system demonstrates that these problems are not insurmountable. The design of this health care system where there is no disparity in access or management guidelines could help guide modifications to bridge the racial gap in cardiac care.

Trauma

There is a small but growing body of literature addressing disparities in ED care of the trauma patient. In the broader trauma literature, however, a number of examples are evident. From pre-hospital mortality rates to ED evaluation to post-injury recovery, trauma care is fraught with examples of the health care race gap.

Motor vehicle collisions (MVCs) are one of the leading causes of death, especially in individuals younger than 34 years of age. While in the past three decades there has been a steady decline in MVC-related fatalities, minorities and those of lower socioeconomic status bear a disproportionate burden of MVC deaths. A 2003 study examining nearly 16,000 MVC related fatalities found increased risk of death for both Hispanic and black patients, though this affect was ameliorated for Hispanics when accounting for socioeconomic status [30]. In addition to identifying factors including educating level and alcohol use, this paper proposes much needed changes in public health outreach and education to bridge these gaps.

More recent studies continue to find significant disparities in trauma mortality in patients of all ages. A 2010 analysis of neatly 17,000 pediatric trauma patients found a markedly higher risk of mortality for both black and Hispanics, and identified self-pay (i.e., uninsured) status as the greatest contributor to the mortality gap [31]. As with other areas of medical care, there is concern that some of this difference may be directly related to the quality of hospitals accessible to minority and socioeconomically disadvantaged patients. Of over 190,000 patients admitted to a trauma center in Pennsylvania between 2000 and 2009, patients admitted to hospitals that treated a higher concentration of blacks (>20 %) had a 45 % higher odds of death and a nearly 75 % higher chance of death or major complication than those treated in hospitals with fewer minority admissions. Interestingly, blacks and whites admitted to the same hospitals experienced no difference in either death or major complications within individual institutions [32]. This finding is important because not only does it give further evidence of systematized disparity within a health system, but shows that differences can be overcome through standardization of care.

Cerebrovascular Accident

The prevalence of stroke in the African-American and Hispanic populations is well documented. African-Americans and Hispanics have a higher stroke frequency, higher mortality rate, and larger incidence of risk factors including diabetes and hypertension [33]. Literature examining this disparity, however, is scant. Early studies found a significantly lower rate of administration of tissue-type plasminogen activator (tPA) to non-white stroke patients, but more recent literature has identified delays in time to hospital arrival as the single-most important factor in this difference.

For patients who were evaluated within the recommended time window for treatment, this disparity essentially disappeared [34, 35]. This provides yet another of both the inherent bias in a system of unequal access and the promise of standardized care as a way to bridge the care gap.

Asthma

It is well-established that not only do African-Americans and Hispanics have a greater incidence of asthma, but they also have more severe symptoms, are more frequently hospitalized, and often receive substandard outpatient care [14, 36]. Recent investigations have sought to establish whether similar disparities exist within the ED.

A review of more than 1800 adult patients enrolled in the Multicenter Airway Research Collaboration (MARC) study examined whether racial or ethnic differences existed in the presentation and management of patients in the ED. The results were mixed. The investigators found that, while African-American and Hispanic patients presented with more severe respiratory symptoms and a history of more severe disease than did whites, the ED treatment they received was similar, and discharge rates were not statistically different. The disparity in asthma severity was largely eliminated through multivariate analysis for socioeconomic status [14].

A second study by the same investigators found similar results for children with asthma presenting to the ED. A proportionally lower use of inhaled corticosteroids was found in minority populations, which likely contributed to their more severe symptoms [37].

Despite what appears to be "less of a treatment gap for asthma, there remain significant differences in prevalence, symptoms severity and outcome for patients from differing ethnic groups. In an analysis of asthma cases between 1996 and 2007, the highest prevalence, ED visit rate, and death rates occurred in blacks when compared to other racial groups. Interestingly, despite a substantially lower diagnosis rate, Hispanics too required more ED visits and had a proportionally higher incidence of deaths than whites [38]. Socioeconomic status, barriers to care, and genetic as well as environmental factors were all identified as contributing to these findings, and the authors posited that culture-specific education and outreach can be effective in offsetting these areas.

Pain Control

There is a fairly substantial body of literature documenting disparate analgesic usage in the ED. In 1993, a retrospective cohort study compared analgesic use in Hispanic and non-Hispanic whites with isolated long-bone fractures. After controlling for multiple variables including injury severity, the investigators found that Hispanics were twice as likely as non-Hispanic whites to receive no analgesic in the ED [39]. A follow-up study utilizing a visual analog scale of perceived pain found no significant difference in either patient or physician estimates of pain severity with a similar degree of disparity between patient and physician estimates for whites and Hispanics [40]. The authors concluded that physician capacity for assessing pain severity was similar for each ethnic group, and therefore could not account for their early finding of disparate analgesic use. And an additional study by the same primary investigator, and found that African-Americans with long bone fractures were much less likely to receive analgesia in the ED [41]. Again, none of the study's covariates could account for this discrepancy.

Two other studies merit consideration, as they analyzed analgesic prescription for a variety of conditions, including long-bone fractures, acute non-traumatic back pain, and migraine headache. The first presented volunteer physicians with a variety of scripted clinical vignettes using African-American, Hispanic, or white patients presenting with migraine headache, back pain, or ankle fracture. The authors report no race or ethnicity-related difference in frequency of opioid prescription, but did find that "socially desirable" characteristics (i.e., a "high prestige occupation and a strong relationship with a primary care provider") were associated with increased rates of narcotic use [42]. The authors admit, however, that as their study was conducted on volunteer physicians in a non-medical setting, their results may not translate into clinical practice. A study published that same year examined analgesic prescription rates among Hispanic, African-American, and white patients with migraine headache, back pain, and isolated long-bone fractures. While rates of analgesia were similar for all three groups with extremity fractures, whites were more likely than both African-Americans and Hispanics to receive pain control for headache and back pain [43]. Perhaps the similar results in pain control for long-bone fractures indicate heightened awareness of the need for analgesia in the ED, but clearly, areas of racial disparity remain.

Other Studies and Future Directions

A few other studies have been published indicating disparity in other areas of ED care. An observational analysis of a full-year sample of pediatric appendicitis cases in California and New York demonstrated significantly increased rupture rates in Hispanic, Asian, and African-American children, with some geographic variability [44]. A chart review of 1.2 million adolescent ED visits for sexually transmitted diseases demonstrated that, not only are males more likely to be treated than females, but that Hispanic patients were particularly at risk for undertreatment [45].

These studies clearly demonstrate that racial and ethnic health care disparity exists within the ED. Many of these areas remain inadequately studied and there are other areas the literature has yet to address. Further examination of these and other disease presentations are needed to further explore areas of ethnic and racial inequality in ED care.

General Recommendations

Our research demonstrates a need to increase awareness of racial and ethnic disparities in health care among the general public and key stakeholders, and to increase health care providers' awareness of disparities. Despite EM's philosophical, historical, and legislative mandate to care for all who present to the ED regardless of racial or ethnic background, we are not immune to these problems.

Legal, Regulatory, and Policy Recommendations

There are a number of important public policy steps that should be taken to eliminate racial and ethnic disparities. Among these steps, we need to (1) avoid fragmentation of health plans along socioeconomic lines, and take measures to strengthen the stability of patient–provider relationships in publicly funded health plans; (2) increase the proportion of underrepresented US racial and ethnic minorities among health professionals; (3) apply the same managed care protections to publicly funded HMO enrollees that apply to private HMO enrollees; and (4) provide greater resources to the US Department of Health and Human Services Office of Civil Rights to enforce civil rights laws [5].

Health System Interventions

From a health systems perspective, there are a number of important potential interventions. These include: (1) promoting the consistency and equity of care through the use of evidence-based guidelines; (2) structuring payment systems to ensure an adequate supply of services to minority patients, and limit provider incentives that may promote disparities; (3) enhancing patient–provider communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice; and (4) promoting the use of interpretation services where community need exists. The use of community health workers and multidisciplinary treatment and preventive care teams should also be supported [5].

Education

Educational interventions are as important as health system and public policy interventions. We need to implement patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions. Emergency medicine literature also supports integrating cross-cultural education into the training of all current and future health professionals as well as diversifying the medical and emergency medicine workforce [46–48].

As Jordan Cohen, president of the Association of American Medical Colleges, stated in a 2003 article in *Academic Emergency Medicine*, “There must be a diverse medical student and faculty group in order for students to live and work and experience the diversity that is critical for developing the sensibilities that we call cultural competence. That is an important element in reducing disparities in healthcare over time” [49].

Minorities are underrepresented in academic emergency medicine compared to other specialties, and their status lags behind that of white academic EM physicians. Therefore, academic departments of emergency medicine must identify strategies to facilitate the recruitment, retention, and promotion of minority faculty [50]. As stated in the literature, efforts to recruit minorities and to eliminate disparities in health care require strong leadership [49].

Conclusion

Disparities in medical care in the emergency medical arena require our continued attention and concerted efforts if we are to reduce disparate health care outcomes of the patients we serve. Emergency Medicine literature examining the issue is the first step toward finding solutions. The next step would be in improved data collection, such as targeting methodological issues (i.e., study design that incorporates within-group comparisons of subgroups within the Hispanic or Asian population) and controlling for confounders. This methodology is a fundamental requirement for producing high-quality research on disparities [51]. Richards and Lowe aptly note that Emergency Medicine has a different lens from other medical specialties, in that ED professionals care for all comers and are therefore more apt to respond uniformly. They also note that ED professionals must determine the extent of the problem within the specialty using rigorous databases and scientific research. To the extent that disparities exist, the causal factors need to be identified and studied. This will lead to further action through the development of appropriate interventions and the tracking of outcome measures, and ultimately to progress toward eradicating racial disparities in health care [52].

References

1. Institute of Medicine. How far have we come in reducing health disparities? Progress since 2000: workshop summary. Washington, DC: The National Academies Press; 2012.
2. Gillespie CD, Wigington C, Hong Y. Coronary heart disease and stroke deaths - United States, 2009. MMWR Surveill Summ. 2013;62(03):157–60.
3. U.S. Cancer Statistics Working Group. United States cancer statistics: 1999–2011 incidence and mortality web-based report [Internet]. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2014. Available from: www.cdc.gov/uscs
4. Kaiser Family Foundation. Health coverage for the black population today and under the Affordable Care Act [Internet]. 2013 Jul. Available at http://kff.org/disparities-policy/fact-sheet/health-coverage-for-the-black-population-today-and-under-the-affordable-care-act/
5. Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: Institute of Medicine, National Academy Press; 2002.
6. Bach PB, Cramer LD, Warren JL, Begg CB. Racial differences in the treatment of early-stage lung cancer. N Engl J Med. 1999;341(16):1198–205.
7. Cone DC, Richardson LD, Todd KH, Betancourt JR, Lowe RA. Health care disparities in emergency medicine. Acad Emerg Med. 2003;10(11):1176–83.
8. Lowe RA, Chhaya S, Nasci K, Gavin LJ, Shaw K, Zwanger ML, et al. Effect of ethnicity on denial of authorization for emergency department care by managed care gatekeepers. Acad Emerg Med. 2001;8(3):259–66.
9. Johnson JA. Ethnic differences in cardiovascular drug response: potential contribution of pharmacogenetics. Circulation. 2008;118:1383–93.
10. Mackie DM, Hamilton DL, Susskind J, Rosselli F. Social psychological foundations of stereotype formation. In: Macrae CN, Stangor C, Hewstone M, editors. Stereotypes and stereotyping. New York: Guilford Press; 1996. p. 41–78.
11. Lillie-Blanton M, Brodie M, Rowland D, Altman D, McIntosh M. Race, ethnicity, and the health care system: public perceptions and experiences. Med Care Res Rev. 2000;57 Suppl 1:218–35.
12. Ragin DF, Hwang U, Cydulka RK, et al. Reasons for using the emergency department: results of the EMPATH study. Acad Emerg Med. 2005;12(12):1158–66.
13. Blanchard JC, Haywood YC, Scott C. Racial and ethnic disparities in health: an emergency medicine perspective. Acad Emerg Med. 2003;10(11):1289–93.
14. Boudreaux ED, Emond SD, Clark S, Camargo Jr CA. Acute asthma among adults presenting to the emergency department: the role of race/ethnicity and socioeconomic status. Chest. 2003;124(3):803–12.
15. The Kaiser Family Foundation. Executive summary: health coverage by race and ethnicity: The potential impact of the Affordable Care Act [Internet]. 2013 Mar 13. Washington, DC:

Henry J. Kaiser Family Foundation; 2015. Available from: http://kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-the-potential-impact-of-the-affordable-care-act/

16. van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. Soc Sci Med. 2000;50(6):813–28.
17. Balsa AI, McGuire TG. Prejudice, uncertainty and stereotypes as sources of health care disparities. Boston, MA: Boston University; 2001.
18. Burgess DJ, Fu SS, van Ryn M. Why do providers contribute to disparities and what can be done about it? J Gen Intern Med. 2004;19(11):1154–9.
19. Laveist TA, Nuru-Jeter A. Is doctor-patient race concordance associated with greater satisfaction with care? J Health Soc Behav. 2002;43(3):296–306.
20. Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. Arch Intern Med. 1999;159(9):997–1004.
21. Bernstein J, Bernstein E, Dave A, Hardt E, James T, Linden J, et al. Does the use of trained medical interpreters affect ED services, reduce subsequent charges, and improve follow-up? Acad Emerg Med. 2000;7(5):523.
22. Geiger HJ. Racial and ethnic disparities in diagnosis and treatment: a review of the evidence and a consideration of causes. In: Institute of Medicine, editor. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: The National Academic Press; 2003.
23. Pezzin LE, Keyl PM, Green GB. Disparities in the emergency department evaluation of chest pain patients. Acad Emerg Med. 2007;14(2):149–56.
24. Takakuwa KM, Shofer FS, Hollander JE. The influence of race and gender on time to initial electrocardiogram for patients with chest pain. Acad Emerg Med. 2006;13(8):867–72.
25. López L, Wilper AP, Cervantes MC, et al. Racial and sex differences in emergency department triage assessment and test ordering for chest pain, 1997–2006. Acad Emerg Med. 2010;17:801–8.
26. Napoli AM, Choo EK, Dai J, Desroches B. Racial disparities in stress test utilization in an emergency department chest pain unit. Crit Pathw Cardiol. 2013;12:9–13.
27. Venkat A, Hoekstra J, Lindsell C, Prall D, Hollander JE, Pollack Jr CV, et al. The impact of race on the acute management of chest pain. Acad Emerg Med. 2003;10(11):1199–208.
28. Bradley EH, Herrin J, Wang Y, McNamara RL, Webster TR, Magid DJ, et al. Racial and ethnic differences in time to acute reperfusion therapy for patients hospitalized with myocardial infarction. JAMA. 2004;292(13):1563–72.
29. Taylor AJ, Meyer GS, Morse RW, Pearson CE. Can characteristics of a health care system mitigate ethnic bias in access to cardiovascular procedures? Experience from the Military Health Services System. J Am Coll Cardiol. 1997;30(4):901–7.
30. Braver ER. Race, Hispanic origin, and socioeconomic status in relation to motor vehicle occupant death rates and risk factors among adults. Accid Anal Prev. 2003;35(3):295–309.
31. Hakmeh W, Barker J, Szpunar SM, Fox JM, Irvin CB. Effect of race and insurance on outcome of pediatric trauma. Acad Emerg Med. 2010;17:809–12.
32. Glance LG, Osler TM, Mukamel DB, Meredith JW, Li Y, Qian F, et al. Trends in racial disparities for injured patients admitted to trauma centers. Health Serv Res. 2013;48(5):1684–706.
33. Sacco RL. Preventing stroke among blacks: the challenges continue. JAMA. 2003;289(22):3005–7.
34. Johnston SC, Fung LH, Gillum LA, et al. Utilization of intravenous tissue-type plasminogen activator for ischemic stroke at academic medical centers: the influence of ethnicity. Stroke. 2001;32(5):1061–8.
35. Siegler JE, Boehme AK, Albright KC, Martin-Schild S. Ethnic disparities trump other risk factors in determining delay to emergency department arrival in acute ischemic stroke. Ethn Dis. 2013;23:29–34.
36. Krishnan JA, Diette GB, Skinner EA, Clark BD, Steinwachs D, Wu AW. Race and sex differences in consistency of care with national asthma guidelines in managed care organizations. Arch Intern Med. 2001;161(13):1660–8.

37. Boudreaux ED, Emond SD, Clark S, Camargo Jr CA. Race/ethnicity and asthma among children presenting to the emergency department: difference in disease severity and management. Pediatrics. 2003;111(5):e615–21.
38. Leong AB, Ramsey CD, Celedón JC. The challenge of asthma in minority populations. Clin Rev Allergy Immunol. 2012;43:156–83.
39. Todd K, Samaroo N, Hoffman J. Ethnicity as a risk factor for inadequate emergency department analgesia. JAMA. 1993;269(12):1537–9.
40. Todd K, Lee T, Hofman JR. The effect of ethnicity on physician estimates of pain severity in patients with isolated extremity trauma. JAMA. 1994;271(12):925–8.
41. Todd K, Deaton C, D'Adamo A, Goe L. Ethnicity and analgesic practice. Ann Emerg Med. 2000;35(1):11.
42. Tamayo-Sarver JH, Dawson NV, Hinze SW, Cydulka RK, Wigton RS, Albert JM, et al. The effect of race/ethnicity and desirable social characteristics on physicians' decisions to prescribe opioid analgesics. Acad Emerg Med. 2003;10(11):1239–48.
43. Tamayo-Sarver JH, Hinze SW, Cydulka RK, Baker DW. Racial and ethnic disparities in emergency department analgesic prescription. Am J Public Health. 2003;93(12):2067–73.
44. Guagliardo MF, Teach SJ, Huang ZJ, Chamberlain JM, Joseph JG. Racial and ethnic disparities in pediatric appendicitis rupture rate. Acad Emerg Med. 2003;10(11):1218–27.
45. Beckmann KR, Melzer-Lange MD, Gorelick MH. Emergency department management of sexually transmitted infections in US adolescents: results from the National Hospital Ambulatory Medical Care Survey. Ann Emerg Med. 2004;43(3):333–8.
46. Scott CJ, Martin M, Hamilton G. Training of medical professionals and the delivery of health care as related to cultural identity groups. Acad Emerg Med. 2003;10(11):1149–52.
47. Hamilton G, Marco CA. Emergency medicine education and health care disparities. Acad Emerg Med. 2003;10(11):1189–92.
48. Powe NR, Cooper LA. Diversifying the racial and ethnic composition of the physician workforce. Ann Intern Med. 2004;141(3):223–4.
49. Cohen JJ. Disparities in health care: an overview. Acad Emerg Med. 2003;10(11):1155–60.
50. Richardson LD, Wilets IF, Cydulka RK. Minority faculty in academic emergency medicine. Acad Emerg Med. 2001;8:474.
51. Weinick RM. Researching disparities: strategies for primary data collection. Acad Emerg Med. 2003;10(11):1161–8.
52. Richards CF, Lowe RA. Researching racial and ethnic disparities in emergency medicine. Acad Emerg Med. 2003;10(11):1169–75.

Chapter 14
Vulnerable Populations: The Homeless and Incarcerated

Ava Pierce

Introduction

The number of persons included in vulnerable populations has been steadily increasing. More than 1.5 million individuals experience homelessness in the USA every year [1]. A more than 12 % increase in homelessness has been reported by cities in the USA from 2007 to 2008 [2, 3]. There are more than 10 million people incarcerated worldwide, with 2.3 million imprisoned within the USA, 1.6 million in China, and 0.9 million in Russia [4, 5]. A study by Greenberg revealed that recent homelessness was 7.5–11.3 times more common among incarcerated persons compared to the general population. Homelessness and incarceration appear to increase the risks of each other [6]. Homeless people often encounter multiple barriers to accessing health care, yet they experience high levels of chronic and acute medical problems [7–9]. There are also heath disparities between prisoners and the general population [4]. Prisoners often have limited access to health care after release from prison.

Discussion

Homeless people often do not have the skills that are required to navigate the health care system [7, 10]. Homelessness is associated with difficulty in accessing primary care, high levels of chronic illness and morbidity, and unmet health needs [1, 11–19]. A study by Hibbs found that the age-adjusted mortality was 3.5 times greater for homeless patients compared to those who were not homeless [2, 20].

A. Pierce, M.D. (✉)
Department of Emergency Medicine, University of Texas Southwestern Medical Center,
Dallas, TX, USA
e-mail: ava.pierce@utsouthwestern.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_14

The perception of unwelcomeness among homeless patients in health care settings may in part reflect negative attitudes towards homeless people in those settings. A study by Fine to assess attitudes towards homeless people in the ED suggested that negative attitudes and beliefs about homeless people were more prevalent among teachers than learners. His results demonstrated that the empathy and interest among medical students might be directed towards providing holistic care and gaining increased insight into the context of homelessness. He concluded that department case-management might improve care for chronic issues and support physicians caring for homeless patients in the ED [21].

Masson documented that medical students' observations of physicians' actions and comments while caring for homeless patients influence students' subsequent views [21, 22]. Role-modeling could have a detrimental effect on medical students if faculty or residents have negative beliefs toward homeless patients. The attitudes and beliefs that health care professionals have about disadvantaged patients in general, and homeless people in particular, can have a significant effect on therapeutic interactions. Past studies have documented homeless people's sense of being unwelcome in health care settings [21, 23, 24].

Incarcerated individuals are a vulnerable minority group with limited access to medical care [25]. The number of incarcerated individuals has increased by more than one million over the last decade. The USA has the highest rate of incarcerated persons with 756 per 100,000 people compared to 145 per 100,000 worldwide [4, 5, 26].

Prisoners have a higher incidence of physical and psychiatric disorders compared to the general population. The health disparity between prisoners and the general population has been attributed to socioeconomic and behavioral factors including increased rates of intravenous drug use which leads to an increased risk of infectious diseases and increased alcohol abuse and smoking, which have increased the risk of cardiovascular disease and some cancers. Approximately one in seven prisoners has a mental illness. In a systematic review and meta-analysis of 62 surveys and 23,000 prisoners, 4 % were found to have psychosis, 10–12 % major depression, and 40–70 % personality disorders [4, 27]. A review of reception to incarceration studies by Fazel documented that approximately 10–24 % of women and 17–30 % of men were diagnosed with alcohol dependence or misuse [4, 28]. Misuse or dependence on illegal drugs at reception to incarceration was present in 30–60 % of women and 10–48 % of men. Post-traumatic stress disorder has been documented to affect up to a fifth of prisoners [4, 29]. When compared with the general population of similar ages, the highest risks are estimated to be for substance misuse and abuse, antisocial personality disorder, and psychosis [4, 27, 28]. Mental illness has been shown to increase the risk of crime and repeat offending [4, 29–32].

Epidemiological studies have consistently reported HIV infection rates in incarcerated individuals that are higher than the general population [4, 33, 34]. Hepatitis B and Hepatitis C infections are also common in prisoners. The most important independent risk factor for transmission of HIV and viral hepatitis in prison is the use of non-sterile injecting equipment [4, 35]. Prisoners have a higher prevalence of tuberculosis than the general population [4, 36, 37]. Most chronic illnesses seem to be more common in prisoners than the general population. A survey of US prisoners by Wilper noted higher age-adjusted rates of diabetes, hypertension, asthma, and arthritis [4, 38]. Suicide is the leading cause of death in prisons and accounts for approximately half of prison deaths [4]. Studies have shown that up to 20 % of prisoners' health problems are either unrecognized or treated late [25].

Physicians can work in partnership with underserved patients to decrease communication barriers and foster therapeutic self-empowerment by increasing their awareness of the use of patient-centered communication in clinical settings. Prejudices that physicians hold about homeless or incarcerated patients can be a barrier to communication. These prejudices can undermine constructive communication between physicians and underserved patients [39].

Another barrier to communication with the underserved is the difference in medical knowledge between providers and underserved patients. Physicians train to acquire technical vocabularies and specialized approaches to problem-solving based on cues, hypotheses, and differential diagnoses. Underserved patients frame their illnesses with words that are common and significant to them. Many of the words physicians use become lost in conversation to these patients. A communicative asymmetry exists between the physician and the patient leaving both parties communicatively incompetent [39].

Physicians and patients often communicate in different interactive frames. They frequently have different expectations of the clinical encounter. Physicians communicate about the disease while patients communicate about their perception of what is wrong and what that means to them. The way physicians conceptualize clinical decision-making is vastly different from the way patients view their own illness. Although underserved patients are fluent in their own language and explanatory models, many physicians in clinical encounters perceive only a patient's lack of formal knowledge about disease. Doctors therefore often confuse patients by not explaining the logic behind their statements. Underserved patients frequently leave these encounters feeling uninformed and frustrated that their concerns were not heard [39].

Physicians alter their communication styles depending on the socioeconomic status of their patients. Ill underserved patients also alter their communication style in physician–patient encounters. Many become passive and don't ask questions and therefore their physicians may not be aware of their true communicative intentions [39].

Two central concepts that affect physician patient communication are language and power. Underserved patients often have minimal power or control in their physician–patient relationships. Power, control, and treatment plans are negotiated through language. Underserved patients often receive the least time and attention from physicians, but have the greatest need to close the gaps in knowledge and power. The use of discourse strategies will facilitate more effective sharing of information and power in the clinical setting [39].

Physicians use technical vocabulary that underserved patients frequently do not understand. Physicians can judge patient understanding by closely listening to the patient's response to their use of jargon. When patients use their own vernacular speech, physicians should clarify to assure mutual understanding [39].

Mishler et al. described a method of communication called the “language of attentive patient care,” where physicians’ listening and responding skills are linked to patients’ speech. It suggests that physicians should structure their questions and statements in response to the expressed needs of the patient. Mishler focuses his analysis on three parameters: (1) Attentiveness—how patients’ concerns and understandings are acknowledged and taken seriously by the physicians; (2) Facilitation—how patients are encouraged to tell their stories in their own words and how their stories then come to be told; and (3) Collaboration—whether there is recognition of and support of patients as partners with physicians in the ongoing process of care [39, 40]. The language of attentive patient care demands that physicians listen to the ways patients express their concerns. This method helps physicians conduct medical interviews with an enhanced understanding of patients’ concerns, working to support the physician’s role as a witness, therefore mitigating the power differential often present in clinical encounters with underserved patients [39, 41].

Physicians can also use self-empowering language through disclosure of personal attitudes and choice of words. In this approach, physicians express ownership of feelings and thoughts in their interactions with patients with an emphasis on personal values in response to patient concerns. Habitual statements of patient care are replaced with words chosen for purposes of empathy, self-disclosure, and empowerment. By self-disclosing information, physicians can show they share a common concern with patients or they might enlist empathy to understand patient feelings. Physicians can also encourage patient self-exploration of thoughts. This communication style focuses the explicit discourse on internal self-identities by reminding the physician and the patient of their own common power. Physicians must value the patient being empowered and work toward the expression of power that originates within the patient. Many underserved feel powerless in the health care system and society and can benefit from treatment approaches of this nature which recognize both their individual abilities to change and the therapeutic nature of successful change [39]. Patient-centered communication influences patients’ health through perceptions that the clinical encounter was patient centered and through perceptions that common ground was achieved with the physician [42].

Homeless individuals often use the ED for non-emergent medical needs because demands for food, shelter, and safety supersede obtaining primary care. Homeless individuals are more likely present to the ED via ambulance because of their lack of transportation. Ku et al. documented an increased tendency toward ED usage shortly after recent ED use or hospital admission, therefore contributing to ED overcrowding [2, 43–46]. In this study, homeless people were three times more likely to have been evaluated in the same ED within the preceding 3 days and were twice as likely to have a visit to the ED after a hospitalization within the previous week. Homeless individuals’ visits to the ED were associated with acute injuries and primary diagnoses related to psychiatric illness and substance abuse. The high prevalence of concomitant substance abuse and psychiatric illness can make treating the homeless population more challenging. Comprehensive discharge planning is required for homeless patients due to their comorbid psychiatric and substance abuse issues combined with their lack of consistent and safe shelter [2, 47, 48].

Incarcerated persons may be distrustful of health care personnel because in the past, prisoners were subjected to harmful experimentation under the auspices that the research would advance medical science [49, 50]. Understanding where health care workers' ideas regarding how care should be provided can be instrumental in limiting or eliminating deferential or less than empathetic care. Health care providers must understand how assumptions, stereotypes, and fears can hinder delivering quality, compassionate care. Health care workers must be aware of the inclination to label incarcerated people as dangerous based on perception, appearance, and media accounts. Essential and supportive care must be provided to all patients [49].

Street medicine focuses on the health needs of homeless individuals through mobile teams that provide care in locations where homeless people are found. Howe documented four categories of best practices that support the delivery of high quality care in the context of Street Medicine and they include: (1) the use of mobile vans, (2) development of Street Medicine-specific electronic medical records, (3) collaboration with community clinics and providers from these clinics, and (4) provision of comprehensive social support by establishing links to resources such as housing, sources of income, and insurance [51].

As the number of homeless has increased, so has the number of shelters. Transitions of care between the health care system and shelters are also increasing. In 2010, approximately 7 % of all homeless individuals and 13 % of newly homeless individuals seeking housing at a shelter were received directly from the hospital [52, 53]. There is often inadequate coordination of care during these transitions, which may further perpetuate high rates of acute care service use by homeless individuals [2, 44, 52]. Sixty percent of homeless individuals interviewed by Greyson reported that they delayed going to a hospital when they knew they needed care, and of those, 44 % indicated that they had done so due to a concern that they would not receive the care they needed. 42 % indicated that they delayed seeking health care because they were concerned that they would not be able to find shelter for the night upon discharge [52].

Medical respite care is defined by the National Health Care for the Homeless Council as acute and post-acute care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital [52, 54]. Medical respite has been shown to improve outcomes for homeless patients [52, 55, 56]. Shelter-based patient navigators can help homeless patients with post-discharge coordination of care [52, 57]. Partnerships between hospitals and community-based organizations can improve care while reducing costs, and is one Medicare innovation funded by the Affordable Care Act [52, 58].

Hospital providers must not only make sure that housing issues are solved but also make sure there are not deficits in coordination and communication between the two systems. Patients have been discharged to shelters, but then were turned away if the discharge occurred too late in the day. These failures in coordination represent missed opportunities to improve outcomes of care. Targeted interventions to improve the coordination of care for the most vulnerable patients who are high utilizers of acute care can improve patient outcomes and reduce overall cost of care

[52, 59, 60]. Health care providers should consistently assess housing status and arrange safe transportation to shelters upon discharge [52].

Conclusion

Communication between physicians and underserved patients fails principally because of inadequately shared information and a power asymmetry in the physician–patient relationship. Underserved patients find themselves increasingly at the margins of medical care in part because of contextual barriers in the physician–patient relationship. Discourse strategies are of critical importance with the underserved [39].

Physicians must acknowledge the issues of the underserved. By improving their communication skills, physicians can be more effective at recognizing the disempowering forces of discrimination that underserved patients encounter and assist their patients by acknowledging the patients' strength and courage in surviving these forces [39].

The emergency department presents a window of opportunity where early intervention strategies may be implemented to improve the health status of homeless patients [7]. Intensive case management has been shown to reduce ED use and result in better health outcomes by connecting homeless patients with available community resources [21, 61, 62]. Greater attention must be given to the hospital services that are provided to homeless people so that not only their health needs, but also their behavioral, environmental, and psychosocial needs are addressed effectively and efficiently [7]. Improved integration of health care facilities and shelters as overlapping systems of care may improve the quality of transitions of care and health care outcomes for homeless patients [52].

The disproportionate degree of physical and psychiatric disease in prisoners presents both unique public health challenges and opportunities for public health intervention. For many underserved individuals, prison provides an opportunity for diagnosis, disease management education, counseling, and treatment that they would not otherwise receive. Upon release from prison, the previously incarcerated return to their communities with their physical and psychiatric morbidity occasionally untreated and sometimes worsened and they can act as reservoirs of infection. Psychiatric morbidity leads to increased suicide rates and contributes to repeat offending. Treating mental and physical illnesses of prisoners can improve public health [4].

Providing quality care for vulnerable populations, including homeless and incarcerated individuals, is challenging. Delivering culturally competent care to this vulnerable population can help decrease health care disparities and improve health care outcomes for these individuals. Health care systems can have a significant impact on public health by delivering integrated health and social services to vulnerable populations. Cost-effective approaches to socio-medical integration of care are critical to promoting the health and welfare of underserved individuals.

Recommendations

- Incorporating health screening and promotion around addictions, mental health disorders, and infectious diseases will enhance understanding of homeless patients.
- Specific discourse strategies are of critical importance when communicating with the underserved.
- Academic physicians can teach discourse strategies which will facilitate a more effective sharing of information and power in the clinical setting.
- The high prevalence of repeat ED visits by homeless patients, underscores the need for policy remedies for homelessness in the USA.
- Identifying risk factors for re-presentation to the ED should facilitate screening and early referral to hospital and community-based services for vulnerable populations.
- Physicians can work in partnership with underserved patients to decrease communication barriers and foster therapeutic self-empowerment by increasing their awareness of the use of patient-centered communication in clinical settings.
- Treating mental and physical illnesses of prisoners can improve public health.
- Hospital providers should consider housing a health concern.
- Hospital and shelter providers should communicate during discharge planning.
- Discharge planning should include safe transportation.

References

1. Doran KM, Vashi AA, Platis S, Curry LA, Rowe M, Gang M, et al. Navigating the boundaries of emergency department care: addressing the medical and social needs of patients who are homeless. Am J Public Health. 2013;103 Suppl 2:S355–60.
2. Ku BS, Scott KC, Kertesz SG, Pitts SR. Factors associated with use of urban emergency departments by the U.S. homeless population. Public Health Rep. 2010;125(3):398–405.
3. The United States Conference of Mayors. Hunger and Homelessness Survey: A status report on hunger and homelessness in America's cities-a 25-city survey. December 2008 [cited 2009 Aug 16]. Available from: http://usmayors.org/pressreleases/documents/hungerhomelessness-report_121208.pdf
4. Fazel S, Baillargeon J. The health of prisoners. Lancet. 2011;377(9769):956–65.
5. Walmsley R. World prison population list. 8th ed. London: King's College London International Centre for Prison Studies; 2009.
6. Greenberg GA, Rosenheck RA. Jail incarceration, homelessness, and mental health: a national study. Psychiatr Serv. 2008;59(2):170–7.
7. Moore G, Gerdtz MF, Hepworth G, Manias E. Homelessness: patterns of emergency department use and risk factors for re-presentation. Emerg Med J. 2011;28(5):422–7.
8. Digiusto E, Treloar C. Equity of access to treatment, and barriers to treatment for illicit drug use in Australia. Addiction. 2007;102(6):958–69.
9. Hwang SW, Bugeja AL. Barriers to appropriate diabetes management among homeless people in Toronto. CMAJ. 2000;163(2):161–5.
10. Thomson Goodall and Associates Pty. Ltd. It can be done: health care for people who are homeless. Melbourne: Royal District Nursing Service; 1992.

11. Shortt SE, Hwang S, Stuart H, Bedore M, Zurba N, Darling M. Delivering primary care to homeless persons: a policy analysis approach to evaluating the options. Healthc Policy. 2008;4(1):108–22.
12. Duchon LM, Weitzman BC, Shinn M. The relationship of residential instability to medical care utilization among poor mothers in New York City. Med Care. 1999;37(12):1282–93.
13. Hwang SW. Homelessness and health. CMAJ. 2001;164(2):229–33.
14. Hwang SW, Aubry T, Palepu A, Farrell S, Nisenbaum R, Hubley AM, et al. The health and housing in transition study: a longitudinal study of the health of homeless and vulnerably housed adults in three Canadian cities. Int J Public Health. 2011;56(6):609–23.
15. Hwang SW, Dunn JR. Homeless people. In: Galea S, Vlahov D, editors. Handbook of urban health: populations, methods, and practice. New York: Spring Science and Media Publishers; 2005.
16. Baggett TP, O'Connell JJ, Singer DE, Rigotti NA. The unmet health care needs of homeless adults: a national study. Am J Public Health. 2010;100(7):1326–33.
17. Zlotnick C, Zerger S. Survey findings on characteristics and health status of clients treated by the federally funded (US) Health Care for the Homeless Programs. Health Soc Care Community. 2009;17(1):18–26.
18. Reid KW, Vittinghoff E, Kushel MB. Association between the level of housing instability, economic standing and health care access: a meta-regression. J Health Care Poor Underserved. 2008;19(4):1212–28.
19. Hwang SW, Ueng JJ, Chiu S, Kiss A, Tolomiczenko G, Cowan L, et al. Universal health insurance and health care access for homeless persons. Am J Public Health. 2010;100(8):1454–61.
20. Hibbs JR, Benner L, Klugman L, Spencer R, Macchia I, Mellinger A, et al. Mortality in a cohort of homeless adults in Philadelphia. N Engl J Med. 1994;331(5):304–9.
21. Fine AG, Zhang T, Hwang SW. Attitudes towards homeless people among emergency department teacher and learners: a cross-sectional study of medical students and emergency physicians. BMC Med Educ. 2013;13:112.
22. Masson N, Lester H. The attitudes of medical students towards homeless people: does medical school make a difference? Med Educ. 2003;37(10):869–72.
23. Wen CK, Hudak P, Hwang SW. Homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters. J Gen Intern Med. 2007;22(7):1011–7.
24. Lester H, Bradley CP. Barriers to primary healthcare for the homeless: the general practitioner's perspective. Eur J Gen Pract. 2001;7(1):6–12.
25. Pfortmueller CA, Aulmann G, Lindner G, Perrig M, Müller TJ, Zimmermann H, Exadaktylos AK. Emergency department admissions to a prison hospital: a retrospective cohort study from Switzerland. Swiss Med Wkly. 2013;143:w13753.
26. Walmsley R. World prison population list. 2nd ed. London: Home Office Research, Development and Statistics Directorate; 2000.
27. Fazel S, Danesh J. Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. Lancet. 2002;359(9306):545–50.
28. Fazel S, Bains P, Doll H. Substance abuse and dependence in prisoners: a systematic review. Addiction. 2006;101(2):181–91.
29. Goff A, Rose E, Rose S, Purves D. Does PTSD occur in sentenced prison populations? A systematic literature review. Crim Behav Ment Health. 2007;17(3):152–62.
30. Wallace C, Mullen P, Burgess P, Palmer S, Ruschena D, Browne C. Serious criminal offending and mental disorder. Case linkage study. Br J Psychiatry. 1998;172:477–84.
31. Fazel S, Gulati G, Linsell L, Geddes JR, Grann M. Schizophrenia and violence: systematic review and meta-analysis. PLoS Med. 2009;6(8):e1000120.
32. Fazel S, Yu R. Psychotic disorders and repeat offending: systematic review and meta-analysis. Schizophr Bull. 2011;37(4):800–10. Epub 2009 Dec 3.
33. Reference Group on HIV/AIDS Prevention and Care among Injecting Drug Users in Developing and Transitional Countries, Dolan K, Kite B, Black E, Aceijas C, Stimson GV. HIV in prison in low-income and middle-income countries. Lancet Infect Dis. 2007;7(1):32–41.

34. UNAIDS. AIDS epidemic update: December 2009. Geneva: Joint United Nations Programme on HIV/AIDS; 2009.
35. Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. Lancet Infect Dis. 2009;9:57–66.
36. Coninx R, Maher D, Reyes H, Grzemska M. Tuberculosis in prisons in countries with high prevalence. BMJ. 2000;320:440–2.
37. Dara M, Grzemska M, Kimerling ME, Reyes H, Zagorskiy A. Guidelines for control of tuberculosis in prisons. Geneva: Tuberculosis Coalition for Technical Assistance, International Committee of the Red Cross; 2009.
38. Wilper AP, Woolhandler S, Boyd JW, Lasser KE, McCormick D, Bor DH, et al. The health and health care of US prisoners: results of a nationwide survey. Am J Public Health. 2009;99(4):666–72.
39. Ventres W, Gordon P. Communication strategies in caring for the underserved. J Health Care Poor Underserved. 1990;1(3):305–14.
40. Mishler EG, Clark JA, Ingelfinger J, Simon MP. The language of attentive patient care: a comparison of two medical interviews. J Gen Intern Med. 1989;4(4):325–35.
41. Berger J, Mohr J. A fortunate man. New York: Pantheon Books; 1967.
42. Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, Jordan J. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49(9):796–804.
43. Gelberg L, Gallagher TC, Andersen RM, Koegel P. Competing priorities as a barrier to medical care among homeless adults in Los Angeles. Am J Public Health. 1997;87(2):217–20.
44. Han B, Wells BL. Inappropriate emergency department visits and use of the Health Care for the Homeless Program services by homeless adults in the northeastern United States. J Public Health Manag Pract. 2003;9(6):530–7.
45. O’Toole TP, Conde-Martel A, Gibbon JL, Hanusa BH, Freyder PJ, Fine MJ. Where do people go when they first become homeless? A survey of homeless adults in the USA. Health Soc Care Community. 2007;15(5):446–53.
46. Kessell ER, Bhatia R, Bamberger JD, Kushel MB. Public health care utilization in a cohort of homeless adult applicants to a supportive housing program. J Urban Health. 2006;83(5):860–73.
47. Backer TE, Howard EA, Moran GE. The role of effective discharge planning in preventing homelessness. J Prim Prev. 2007;28(3–4):229–43.
48. Simmons WJ. Discharging the homeless. Hosp Health Netw. 2007;81(7):10.
49. Cooke CL. Understanding incarcerated populations. AORN J. 2002;75(3):568–70. 573–6, 578 passim.
50. Hornblum AM. Acres of skin: human experiments in at Holmesburg prison: a story of abuse and exploitation in the name of medical science. New York: Routledge; 1998.
51. Howe EC, Buck DS, Withers J. Delivering health care on the streets: challenges and opportunities for quality management. Qual Manag Health Care. 2009;18(4):239–46.
52. Greysen SR, Allen R, Lucas GI, Wang EA, Rosenthal MS. Understanding transitions in care from hospital to homeless shelter: a mixed-methods community-based participatory approach. J Gen Intern Med. 2012;27(11):1484–91.
53. U.S. Department of Housing and Urban Development. The 2010 Annual Homeless Assessment Report to Congress. [cited 2012 May 11]. Available from: http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf
54. National Health Care for the Homeless Council. Medical Respite [Internet]. Nashville: National Health Care for the Homeless Council, Inc; c2015 [cited 2012 May 11]. Medical Respite; [about 2 p.]. Available from: http://www.nhchc.org/resources/clinical/medical-respite/
55. Buchanan D, Doblin B, Sai T, Garcia P. The effects of respite care for homeless patients: a cohort study. Am J Public Health. 2006;96(7):1278–81.
56. Kertesz SG, Posner MA, O’Connell JJ, Swain S, Mullins AN, Shwartz M, et al. Post-hospital medical respite care and hospital readmission of homeless persons. J Prev Interv Community. 2009;37(2):129–42.

57. Substance Abuse and Mental Health Services Administration (SAMHSA) Recovery support services: Behavioral health peer navigator program. [cited 2012 May 11]. Available from: http://www.williamwhitepapers.com/pr/SAMHSA%20BH%20Peer%20Navigator%20Definition%202011.pdf
58. Center for Medicare & Medicaid Innovation. Health Care Innovation Challenge. [cited 2012 May 11]. Available from: http://innovations.cms.gov/Files/x/Health-Care-Innovation-Challenge-Funding-Opportunity-Announcement.pdf
59. Raven MC, Doran KM, Kostrowski S, Gillespie CC, Elbel BD. An intervention to improve care and reduce costs for high-risk patients with frequent hospital admissions: a pilot study. BMC Health Serv Res. 2011;11:270.
60. Shumway M, Boccellari A, O'Brien K, Okin RL. Cost-effectiveness of clinical case management for ED frequent users: results of a randomized trial. Am J Emerg Med. 2008;26(2):155–64.
61. Kumar GS, Klein R. Effectiveness of case management strategies in reducing emergency department visits in frequent user patient populations: a systematic review. J Emerg Med. 2013;44(3):717–29. Epub 2012 Nov 29.
62. Hwang SW, Tolomiczenko G, Kouyoumdjian FG, Garner RE. Interventions to improve the health of the homeless: a systematic review. Am J Prev Med. 2005;29(4):311–9.

Chapter 15
Vulnerable Populations: The Elderly

Anne Beth Smith

Introduction

Over the last few decades, the number of elderly patients—defined as over age 60—has steadily increased, in both developing and developed countries. This trend is likely to continue, and the expected global population of elderly is projected to be 1.2 billion by 2025 [1]. Currently, 60% of the elderly live in developing countries. Globally, the average life expectancy at birth has improved, while fertility rates and birth rates have declined [1]. This, coupled with better and more advanced medical care, and improved nutrition and sanitation, have led to a larger than ever population of elderly people.

As the global population ages, the percentage of patients accessing medical care also increases. This presents unique problems to healthcare providers and systems. This chapter will focus on some of the challenges faced by those providing care to elderly patients and how the quality of this care can be improved.

In addition to the added burden of elderly patients, many healthcare providers may be inadequately trained to effectively manage the elderly. A multidisciplinary team approach is required, and healthcare providers need to be trained and gain expertise in the specific healthcare challenges facing the elderly. Although some countries which have a large elderly population have adequate training and focus in geriatrics at medical school level (Norway, the Netherlands), many do not (Spain, Germany) [2]. Coupled with a lack of training, there may be still be opposition and negative perceptions from healthcare providers that the field of geriatrics is "boring" and "frustrating" [3]. In developing countries, the field of geriatrics is often underdeveloped, and coupled with a lack of resource, healthcare providers may not be sufficiently equipped to deal with the elderly [4, 5].

A.B. Smith, M.B.Ch.B., F.C.E.M. (S.A.) (✉)
Emergency Centre, George Regional Hospital, George, South Africa
e-mail: annebsmith@gmail.com

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_15

Quality care may be defined by six specific aims, represented here by the mnemonic STEEEP [6]. Quality care should be:

*S*afe—to ensure that patients are not harmed during medical attention and care.
*T*imely—to ensure reduced waiting times and avoiding harmful delays.
*E*ffective—that services provided are based on scientific knowledge, preventing under or over use of treatment modalities.
*E*fficient—that waste of supplies, human resources, equipment or consumables does not occur.
*E*quitable—that the quality of care is consistent regardless of geographic location, patient characteristics or socio economic circumstances.
*P*atient-centered—that care takes into account individual preferences, concerns and values, and ensuring that the patient is part of the decision making process.

In the context of the elderly patient, this chapter will examine the above aims in the following areas of medical care: Long term and primary healthcare; the acute setting and emergency departments; palliative and end of life care; and transitions of care between any of the above.

Discussion

Acute Care: the Emergency Department

Elderly patients make up some 20% of emergency department (ED) visits [7]. Healthcare providers in EDs may find elderly patients challenging due to the higher burden of severe illness and the complexity required in making a diagnosis [8]. The traditional model of ED care (a linear approach from triage, history and physical examination, special investigations and disposition) often does not take into account several elements essential to the care of elderly patients: their functional status, social situation and emotional or cognitive state [9, 10]. "Geriatric friendly" EDs need to have a broader approach to these patients, and focus on improving quality of life, while paying attention to the delicate relationship between the patient and their family or care providers [10]. EDs which serve a significant percentage of geriatric patients should be staffed appropriately with nurses, doctors and auxiliary medical services such as physiotherapists and occupational therapists who are skilled in diagnosing, managing and discharging elderly patients.

Elderly patients often present with atypical or unusual complaints, and their clinical signs may be masked by normal physiological variances due to their age, or by psychological or cognitive decline. Any acute illness may cause profound loss of autonomy, put the elderly patient at risk of falls, delirium or immobilization [9]. A classic example of a potentially dangerous condition frequently missed in the elderly is chest pain: in patients over 65, there is a threefold incidence in "atypical" presentations of acute coronary syndromes, which not only causes a delay in getting them to the ED, but also notable delays in getting treatment which may lead to an increase in mortality [11, 12]. Elderly patients often also have multiple co-morbidities, which influence prognosis and disposition regardless of the presenting complaint.

Polypharmacy is a very common problem with elderly patients presenting to EDs. These may take multiple medications with potential drug interactions, have difficulty remembering the times to take them, or have trouble understanding the prescription they are given. Adverse drug reactions occur more frequently in this particular group of patients, although this is frequently not recognized by emergency physicians [13]. Screening criteria such as the Beers criteria, a tool specifically designed to warn physicians of drugs that have high incidences of adverse reactions in the elderly; developed by the American Geriatric Society and available at low cost from amerciangeriatrics.org, should be readily available and used for elderly patients at any presentation to a healthcare facility, and all current prescriptions should be checked before supplying further medication that may cause adverse drug reactions or interactions with those currently prescribed [14].

The physical environment in the ED can play a great role in improving the patient experience, and this is particularly important for the elderly, who may be anxious and disoriented on arrival in the ED. Their co-morbidities or presenting complaint may put them at high risk for falls and the development of delirium, both of which will increase length of stay and worsen prognosis [15]. Simple measures such as providing comfortable reclining chairs and furniture with sturdy armrests will go a long way to prevent adverse events in the ED. Mattresses should be thick and soft, and preferably able to redistribute pressure to prevent skin breakdown and pressure sores on thin and friable elderly skin. Floors should be non-slip, with no raised joins or seams. Light, matte wall and floor colours with minimal patterns should be employed to assist the elderly patient in orientating themselves and seeing clearly in the department. Elderly patients may have high frequency hearing loss, and be more sensitive to background noise, thus acoustic enhancements such as sound absorbing materials (curtains, ceiling tiles) will improve the patient experience and create a more private and secure environment for examinations and clinical counselling. Access to bathrooms and examination rooms should be wheelchair or walking frame friendly, and the entire ED clearly signposted.

Managers and physicians who are concerned about the quality of care provided to elderly patients in their EDs should institute Continuous Quality Improvement (CQI) measures to track these patients through their units and should maintain a log of adverse or dangerous events. Suggested data for collection in such a CQI programme would include: numbers of geriatric patients compared to total patient load; percentage of admissions and readmissions among the elderly as compared to the total ED population; percentage of deaths in each age group; and episodes of suspected or confirmed geriatric abuse. More disease-specific data can also be collected to gain a greater understanding of the burden of disease specific to the ED's elderly population. Some suggested parameters include numbers of falls—resulting in blunt abdominal trauma, hip fractures or death; medicine management, including screening for high risk drug interactions and polypharmacy; and the incidence of delirium and use of chemical or physical restraints [16].

Long Term and Primary Healthcare for the Elderly Patient

As patients age, they may require increasing assistance with daily care—both for medical care as well as for activities of daily living. Determining where this care is provided and who should provide it is often difficult for healthcare providers, elderly patients and their families.

Care scenarios for the elderly range from living at home completely independently, to living in care facilities, where patients require full care and are completely dependent on others for their daily needs and nursing care. In between these two extremes, there are many options, including assisted living facilities, adult "day care" centres and community care.

It is more cost-effective, and often provides improved quality of life, to keep elderly people in their own homes and provide supportive community care, than to place them in institutions or healthcare facilities [17].

A coordinated team of healthcare workers, which should include a general internist to act as a first point of contact with medical services and the coordination of care, a nurse to coordinate nursing care needs such addressing changes or medication administrations, a social worker to act as a link to support and social services such as day care centers and meal provision services, an occupational therapist to visit the patient at home and ensure that access and mobility is suitable, a physiotherapist to ensure mobility and safe transfers, and provide assistive devices where needed, and home help to assist with cleaning and home maintenance [17].

Providing good home support or community care requires buy-in from healthcare policy makers, politicians, health budget planners as well as patients and healthcare workers themselves. The financial support and provision of human resources remain a challenge, even in developed countries [18]. In many developing countries, elderly patients live in households with multigenerational families who are their primary caregivers [19]. Home-based care resources and research in developing countries is often focused on other diseases perceived to present a higher burden, such as HIV/AIDS.

For all elderly patients and their long term healthcare providers, discussion around the goals of care should take place and be agreed on in advance. This becomes particularly relevant for palliative care and end of life issues (see below). Appropriate outcomes of quality care may include "improved quality of life" or "improved physical function". Outcomes such as "reduction of mortality" may prove less important [20].

Nursing home and long term care facilities should develop and monitor quality care indicators specific to the needs of elderly people and ensure their ongoing safe and sensitive care [21]. Parameters such as the incidence or risk of falls, the provision of adequate pain relief or end of life care, and the screening and management of polypharmacy and adverse drug reactions are all examples of care indicators which should be closely monitored.

Two additional topics which must be addressed when dealing with the long term care of the elderly are carer compassion fatigue and depression in the elder.

Compassion fatigue occurs in both formal (healthcare-trained) and informal carers [17, 22]. It may cause depression and alter the relationship between the carer and patient, and at worse, result in abuse or early institutionalization [23, 24]. Careful screening, education and self-awareness are required to identify and treat compassion fatigue.

Depression in the elderly is common and often unrecognised. Those with prior depression, bereavement, disability and sleep disturbances are at higher risk for depression [25].

Palliative and End of Life Care in Geriatric Patients

Palliative care and end of life care are not the same thing. All terminal disease processes will follow a similar progression. Initially curative treatment may be offered, where the goal of treatment is curing the patient of the disease. At a point when it is realized that the disease is too advanced or terminal, the goal may be changed to palliative care. The treatment goals here focus on improving quality of life and relieving symptoms such as nausea or pain. End of life or hospice care refers to the care offered to patients who have advanced end stage disease, and where life-prolonging treatment may be considered to prolong suffering [26]. Geriatric patients with various conditions, for example, dementia, cancer or cardiac failure, may present to healthcare providers at any of these stages requesting care. It is important to take into account the patients' medical history and the treatments offered so far when making a decision regarding their future management.

One should also consider various disease trajectories. All dying falls into one of these four projected trajectories: sudden death such as massive myocardial infarction or stroke; terminal illness, where quality of life and function gradually decreases over time; organ failure, where an overall decrease in function and quality of life continues, with acute events along the way which may temporarily improve or worsen the situation; and frailty, where patients may begin with a poor baseline of function that will gradually decrease, but continue at the baseline for some time before death occurs [27]. Geriatric patients may die from any one of these trajectories, and may present for healthcare several times along this path. Death is the natural and inevitable end of all life. Assisting patients and their families to accept when they are in the palliative care phase of their lifetime may prevent expensive, uncomfortable and unnecessary tests, procedures and medications [26].

Patients may present to EDs or other healthcare providers for one of three reasons—for relief of symptoms caused by their primary condition, for secondary conditions of disease or trauma or, more unusually, as a first presentation of a terminal condition. In all circumstances, honest communication regarding the goals of treatment with the patient and their family is warranted. Unfortunately, the time pressured and frequently chaotic environment of the ED may result in inadequate care for palliative patients and expedient admission to hospital—which may not be in the patients' best interests or wishes. Quality ED palliative care delivery requires cooperation from hospital and hospice programmes. Helping patients and their families define the desired goals of care and remain at the centre of the decision making process is essential to providing quality palliative care. These are difficult questions which seldom have “yes/no” answers, and so the approach should be a broader one, eliciting the overall goals and feasible options before deciding on specific treatments [28].

Advance care planning is fraught with difficulty—different countries and even hospitals have different legal policies, but the principle of letting the patient decide in advance how they would want to be treated or want to die lies at the heart of all of these. Advance planning documents are generally either instructional directives which provide guidance regarding specific interventions, or proxy directives, which designate a surrogate decision maker. Unfortunately, in a crisis these documents may not be useful—particularly with the acutely unwell geriatric patient where a great deal of anxiety, conflict and uncertainly exists [29]. More useful are carefully directed conversations with family or the patient at the time of presentation, clarifying prognosis and allowing the patient to be the decision maker. In general, it is better to clarify “big picture” goals and not get caught up in specific isolated interventions—e.g. “patient does not want to be ventilator dependent” vs. “patient does not want to be intubated” [30].

The approach to the elderly palliative care patient who presents to the ED or other healthcare provider should always be to provide care that improves quality of life. This includes symptom management, exclusion of reversible secondary diseases or conditions which will improve quality of life if treated, and discussion regarding future care and goals of treatment [26]. An assessment of the patients’ performance status, as well as the likely performance status after the immediate condition is managed, should be done [26]. If the patient has reached the end of life phase, the patient should be referred appropriately to hospice services, who will assume the final care of the patient.

Conclusion

As numbers of geriatric patients continue to rise worldwide, healthcare providers will need to become adept at assessing and managing the unique challenges that the elderly provide.

Recommendations

- To ensure quality care for the elderly in emergency departments, staff should be trained to recognise the atypical disease presentations the elderly may present with, and also implement screening for conditions such as polypharmacy.
- Infrastructure and equipment in emergency departments should enhance the comfort and safety of the elderly patients who are treated there.

- Consultation with services such as palliative care and hospice should be readily available.
- As far as possible, elderly patients should be managed in the community, or at home, with help and support from medical and social services.
- Both formal and non-formal carers should be closely watched for compassion fatigue and respite offered when necessary.
- Elderly patients with terminal disease should be involved in their treatment goal decision making process.
- Symptom control, management of reversible conditions and a discussion around the wishes of the patient in the context of their prognosis are essential elements of quality care in the palliative geriatric patient.

References

1. United Nations. World population prospects: the 2000 update [Internet]. Available from: http://www.un.org/esa/population/publications/wpp2000/highlights.pdf
2. Keller I, Makipaa A, Kalenscher T, Kalache A. Global survey on geriatrics in the medical curriculum. Geneva: World Health Organization; 2002.
3. Higashi RT, Tillack AA, Steinman M, Harper M, Johnston CB. Elder care as ‘frustrating’ and ‘boring’: understanding the persistence of negative attitudes toward older patients among physicians-in-training. J Aging Stud. 2012;26:476–83.
4. Keller I, Kalache A, Gupta N, Moraru M, Chooi JL, Brown C. Teaching geriatrics in medical education II. Geneva: World Health Organization; 2007.
5. Dotchin CL, Akinyemi RO, Gray WK, Walker RW. Geriatric medicine: service and training in Africa. Age Ageing. 2013;42:124–8.
6. Institute of Medicine. Medicare: a strategy for quality assurance, vol. 1. Washington, DC: National Academy Press; 1990.
7. McCusker J, Healey E, Belavance F, Connoly B. Predictors of repeat emergency department visits by elders. Acad Emerg Med. 2006;48:1–8.
8. Schumacher JG. Emergency medicine and older adults: continuing challenges and opportunities. Am J Emerg Med. 2005;23:556–60.
9. Salvi F, Morichi V, Grilli A, Giorgi R, De Tommaso G, Dessi-Fulgheri P. The elderly in the emergency department: a critical review of problems and solutions. Intern Emerg Med. 2007;2:292–301.
10. Carpenter C, Platts-Mills TF. Evolving prehospital, emergency department and ‘inpatient’ management models for geriatric emergencies. Clin Geriatr Med. 2013;23:31–47.
11. Then KL, Rankin JA, Fofonoff DA. Atypical presentation of acute myocardial infarction in 3 age groups. Heart Lung. 2001;30:285–93.
12. Grossman SA, Brown DF, Chang Y, et al. Predictors of delay in presentation to the ED in patients with suspected acute coronary syndromes. Am J Emerg Med. 2003;21:425–8.
13. Hohl CM, Dankoff J, Colacone A, Afilalo M. Polypharmacy, adverse drug related events, potential adverse drug interactions in elderly patients presenting to an emergency department. Ann Emerg Med. 2001;38:666–71.
14. Beers MH. Explicit criteria for determining potentially inappropriate medication use by the elderly. Arch Intern Med. 1997;157:1531–6.
15. Wilber ST, Burger B, Gerson LW, Blanda M. Reclining chairs reduce pain from gurneys in older emergency department patients: a randomized controlled trial. Acad Emerg Med. 2005;12:119–23.

16. American College of Emergency Physicians. Geriatric Emergency Department guidelines [Internet]. 2013. Des Plaines, IL: SAEM; 2015. Available from: www.saem.org/education/geriatric-ed-guidelines
17. Havens B, The World Health Organization. Home care issues at the approach of the 21st century from a World Health Organization perspective: a literature review. Geneva: WHO; 1999.
18. Abas M, Silverman M. Community care of the elderly: problems viewed from one inner city area. Psychiatr Bull. 1996;20:169–71.
19. Shaji KS. Dementia care in developing countries: the road ahead. Indian J Psychiatry. 2009;51(Suppl1):S5–7.
20. Akashita M, Ishii MD, Kojima T, Kozaki K, Kuzuya M, Arai H, et al. Priorities of health care outcomes for the elderly. J Am Med Dir Assoc. 2013;14(7):479–84. doi:10.1016/j.jamda.2013.01.009. Epub 2013 Feb 14.
21. Tolson D, Rolland Y, Andrieu S, Aquino JP, Beard J, Benetos A, et al. International association of Gerontology and Geriatrics: a global agenda for clinical research and quality of care in nursing homes. J Am Med Dir Assoc. 2011;12:184–9.
22. Jorm AF, Henderson S, Scott R, Mackinnon AJ, Korten AE, Christensen H. The disabled elderly living in the community: care received from family and formal services. Med J Aust. 1993;158(6):383–5. 388.
23. Braun M, Scholz U, Bailey B, Perren S, Hornung R, Martin M. Dementia caregiving in spousal relationships: a dyadic perspective. Aging Ment Health. 2009;13(3):426–36.
24. Gainey RR, Payne BK. Caregiver burden, elder abuse and Alzheimer's disease: testing the relationship. J Health Hum Serv Adm. 2006;29(2):245–59.
25. Cole MG, Dendukuri N. Risk factors for depression among elderly community subjects: a systematic review and meta-analysis. Am J Psychiatry. 2003;160:1147–56.
26. Rosenberg M, Lamba S, Misra S. Palliative medicine and geriatric emergency care: challenges, opportunities and basic principles. Clin Geriatr Med. 2013;29:1–29.
27. Lunney JR, Lynn J, Hogan C. Profiles of older decedents. J Am Geriatr Soc. 2002;50:1108–12.
28. Weissman DE, Quill TE, Arnold RM. The family meeting: end of life goal setting and future planning. Fast facts and concepts. 2010: 227. Available at: http://www.eperc.mcw.edu/fastfact/ff_227.htm
29. Prendergast TJ. Advance care planning: pitfalls, progress, promise. Crit Care Med. 2001;29:N34–9.
30. Arnold R, Nelson J, Prendergast T et al. Critical care communication. Module III: determining goals of care. Available at: www.capc.org/palliative-care-professional-development/Training/c3-module-ipal-icu.pdf

Chapter 16
Vulnerable Populations: Children

Kevin Ferguson, John S. Misdary, Alex Diaz, and Darcy Mainville

Introduction

Amongst the pediatric patient population there are clearly defined disparities that appear to be associated with race and ethnicity, even after accounting for socioeconomic variables. These disparities extend from the individual patient encounter, through hospital systems, to the national health care system, and include a lack of funding for medical research of diseases that predominate in distinct racial or ethnic populations. Disparities at the individual encounter level include inadequate analgesia of long bone fractures, and at the systems level, inadequate translation services. Demonstration of the issue at the national health care systems level is how the extensive National Institutes of Health (NIH)-funded research program has markedly improved treatment of cystic fibrosis, a disease predominantly found in people of European heritage. As a result, in one generation the life expectancy of a patient diagnosed with cystic fibrosis has been greatly extended. In contrast, NIH funding has not provided for research that could produce a significant increase in the life expectancy of patients with sickle cell anemia, a disease predominantly found in people of African descent. While the care of cystic fibrosis now includes new medications and specialized treatment protocols, including lung transplantation, the

---

K. Ferguson, M.D. (✉)
Emergency Department, Kaweah Delta Health Center, Visalia, CA, USA
e-mail: KevinFerguson@CEP.com

J.S. Misdary, M.D.
Pediatric Emergency Department, St. Joseph's Children's Hospital, Tampa, FL, USA

A. Diaz, D.O.
College of Osteopathic Medicine of the Pacific, Western University of Health Sciences, Pomona, CA, USA

D. Mainville, B.S., M.S-4
School of Medicine, Loma Linda University, Loma Linda, CA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_16

treatment of sickle cell anemia remains as management by crisis, i.e., reacting to acute illnesses or complications of sickle cell disease, but permitting the underlying pathology to remain unchanged. There have been, remarkably, no significant therapeutic breakthroughs, despite extensive advancement in knowledge of the human genome [1].

It is unlikely that health care disparities are the result of overt bigotry and racism; the extent of the disparities seen and measured in our health care system cannot be accounted for by isolated acts of bigotry, and no argument is being made of rampant racism among the providers in emergency medicine. Indeed, most emergency medicine providers are more familiar and facile with multicultural patient populations than many other providers. Rather, these findings are likely a result of culturally insensitive systems and processes in the delivery of health care. Disparities may also be due to some degree of inadequate cultural awareness or poor utilization of cultural competencies on behalf of the health care providers. Emergency medicine providers, in general, do not develop as in-depth relationships with patients as do primary care providers or pediatricians. The ability of emergency medicine providers to bridge the cultural divide with their patients would contribute greatly to diminishing the disparities in health care provided by emergency departments.

Discussion

Some of the pediatric disparities found in the emergency department may be related to the insurance status and other socioeconomic factors. Children from low-income families are more likely to be uninsured or covered by public insurance and less likely to have private insurance than patients who come from middle-income families. Payer type alone has an influence on patient follow-up and compliance [2, 3]. In a 2013 study of 409 patients, 111 were prescribed medications and 364 were given specific follow-up instructions. Subtypes of insurance status were associated with medication noncompliance. Both insurance status and low-acuity discharge diagnoses were associated with follow-up noncompliance. In this case, the disparity of health insurance status is a predictor of poor aftercare and compliance for pediatric ED.

Children from low-income families are less likely to be seen in a private physician's office than are middle to high-income children [2]. They are also less likely to be on medications prescribed by a primary care physician, less likely to have significant diseases diagnosed early, and are less likely to visit hospital outpatient clinics [4]. These factors and others contribute to the increased utilization of the emergency department by children of low-income families; some estimate that these visits account for 25 % of these children's medical expenditures. Low-income children are less likely to have office-based visits and are also less likely to have referrals to specialty care. Parents of low-income children are more likely than middle-income parents to report that they were provided with poor quality care, specifically that physicians are less likely to listen to their complaints or to clearly explain the diagnostic and therapeutic reasoning [2, 4–6].

The State Children's Health Insurance Program (SCHIP) program was created through Balanced Budget Act of 1997 to address the 11 million American children that were uninsured and therefore at increased risk for preventable health problems. The beginning of the SCHIP in most states has had a positive effect on the insurance status of pediatric patients, their access to care and ability to follow up. In one study on the impact of the program, the authors found that in a population of children which was 25 % white, 31 % black, and 44 % Hispanic, 62 % were uninsured for greater than or equal to 12 months before SCHIP. Before SCHIP, greater than 95 % of white children had any coverage, compared with 86 % of black or 81 % of Hispanic children. Almost all children obtained coverage through SCHIP (95 % or greater for each group). Before SCHIP, black children had significantly greater rates of inadequate coverage (no coverage or Medicaid vs. commercial insurance) relative to white children (38 % vs. 27 %), whereas white and Hispanic children rates were essentially the same, 27 % vs. 29 % [7].

After SCHIP, disparities in access to care were eliminated, with unmet needs at 19 % for all racial and ethnic groups. Before SCHIP, a greater percentage of white children made all/most appointments relative to black or Hispanic children (61 %, 54 %, and 34 %, respectively); all groups improved during SCHIP, eliminating access disparities. Parents' survey responses regarding their visit quality improved for all groups, but preexisting racial/ethnic disparities remained, with improved but still lower levels of satisfaction among parents of Hispanic children [7]. However, socio-demographic and health system factors did not account for disparities in either the pre-SCHIP or post-SCHIP periods. These socio-demographic and health system factors cannot fully explain the disparity in health care received by Hispanic and African American children in the emergency department. Utilization patterns of service were similar for low and middle-income black children and were universally lower than for white children. Therefore, while income and insurance status adequately explains some of the disparity seen, there clearly are other forces at work. We explore some of the documented race and ethnicity related disparities that appear to be independent of income and insurance status.

Disparities in Patient Access to Care

Several studies have demonstrated that, for children treated in emergency departments, wait times are associated with race and ethnicity. This again may be explained partially by the utilization rates of these groups of emergency departments for primary care and also payer status. However, research suggests other potential causes, such as lack of cultural competency, language barriers, social factors, and outright discrimination. Data collected from the National Hospital Ambulatory Medical Care Survey on patient visits to EDs from across the USA during the study period of 1997–2000 suggested that for patients 15 years of age or younger who presented to EDs there may be nonclinical influences on triage and wait times for patients that appear to correlate to race and ethnicity. In this study over a 4-year period, 20,633 patient visits were surveyed. The wait time for all groups was 43.6 ± 1.7 min. There were significant unadjusted intergroup differences in wait times from 38.5 ± 1.6 min for non-Hispanic whites, 48.7 ± 0.5 min for non-Hispanic black, and 54.5 ± 0.1 min for Hispanic children. Triage status was categorized as <15 min: 17.1 %, 15–60 min: 41.4 %, 1–2 h: 25.1 %, and >2–24 h: 16.4 %. There were significant unadjusted differences in triage status according to race, with 14.6 % of white patients being placed in the > 2 hour immediacy range, compared with 18.8 % of non-Hispanic black patients and 20.0 % of Hispanic patients. In a linear regression analysis with wait time as a dependent variable and with adjustment for potential confounders, including payer status, the results were statistically significant that Hispanic patients waited longer than white patients [8]. Once again there are several potential explanations for this observation outside of discrimination, including cultural incompetence, language barriers, and social factors.

These data and similar data from the National Hospital Ambulatory Medical Care Survey have identified nonclinical factors on the delivery of pediatric emergency care. Black and Hispanic patients are more likely to have longer length of stay in the emergency department even though these patients did not show significant difference in documented pain scores, use of diagnostic procedures, 72 hour return visits or hospital admission rate. The application of diagnostic or treatment protocols appears to ameliorate this effect [8–11]. In EDs that use decision rules for X-rays, CT scans, and other diagnostics showed less disparity in their use. Similar results come from use of treatment protocols for pain, asthma, fever, etc.

These disparities in emergency care extend to pediatric patients and their parents with limited English language proficiency. There are several reports of both the increased length of stay as well as increase frequency of return visits (including return visits requiring admission) for patients of families with limited English language proficiency. Investigations of almost 120,000 patients demonstrated that patients with limited English language proficiency have a higher likelihood of return visits for admission of 1.30. This risk of return visits remained significant after controlling for age, emergency severity index, and presentation time. These children were 1.43 times more likely to return and need admission than English language speaking patients. Adjusted and unadjusted emergency wait times were also significantly greater for Hispanic children than for white children, and Hispanic children waited 10.4 % longer than white children treated in the same emergency department. These wait times were not significantly affected by payer source. These authors concluded that there is a sizable racial and ethnic disparity in children's wait times as well as care quality based on race and/or ethnicity [8, 12, 13].

Disparities in Patient Evaluation

Particularly disturbing is that the increased length of stay has not led to greater diagnostic accuracy. In a 2014 publication in *Pediatrics*, racial and ethnic disparities were found in the rate of appendix rupture [14]. This is a wholly preventable negative outcome. In the study of Hispanic and Asian children in the state of California, both groups had higher odds of appendix rupture prior surgery. These differences paralleled the state's proportion of immigrant children. Multivariate adjustment for family, social economic and hospital characteristics did not attenuate these disparities [15]. While the authors did not subdivide these patients by their English language proficiency, both immigrant groups were at a higher risk of delayed emergency care and subsequent appendiceal rupture than both white and African American patients. This finding suggests that immigrant status or language proficiency was a contributing factor in the delay in diagnosis and surgery. In a different study, multivariate analysis suggested African Americans as compared to Caucasians were less likely to develop appendicitis; however, they were more likely to have a complicated appendicitis. Hispanics were both more likely to develop appendicitis and more likely to have complicated appendicitis. Finally, both minority groups were more likely to have an open, as opposed to laparoscopic, appendectomy [16].

Again, another potential contributor to disparity is having public insurance or being uninsured, since patients with private insurance were also less likely to have complex appendicitis compared to children in public insurance or self-pay status. African American children with appendicitis have lower hospitalization rates, greater rates of perforation, a longer delay to surgery, and lower laparoscopic rates. In contrast, Hispanic children have higher rates of appendicitis and complex disease. In a similar study which compared the treatment differences related to ethnicity of children with acute appendicitis, Hispanic and Asian children have higher odds of rupture in California, whereas Asian and black/African American children have higher odds in New York [15]. These differences again roughly parallel to the state's proportion of immigrant children in these groups. Adjustments for family, socioeconomic, and hospital characteristics did not eliminate the disparities. These authors found evidence of significant racial/ethnic disparities in rate of appendiceal rupture, in two large but dissimilar states. Hispanic ethnicity with limited English proficiency is an important risk factor for appendiceal perforation in pediatric patients with abdominal pain. Among patients with moderate clinical severity, Hispanic ethnicity with limited English proficiency had lower imaging rates. Immigrant groups may be most at risk for delayed emergency care. The treatment of African American and Hispanic children overall was associated with a longer hospital stay and higher charges. Given the lower incidence of appendicitis in African American children but a greater incidence of complex appendicitis, the disparity in surgical management of minority children is disturbing.

There is also a discrepancy in the rate of diagnostic testing amongst minority children compared to white children [9, 17–19]. A 2013 publication in *Pediatric Emergency Care* demonstrated that racial disparities in laboratory and radiological testing were found in pediatric emergency department patients [9]. Of the 49,000 individual patients, 31 % had laboratory testing and 30.5 % had radiologic testing. African Americans had adjusted odds ratio for getting tested of 0.93, and specialty consultation odds ratio of 0.91, compared to non-Hispanic. Subgroup analysis of these visits demonstrated that evaluations for conditions using protocols have a lower disparity rate in laboratory over radiologic testing by race than conditions for which there were no treatment protocols. For example, children being evaluated for upper respiratory infections for which there is no evaluation protocol were more likely to have disparities than children with head injury for which there are protocols.

Other investigations demonstrate that patient race, age, and presentation to a pediatric vs. general hospital were also associated with disparate use of neuroimaging in children with closed head injuries [18]. In one study which included 50,835 pediatric visits in the 5-year sample, of which 1256 were for head injury, 39 % underwent evaluation with neuroimaging. In multivariable analyses, factors associated with neuroimaging included white race, older age, or presentation to a general hospital vs. a pediatric hospital. The effect of race was seen less at the pediatric hospitals [18]. While there was an increased use of neuroimaging in patients with a higher injury severity, the data presented did not evaluate the inappropriate use of neuroimaging use in minority vs. white patients in low severity of injury patients. In some of these cases the increases of neuroimaging may have been detrimental to white pediatric patients seen with minor head injuries due to the increased lifelong risk of ionizing radiation to which they were exposed.

Conversely, when evaluating adolescent females with potential sexually transmitted disease related complaints, African American and non-private insurance patients were nearly five times more likely to be tested for sexually transmitted diseases [19]. In the multivariable sub analysis, being black American was associated with increased performance of sexually transmitted disease testing. This finding is most telling as it may indicate a subliminal effect of socialization of the health care professionals. Providers believing that African Americans are more likely to be sexually promiscuous, will hence see them as being at higher risk of sexually transmitted diseases than other adolescent females. As stated above, while it is unlikely that overt racism and bigotry plays a role in most of the disparities that are observed, it is certainly a possibility that learned cultural biases are playing a role in the thought processes and decision-making of these providers.

Disparities in Patient Therapy

Since the late 1990s there have been multiple reports of under treating pain both in children as a group and minority children in the emergency department [20, 21]. Undertreatment of painful conditions in minority children has been documented in multiple publications. Treatment of painful conditions in children can be a significant problem and also more difficult due to the aversion some physicians have to the use of narcotics as well as the concern for adverse effects from these medications. In one study of 878 patients, 60 % received a prescription for an opioid-containing medicine, while 19 % received a prescription for an analgesic that was available over-the-counter at emergency department discharge [20]. Patients that identified as African American, biracial, and Hispanic/Latino had significantly lower rates of opioid analgesic prescriptions. White patients had lower rates of over-the-counter analgesic medicine at discharge. Minority patients were also less likely to have fracture reduction in the emergency department compared to white patients. The conclusion of several authors has been that race and ethnicity are associated with variable analgesic prescription patterns in children treated with long bone fractures in the emergency department [21]. Race/ethnicity is associated with different analgesic prescription patterns in children treated in the emergency department for a long-bone fracture. The use of opioid analgesics and abdominal pain patients in the emergency department has seen similar disparities [20].

In 2013, *Pediatric Emergency Care* reported that black children were less likely to receive any analgesia while being evaluated in the emergency department compared to white children, who were used as a reference group. In a report on pediatric trauma patients, out of 1,945 patients, 58 % being white; 29 % black, and 13 % Hispanic, after multivariable adjustment, black patients were less likely to receive any analgesic treatment or opioid treatment; took longer to receive analgesia, with a mean difference in time to analgesic treatment of 32 minutes; and were less likely to receive reassessments of pain, compared with white patients [21]. In this particular study there were no ethnic disparities in most of the care measures between Hispanic and white pediatric patients. There were no disparities in pain assessment, pre- and post-procedural neurovascular assessment, procedural monitoring, or success of joint reduction across the racial/ethnic groups. Recent studies demonstrate a reduction in this disparity; however, there remains a distinct difference in the rate and the amount of narcotic prescribing for black and Hispanic patients as opposed to white patients.

Similar outcome disparities have been noted in pediatric pneumonia and asthma [22–26]. Data published in the *Journal of Health Care for the Poor and Underserved* in 2004 showed that minority populations were admitted at younger ages and were more likely to be admitted through the emergency department than white patients. Substantial variation exists in both types of care and outcomes for pneumonia in pediatric patients among different ethnic/racial groups. Several studies have demonstrated substantial differences in asthma rates as well as severity among minority children. Among the potential variables listed previously, geographic location, specifically large urban centers and areas with poor air quality, likely affects asthma care. Asthma was more prevalent among black children than white children, but not significantly different between Hispanic children and white children. When stratified by income, data reveals that only among children from families with incomes less than half the federal poverty level did black children have a higher risk of asthma than white children. Black vs. white differences did not exist at higher income levels, as those groups likely lived in areas with better air quality [22–26].

Conclusion

The review above and multiple other publications have already demonstrated that the problem is multifactorial. These factors include financial and payer status, cultural incompetence, systems related problems, learned cultural bias, and in a small percentage of cases, overt bigotry. Due to this multifactorial relationship it is reasonable to conclude that multiple remedies will be required.

Recommendations

1. While only responsible for a small percentage of the problem, there are likely some providers that are simply racially and culturally intolerant. These providers need to be identified, educated, and advised that such behavior is not acceptable. Those unable or unwilling to alter their behavior should be reassigned to areas that would not allow them to impact patient care.
2. Cultural competency education; in the same way as billing compliance and Health Insurance Portability and Accountability Act (HIPAA), specific cultural competency educational modules and testing on a regular basis should be implemented. All institutions should be encouraged to screen for disparities, identify the source, and bring resources needed to resolve disparities. Institutions should also be encouraged to track response to these remedies and refine them as needed. Such education should be part of new employee orientation as well as regular and ongoing training for all staff that have direct patient contact.
3. Improving access to care through reimbursement process. Given that SCHIP is now nearly universal, and full implementation of the Affordable Care Act is anticipated to increase coverage for the vast majority of Americans, pediatric patients should now have access to both primary care and specialty consultations. One may expect disparities based on payer status to diminish. Those at the margins who are not eligible for these programs will still continue to rely on the emergency room as the safety net of the health care system. However, given that the financial burden of uncompensated care is being lightened, health care systems should be in an improved position.
4. Decreasing disparities using diagnostic and treatment protocols. Several authors have identified that in situations where diagnostic or treatment algorithms are in place, disparities in these areas are greatly diminished. Furthermore, these protocols are typically evidence-based and should improve care for all. Once validated, they should be put forth as best practices. Quality markers and core measures should be attached to their use for reimbursement. This will provide financial rewards for the implementation. Where possible, institutions should be encouraged and incentivized or rewarded for creating treatment protocols and practice guidelines for providers designed to eliminate disparities in the diagnosis, evaluation and treatment of all patients. It will be most advantageous for many of these to become quality markers to be used for reimbursement purposes. By improving access to care, removing disparities, and providing follow-up and specialty treatment, the overall costs to the health care system should be greatly reduced. Since patient care should improve in these events, providers incorporating these best practices should be rewarded.
5. Universal ability and use of translators. Under current federal civil rights law, health care facilities are required to provide language translation services at no additional charge to a patient in need. Depending on the facility, this requirement can be seen as anything from a suggestion to a best practice. Facilities must provide full time translation services on an as-needed basis.

6. Further research into the causes and potential solutions. Future research efforts should be aimed at defining solutions for the problems that have been identified. While there may very well be additional disparities to be defined, it is also important to begin establishing what the appropriate remedies for the identified disparities are. Research identifying management treatment protocols as well as best practices and defining which should be core measures will significantly advance this effort.
7. Make reducing known disparities a core measure and tie their reduction to both institutional and provider reimbursement. Most institutions track core measures and provide rapid feedback to providers on their performance in adhering to them. Since improvement in many of these disparities like length of stay for appendicitis, and advanced imaging for minor head injuries will also save the institution money, addressing these will be doubly rewarding. There is also likely going to be an improvement in patient satisfaction if wait times are reduced and interpreter services are more available.

References

1. Wolfson J, Schrager S, Khanna R, Coates T, Kipke M. Sickle cell disease in California: sociodemographic predictors of emergency department utilization. Pediatr Blood Cancer. 2012;58(1):66–73. doi:10.1002/pbc.22979.
2. Simpson L, Owen PL, Zodet MW, Chevarley FM, Dougherty D, Elixhauser A, McCormick MC. Health care for children and youth in the United States: annual report on patterns of coverage, utilization, quality, and expenditures by income. Ambul Pediatr. 2005;5(1):6–44. doi:10.1367/A04-119R.1.
3. Venkat A, Onyekwere U, O'Neill J, Hegde G, Shang J, Campbell T. Racial disparities in insurance reimbursement for physician professional services in the ED. Am J Emerg Med. 2014;32(9):1060–7. doi:10.1016/j.ajem.2014.06.029.
4. Lau M, Lin H, Flores G. Racial/ethnic disparities in health and health care among U.S. adolescents. Health Serv Res. 2012;47(5):2031–59. doi:10.1111/j.1475-6773.2012.01394.x.
5. Carroll K, Cooper W, Blackford J, Hickson G. Characteristics of families that complain following pediatric emergency visits. Ambul Pediatr. 2005;5(6):326–31. doi:10.1367/A04-187R1.1.
6. Hausmann L, Jeong K, Bost J, Ibrahim S. Perceived discrimination in health care and health status in a racially diverse sample. Med Care [serial on the Internet]. 2008 [cited 2014 Oct 24];46(9):905–14. Available from: CINAHL.
7. Shone LP, Dick AW, Klein JD, Zwanziger J, Szilagyi PG. Reduction in racial and ethnic disparities after enrollment in the State Children's Health Insurance Program. Pediatrics. 2005;115(6):e696–705. doi:10.1542/peds.2004-1726.
8. Park C, Lee M, Epstein A. Variation in emergency department wait times for children by race/ethnicity and payment source. Health Serv Res. 2009;44(6):2022–39. doi:10.1111/j.1475-6773.2009.01020.x.
9. Payne NR, Puumala SE. Racial disparities in ordering laboratory and radiology tests for pediatric patients in the emergency department. Pediatr Emerg Care. 2013;29(5):598–606. doi:10.1097/PEC.0b013e31828e6489.
10. Shafi S, Gentilello LM. Ethnic disparities in initial management of trauma patients in a nationwide sample of emergency department visits. Arch Surg. 2008;143(11):1057–61. doi:10.1001/archsurg.143.11.1057.

11. Howard I, Joseph J, Natale J. Pediatric traumatic brain injury: do racial/ethnic disparities exist in brain injury severity, mortality, or medical disposition? Ethn Dis [serial on the Internet]. 2005 [cited 2014 Oct 24];15(4):S51–6. Available from: Science Citation Index.
12. Wallbrecht J, Hodes-Villamar L, Weiss SJ, Ernst AA. No difference in emergency department length of stay for patients with limited proficiency in English. South Med J. 2014;107(1):1–5. doi:10.1097/SMJ.0000000000000037.
13. Sabharwal S, Zhao C, McClemens E, Kaufmann A. Pediatric orthopaedic patients presenting to a university emergency department after visiting another emergency department: demographics and health insurance status. J Pediatr Orthop. 2007;27(6):690–4. doi:10.1097/BPO.0b013e3181425653.
14. Levas M, Dayan P, Mittal M, Stevenson M, Bachur R, Dudley N, et al. Effect of Hispanic ethnicity and language barriers on appendiceal perforation rates and imaging in children. J Pediatr. 2014;164(6):1286–91.e2. doi:10.1016/j.jpeds.2014.01.006.
15. Guagliardo MF, Teach SJ, Huang ZJ, Chamberlain JM, Joseph JG. Racial and ethnic disparities in pediatric appendicitis rupture rate. Acad Emerg Med. 2003;10(11):1218–27. doi:10.1197/S1069-6563(03)00492-5.
16. Kokoska ER, Bird TM, Robbins JM, Smith SD, Corsi JM, Campbell BT. Racial disparities in the management of pediatric appendicitis. J Surg Res. 2007;137(1):83–8. doi:10.1016/j.jss.2006.06.020.
17. Lane W, Rubin D, Monteith R, Christian C. Racial differences in the evaluation of pediatric fractures for physical abuse. JAMA. 2002;288(13):1603–9. doi:10.1001/jama.288.13.1603.
18. Mannix R, Bourgeois F, Schutzman S, Bernstein A, Lee L. Neuroimaging for pediatric head trauma: do patient and hospital characteristics influence who gets imaged? Acad Emerg Med. 2010;17(7):694–700. doi:10.1111/j.1553-2712.2010.00797.x.
19. Goyal MK, Hayes KL, Mollen CJ. Racial disparities in testing for sexually transmitted infections in the emergency department. Acad Emerg Med. 2012;19(5):604–7. doi:10.1111/j.1553-2712.2012.01338.x.
20. Quazi S, Eberhart M, Jacoby J, Heller M. Are racial disparities in ED analgesia improving? Evidence from a national database. Am J Emerg Med. 2008;26(4):462–4. doi:10.1016/j.ajem.2007.05.007.
21. Tsai CL, Sullivan AF, Gordon JA, Kaushal R, Magid DJ, Blumenthal D, et al. Racial/ethnic differences in emergency care for joint dislocation in 53 US EDs. Am J Emerg Med. 2012;30(9):1970–80. doi:10.1016/j.ajem.2012.04.023.
22. Washington EL, Shen JJ, Bell R, Coleman C, Shi L. Patterns of hospital-based pediatric care across diverse ethnicities: the case of pneumonia. J Health Care Poor Underserved. 2004;15(3):462–73. doi:10.1353/hpu.2004.0050.
23. Smith L, Hatcher-Ross J, Wertheimer R, Kahn R. Rethinking race/ethnicity, income, and childhood asthma: racial/ethnic disparities concentrated among the very poor. Public Health Rep [serial on the Internet]. 2005 [cited 2014 Oct 24];120(2):109–16. Available from: CINAHL.
24. Oraka E, Iqbal S, Flanders W, Brinker K, Garbe P. Racial and ethnic disparities in current asthma and emergency department visits: findings from the National Health Interview Survey, 2001-2010. J Asthma. 2013;50(5):488–96. doi:10.3109/02770903.2013.790417.
25. Law H, Oraka E, Mannino D. The role of income in reducing racial and ethnic disparities in emergency room and urgent care center visits for asthma-United States, 2001-2009. J Asthma. 2011;48(4):405–13. doi:10.3109/02770903.2011.565849.
26. Wright K. Disparities and predictors of emergency department use among California's African American, Latino, and White children, aged 1-11 years, with asthma. Ethn Dis [serial on the Internet]. 2009 [cited 2014 Oct 24];19(1):71–7. Available from: Science Citation Index.

Chapter 17
Religio-cultural Considerations When Providing Health Care to American Muslims

Ugo A. Ezenkwele, Gholamreza Sadeghipour Roodsari, and Aasim I. Padela

Introduction

Background

Culture is a set of beliefs, customs, and ways of thinking and, while a potentially separate aspect of one's identity, religion informs culture and impacts the meaning making activities of human behavior. Culture and religion can impact the communication between patients and health care providers, and informs for both parties the meanings attached to illness, preventive health care, and understandings of how illnesses are ameliorated [1–3].

The importance and necessity of cultural awareness in health care delivery has been discussed extensively in the extant health literature [4, 5]. Defined as "the ability of the health care providers to understand and respond to the unique cultural needs brought by patients to the health care encounter" [4], cultural awareness can affect diagnosis and treatment of diseases and may reduce minority health disparities by helping reduce miscommunication and promoting greater understanding and satisfaction within the patient–provider dyad [1, 5, 6]. Cultural awareness leads to cultural competency as a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables them to

---

U.A. Ezenkwele, M.D., M.P.H. (✉)
Department of Emergency Medicine, Woodhull Medical and Mental Health Center,
New York University School of Medicine, Brooklyn, NY, USA
e-mail: Ugo.Ezenkwele@nyumc.org

G.S. Roodsari, M.D., M.P.H.
Emergency Department, King's County Hospital—SUNY Downstate Medical Center,
Brooklyn, NY, USA

A.I. Padela, M.D., M.Sc.
Department of Medicine, The University of Chicago, Chicago, IL, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_17

work effectively in cross-cultural situations" that engenders delivery of health care responsive to unique cultural needs [5, 7].

Some studies have reported that health care providers may hold the belief that "treating patients equally, regardless of their ethnicity and culture" [8] is sufficient for quality health care delivery. However, this attitude is viewed by some health care experts to reflect a "cultural blindness" [8, 9]. Seeing all patients in the same way may overlook the specific needs of each social, cultural, and religious group and result in a lack of patient-centered care and the perpetuation of health care disparities [5, 7]. Instead, patient centeredness and cultural competence, two different but overlapping concepts, call for addressing the specific cultural needs of each patient and mitigating the disparities resulting from the lack of cultural accommodations [10].

The lack of culturally sensitive care can impair health care delivery in many different ways, the most prominent being poor patient–doctor communication and discriminatory care provision [3, 12]. In the emergency medical setting, effective communication is critically important for several reasons. Emergency departments (EDs) act as a triage center and the initial patient–provider communication may dictate the sorts of clinical care delivered downstream [3]. In critical and highly emergent situations the possibility for misunderstanding to lead to low quality care is high; thus, clear communication that attends to the cultural dimensions of patient's understandings of health and disease is critical for providing quality care [3, 11].

Studies show that racial, ethnic, and religious minority populations receive lower quality care, even with equal insurance status and income [2, 6]. Some of these differences in health outcome relate to poor cross-cultural communication skills on the part of the provider that may lead to mistrust, stereotyping, and discrimination. Culture and religion-based discrimination can appear in two forms: direct discrimination, which includes deliberate unfair treatment of a cultural, ethnic, or religious group, and an indirect form where the health care provider does not appreciate the beliefs and practices of the patient due to ignorance and may not be aware of the patient's specific health care needs because of a lack of cultural awareness [12].

Fortunately, intolerance of stereotyping, cultural competency training, diversification of the health care workforce, and clinical system modifications that are attuned to the religious and cultural sensibilities of patients are effective means for addressing concerns regarding miscommunication and discrimination and may help to reduce health disparities [1, 3, 11].

The Muslim American Population

There are 1.57 billion Muslims in the world comprising 23 % of the total world population [13]. The estimated number of Muslims in the USA varies considerably from 2.5 to 8 million [8, 13–16]. There are many reasons for the wide variance in Muslim population estimates including the lower likelihood of self-reporting

Muslim identity especially in a post-9/11 climate that is at time hostile to Muslim identity and the lack of religious affiliation captured by national census data [16, 17].

In the near future, Islam is expected to be the second largest religion in the USA [8]. A common mistake is to conflate "Arab" ethnicity for "Muslim" identity. The word "Arab" refers to a regional ethnicity or group of individuals tied by a shared language, while the word "Muslim" defines a much larger religious group with common beliefs and values that may not share ethnicity and language [12]. Indeed only 20 % of the Muslims in the world are Arab and in the USA, Arab descendents at highest estimation comprise only 25 % of the total number of Muslims [15, 17, 18].

One fourth of the Muslim American population is African American and another one fourth is from the Middle East and North Africa, including Arabs [18]. Around 25–34 % is from South Asia, mainly including Pakistan, Bangladesh, Indonesia, India, and Malaysia [18]. Muslims, therefore, are a very heterogeneous population, especially in North America, and come from very different cultural, educational, and socioeconomic backgrounds [15]. Despite this and the fact that individuals have different levels of religiosity, Islam plays a central role in daily life of Muslims, they share similar values and ideologies and certain religious beliefs are homogenous [15, 19].

Around 65 % of Muslim population in the USA is foreign born and most of them (94 %) reside in metropolitan areas [17]. Furthermore nearly one-third of Muslim Americans reside in Michigan, California, New York, and Illinois [20].

Discussion

Health Disparities Among Muslim Americans

Studies focusing on health issues of Muslim Americans are limited in number and much of the extant health literature is not empirically based [16, 17]. Nonetheless, the available research confirms that several key Islamic values and concepts impact the health behaviors and hence are important to recognize and acknowledge for the delivery of religio-culturally sensitive health care.

Since 9/11, Muslims are a target of hate and discrimination in the USA and many feel unwelcome in the health care system [7, 17]. For example, Muslim women report being harassed for wearing *hijab* in the health care environment [12, 17]. Muslim immigrants also find the health care system in the USA complicated and confusing. Language barriers, cultural misconceptions and perceptions of disrespect, discrimination, mistrust of the system, lack of knowledge about their religious and cultural practices, fear of poor treatment, and gender preferences in health care are some of the posited reasons leading to health inequities in this population [6–9, 20]. In a recent study, 83 % of health care providers reported challenges while providing care for Muslim women and 94 % of patient participants (Muslim Women) reported that the health care providers did not understand their cultural needs [21].

Islam and Islamic Beliefs

Islam is one of the three Abrahamic religions, along with Christianity and Judaism, and shares many beliefs with these two faiths including the belief in life and judgment after death, one's moral accountability to God and social teachings regarding caring for the indigent [12, 22]. Islam was established in seventh century by Mohammad in Mecca, Saudi Arabia [8, 15]. Shortly after his death, Muslims divided into two main branches: *Sunnis*, which includes the majority (80–90 %) and a *Shiite* minority (10–20 %) who mainly live in Iran, Iraq, and parts of Lebanon [15, 17]. There are two main sources for Islamic morality: the Qur'an, which is considered to be the literal word of God conveyed to the Prophet Mohammad, and the *Sunnah*, which includes the statements, tacit approvals, and actions of the Prophet Mohammad [15, 23]. Of note the Qur'an is also held to be a source of healing and a comfort for the ill, and thus Muslim patients may recite it or have others do so while in the hospital [15, 23].

For some Muslims, the community religious leader, called an *Imam* or *Shaykh*, may provide religious guidance regarding treatment decisions. These leaders can be helpful in encouraging healthy behaviors (e.g., sending messages during religious gatherings) and performing life and death rituals, and are seen as a source of religious guidance for Muslim patients and providers facing moral dilemmas in health care [14, 24].

General Beliefs about Health and the US Health Care System among Muslim Americans

Islam encourages the use of science and medicine [17] and many Muslims respect Western medicine's healing capacity [9, 20, 25]. Physicians are held in high regard with great respect and trust in Muslim communities and therefore, patients tend to submit to their authority without questioning [20, 22]. Qualitative studies have shown that Muslim populations do not consider good health as solely the absence of disease; but rather good health is perceived as a state of balance and poor health as a state of imbalance [25].

There is, in general, the expectation that patients will receive medications: either a prescription to take home or an injection at the hospital. If the health care provider does not prescribe any medicine, the patient may think nothing was done. Therefore, managing expectations or an explanation about the importance of other kinds of treatment or consultation may be required [25].

Prayer

One of the five pillars of Islamic worship is prayer. Muslims are enjoined to pray five times a day at specific intervals starting at dawn and extending into the night with the time of prayer slightly changing daily according to the changes in daylight hours. The most important prayer of the week occurs on Friday around midday and it is a congregational prayer usually performed in mosques [15]. For prayer, Muslims must stand facing Mecca, the holy city in Saudi Arabia. Therefore, patients may ask about compass directions so that they may face northeast which is the direction towards Mecca in North America [15]. During prayer Muslims observe cycles of standing, bending, and kneeling with the head on the floor [15]. If the patients cannot stand up, they can pray sitting in a chair or bed and prayer should not be interrupted until finished [22]. A quiet environment should be provided for the patient during prayer, if possible [2, 8]. Neutral prayer space has been reported as one of the key health care accommodations asked by Muslim Americans, along with no interruption during the prayer [7].

Before prayer, Muslim patients may request to perform a ritual ablution called *wudu* including washing of the face, hands, arms up to the elbows, and feet [15, 20]. Also important is the general cleanliness of the area. For prayer, one's body, clothes, and place should be free of "dirtiness," including blood, stool, and urine. For this reason, patients usually prefer the bathroom to a bed pan, and use a prayer rug for prayer [2, 8].

Fasting

Fasting during the month of Ramadan is mandatory in Islam. The Islamic calendar is lunar and therefore the time of Ramadan varies and can be in any of the four seasons. As a result, Muslims may face greater challenges when Ramadan occurs during the longer, hotter summer days [15, 22, 26]. During the month, Muslims avoid eating, drinking, and sexual activity from dawn to dusk. Generally, Muslims eat a light meal before dawn and a complete meal after sunset. After sunset, there is usually a family feast and therefore food consumption may paradoxically increase during Ramadan [15, 20].

Although people who are travelling, menstruating women, and sick individuals are exempt from fasting, many Muslims try to fast during illness because not fasting is perceived as a personal failure [15, 20, 22, 26]. We recommend a thorough history to include questions about fasting because it can impact the care being provided, i.e., a diabetic Muslim patient on long-acting insulin will need medication adjustment during a fast [20]. All medications, both oral and injectable, should be adjusted to nighttime administration during Ramadan, when possible. Health care providers should provide positive support and avoid advising patients not to fast if the patient wants to. Muslims may be more likely to take the advice if they believe that their health care provider is knowledgeable about fasting [20, 26]. Involving religious leaders may help in promoting informed choice (both religiously and medically) regarding decisions to fast [26].

Diet

There are specific dietary codes in Islamic law. Not only are pork and alcohol strictly prohibited in Islam, but they are considered "religiously dirty." Therefore, any medicine that is prepared using products derived from swine or alcohol is forbidden by most religious authorities [19, 20]. Furthermore, meat should only be consumed if it is "*Halal*," meaning the animal is killed in a particular way and specific prayers are recited before slaughtering the animal. *Halal* food is also perceived by some Muslims to be healthier and assists the body to heal [7, 15, 19]. If not available, vegetarian food should be served for Muslim patients who observe these dietary regulations [20].

God's Will and Fatalism

Muslims frequently refer to God in daily conversations. "Praise to God" follows statements with positive connotations, including health. "*In-sha-allah*" (God willing) is used frequently when any plan, wish, or future result is expected; even when making an appointment. These phrases are often a sign of being polite and not being assertive about the future [20]. However, the idea that nothing occurs without the will of God is a major doctrine that may impact health behaviors [14, 22, 23]. Muslims view physicians as the means through which help is received; whereas the healing is endowed by God [14, 22, 23]. Muslim Americans may also view religious leaders (Imam) or family members as adjuncts to healing [14]. The concept of "God's will," however, does not imply that Muslims are fatalistic, but rather that they have a personal responsibility to God to maintain their health and should actively seek help when necessary [20, 25].

Family's Role

The family is a core institution of Muslim society. Decisions about important issues are often made collectively and many family members are often present at the times of birth, illness, and death. Loyalty to one's family and a respect for the elderly are considered important Islamic social teachings [9, 20, 25]. Therefore, a health care provider should build trust with family members, alongside the patient. Complex decision-making may proceed through a family spokesperson—usually the oldest male. Providers should be cognizant of the potential norms regarding surrogate decision-making and familial negotiation [12, 25]. Visiting the sick members of one's community is a communal obligation in Islam and health care providers should expect many people to visit the patient, even if they are not directly related [27].

Death

Death is considered to be a parting from this temporal life towards the eternal one. It is an occasion for many religious rituals [15, 27]. Near the time of death, family members may want to turn the patient's face toward Mecca and to read the Qur'an to the patient. They may want the patient to say "*shahada*" (testimony of faith) [15, 20, 28]. Brain death and organ donation present complicated ethical challenges and are treated with some ambiguity in Islamic law. Different authorities have endorsed different definitions of death. Some acknowledge brain death as equivalent to death proper in Islam, while others consider only cessation of the heart beat and respiration as death [23, 29]. Similarly some authorities suggest that organ donation is Islamically permissible while others find it problematic. This plurality has its roots in the differences among schools of Islamic law and different moral reasoning methodologies [15, 17, 23]. While some studies have reported that Islamic religiosity might negatively affect the attitude towards organ donation [17, 30, 31], mosque community-based research did not confirm such a relationship [17]. It is even reported that religion can be a motivating factor among Muslims who agree to organ donation [31]. Ethnicity appears to play a role in organ donation attitudes, with Middle Eastern Muslims having the highest rates of belief in cadaveric organ donation, followed by South Asians and African American Muslims [17, 28].

After death, a large group of family members may come to the hospital and participate in the grieving process [20, 28]. Religious rituals performed by family members may include ritual washing and wrapping of the body in a simple white cloth and prompt burial at a Muslim cemetery [27, 28]. Autopsy is another controversial topic. While it is performed on a regular basis in many Muslim countries, it is considered undesired because it is believed that the physical body should be clean, normal appearing, and not distorted to preserve dignity [32, 33].

Gender Roles

In Muslim communities, gender is an important factor of identity and influences social roles. It even affects self-reported health, as women are more likely to self-evaluate their health as poor [34]. Separation of genders is a norm of Muslim societies and depending on acculturation, contact between male and female may be limited to only family members. Skin-to-skin contact, even shaking hands between men and women, is considered inappropriate and is strongly discouraged, although these rules are relaxed somewhat if medical treatment is required. Female patients may also deny physical examinations or delay care if the health care provider is from the opposite gender [8, 15]. Asking for same-gender health care provider is repeatedly the single most frequent cultural accommodation asked by Muslims of both genders [7, 8, 15]. Islamic law dictates a priority-order for physician selection founded upon preserving modesty in cross-gender interaction where Muslim patients are encouraged to seek out Muslim physicians of the same gender, and if not available a non-Muslim from the same gender [35]. Touching the opposite gender, even tapping on their shoulder can make the patient very uncomfortable and be considered offensive [15]. If there is no other choice, having gloves on during a physical exam may help the patient feel more comfortable since it prevents skin to skin contact [2, 35]. Religious teachings also inform dress codes, including covering of the body of both males and particularly females [20, 35]. Therefore, gowns which adequately cover the patient's body or allowing them to remain dressed in their own clothing is helpful. During the exam, expose only the body part which is being examined, and allow the rest of the body to remain covered [35]. Some women may want to follow the rules of *Hijab*, in which they are instructed to cover the whole body, including the hair, except for face and hands [17, 20, 35].

Sexual relations prior to and outside of marriage are strictly prohibited by Islamic law [9], thus rates of premarital and extramarital sex are quite low in Muslim communities and those relationships bring stigma and shame to the person and the family [8, 20]. It is recommended that sexual history taking be performed with extreme sensitivity (in private and indirectly) and only when necessary [6]. As in all cultures, Islamic gender norms are increasingly variable and as attitudes are evolving, traditional interpretations of gender roles are evolving as well.

Conclusion

Religio-cultural competence is important for delivering high-quality health care. This chapter serves as a basic resource for providing culturally sensitive care to American Muslims. Although Muslim Americans are a population with a common religious identity, significant heterogeneity in religiosity is present within this group. It is important, therefore, to take our guidelines as a general framework for understanding Muslim patient values and health behaviors while being attuned to providing health care accommodations for the specific needs and values of the "Muslim" patient you are treating [9, 20].

Recommendations

- Consider same-gender health care provider and principles of modesty. Avoid opposite gender skin to skin contact. If opposite gender care cannot be avoided, keep the patient covered as much as possible and use a barrier (i.e., gloves).
- Involve family. Discuss severe illness or disease with the elder family member and involve the decision maker member (after patients' consent is obtained).
- Respect and understand the needs for prayer: space, no interruption, cleanliness.
- Meet dietary needs, including Halal meat or vegetarian food, fasting, and adjustments to medication administration.

References

1. Brach C, Fraserirector I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Med Care Res Rev. 2000;57(S1):181–217.
2. Padela A. Can you take care of my mother? Reflections on cultural competency and clinical accommodation. Acad Emerg Med. 2007;14(3):275–7.

3. Richardson LD, Irvin CB, Tamayo-Sarver JH. Racial and ethnic disparities in the clinical practice of emergency medicine. Acad Emerg Med. 2003;10(11):1184–8.
4. American College of Emergency. Cultural awareness and emergency care. Ann Emerg Med. 2008;52(2):189.
5. Betancourt JR, Green AR, Carrillo E, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep. 2003;118(4):293–302.
6. Ezenkwele UA, Roodsari GS. Cultural competencies in emergency medicine: caring for Muslim-American patients from the Middle East. J Emerg Med. 2013;45(2):168–74.
7. Padela AI, Gunter K, Killawi A, Heisler A. Religious values and healthcare accommodations: voices from the American Muslim community. J Gen Intern Med. 2012;27(6):708–15.
8. Yosef AR. Health beliefs, practice, and priorities for health care of Arab Muslims in the United States: implications for nursing care. J Transcult Nurs. 2008;19(3):284–91.
9. Kulwicki AD, Miller J, Schim SM. Collaborative partnership for culture care: enhancing health services for the Arab community. J Transcult Nurs. 2000;11(1):31–3.
10. Saha S, Beach MC, Cooper L. Patient centeredness, cultural competence and healthcare quality. J Natl Med Assoc. 2008;100(11):1275–85.
11. Padela AI, Punekar I. Emergency medical practice: advancing cultural competence and reducing health care disparities. Acad Emerg Med. 2009;16(1):69–75.
12. Laird LD, Amer MM, Barnett ED, Barnes LL. Muslim patients and health disparities in the UK and the US. Arch Dis Child. 2007;92(10):922–6.
13. Pew Research Center's Forum on Religion & Public Life. Mapping the global Muslim population, a report on the size and distribution of the world's Muslim population, 2009 [cited Nov 1st 2014]. Available from: http://www.pewforum.org/2009/10/07/mapping-the-global-muslim-population/
14. Padela AI, Killawi A, Forman J, DeMonner S, Heisler M. American Muslim perceptions of healing: key agents in healing, and their roles. Qual Health Res. 2012;22(6):846–58.
15. Lawrence P, Rozmus C. Culturally sensitive care of the Muslim patient. J Transcult Nurs. 2001;12(3):228–33.
16. Padela AI, Raza A. Studying healthcare disparities among American Muslims: Mining the MEDLINE literature, using ethnic and nationality markers as a proxy for religious affiliation. J Health Dispar Res Pract. Forthcoming.
17. Inhorn MC, Serour GI. Islam, medicine, and Arab-Muslim refugee health in America after 9/11. Lancet. 2011;378:935–43.
18. Muslim American demographic facts: Allied Media Corporation. Bridges TV- American Muslim Lifestyle Network. 2000. [cited Dec 10th 2014]. Available from: http://www.allied-media.com/AM/
19. Padela AI, Curlin F. Religion and disparities: considering the influences of Islam on the health of American Muslims. J Relig Health. 2012;52(4):1333–45.
20. Hammad A, Kysia R, Rabah R, Hassoun R, Connelly M. Guide to Arab culture: health care delivery to the Arab American community. ACCESS (Arab Community Center for Economic and Social Services), Public Health Education and Research Department; 1999.
21. Hasnain M, Connell KJ, Menon U, Tranmer PA. Patient-centered care for Muslim women: provider and patient perspectives. J Womens Health (Larchmt). 2011;20(1):73–83.
22. Sirois ML, Darby M, Tolle S. Understanding Muslim patients: cross-cultural dental hygiene care. Int J Dent Hyg. 2013;11(2):105–14.
23. Sachedina A. End-of-life: the Islamic view. Lancet. 2005;366:774–9.
24. Padela AI, Killawi A, Heisler M, Demonner S, Fetters MD. The role of Imams in American Muslim health: perspectives of Muslim community leaders in Southeast Michigan. J Relig Health. 2011;50(2):359–73.
25. Basil H, Faisal H. The cultural gap delivering health care services to Arab American population in the United States. J Cult Divers. 2010;17(1):20–3.
26. Kridli SA. Health beliefs and practices of Muslim women during Ramadan. MCN Am J Matern Child Nurs. 2011;36(4):216–21.

27. Sarhill N, LeGrand S, Islambouli R, Davis M, Walsh D. The terminally ill Muslim: death and dying from the Muslim perspective. Am J Hosp Palliat Care. 2001;18(4):251–5.
28. Gatrad R, Sheikh A. Palliative care for Muslims and issues after death. Int J Palliat Nurs. 2002;8(12):594–7.
29. Padela AI, Arozullah A, Moosa E. Brain death in Islamic ethico-legal deliberation: challenges for applied Islamic bioethics. Bioethics. 2013;27(3):132–9.
30. Padela AI, Zaganjor H. Relationships between Islamic religiosity and attitude toward deceased organ donation among American Muslims: a pilot study. Transplantation. 2014;97(12):1292–9.
31. Padela AI, Rasheed S, Warren GJ, Choi H, Mathur AK. Factors associated with positive attitudes toward organ donation in Arab Americans. Clin Transplant. 2011;25(5):800–8.
32. Mohammed M, Kharoshah MA. Autopsy in Islam and current practice in Arab Muslim countries. J Forensic Leg Med. 2014;23:80–3.
33. Rady MY, Verheijde JL. Brain-dead patients are not cadavers: the need to revise the definition of death in Muslim communities. HEC Forum. 2013;25(1):25–45.
34. Asfar T, Ahmad B, Rastam S, Mulloli TP, Ward KD, Maziak W. Self-rated health and its determinants among adults in Syria: a model from the Middle East. BMC Public Health. 2007;7(1):177.
35. Padela AI, Rodriguez del Pozo P. Muslim patients and cross-gender interactions in medicine: an Islamic bioethical perspective. J Med Ethics. 2011;37(1):40–4.

Chapter 18
Disparities and Diversity in Biomedical Research

Lynne Holden and Lynne D. Richardson

Introduction

Despite the remarkable scientific advances achieved by biomedical research over the past 50 years, there is convincing evidence that not all segments of the population have benefited equally from this progress. Persistent differences exist in health status and health care outcomes as a function of race, ethnicity, English language proficiency, insurance status, and other social, economic, and demographic characteristics [1–4]. Eliminating these disparities in health and health care has been a national priority for federal public health and research agencies for the past decades but progress towards this goal has been painfully slow [4–6].

The research community is central to accelerating the achievement of health equity through the creation of scientific knowledge to inform our understanding of the underlying mechanisms that cause disparities and the development of evidence-based interventions to reduce and ultimately eliminate health and health care disparities. This undertaking involves significant conceptual and methodological challenges, as well as consideration of the current scientific context within which research on minority populations occurs, and the diversity and cultural competency of the research workforce. Research on health disparities has already yielded substantial information about the magnitude of the problem as well as insights about etiologies, mechanisms, and possible interventions to improve health equity. Continuing efforts and new approaches are needed to identify, measure, understand, and eliminate disparities.

L. Holden, M.D.
Department of Emergency Medicine, Montefiore Medical Center, Bronx, NY, USA

L.D. Richardson, M.D. (✉)
Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai,
New York, NY, USA
e-mail: lynne.richardson@mssm.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_18

A 2006 IOM Report noted that the "study of disparities is the study of the multiple, complex, and sometimes subtle relationships among genetic susceptibility, individual behavior, social environment, physical surroundings, disease prevention, and treatment interventions that lead to the observed differences in health status and health outcomes" [6]. Over the past decade, it has become widely accepted that examination of the social determinants of health is crucial to understanding disparities and to designing interventions to eliminate them [7]. Recent advances in genomic science and the emergence of personalized medicine are creating new ways to identify those at highest risk of poor outcomes and to target treatments to optimize benefits. Successful development of the science of disparities will require the full range of research approaches: basic, translational, clinical, epidemiological, behavioral, and health services research [6].

Achieving diversity in the biomedical, health services and behavioral research workforce is critical to ensuring that the best and brightest minds are available to contribute their efforts to our national research goals. Despite long-standing efforts from the public and the private sectors to increase the number of scientists from underrepresented groups, diversity in the biomedical research workforce still falls far short of mirroring that of the US population [8]. This has implications for both the quality and the fairness of the research enterprise. Diverse teams working together outperform homogenous teams, particularly when teams address complex problems in biomedical and behavioral research, technology, and health [9, 10]. Increasing workforce diversity has also been shown to expand the range of research questions, some of which may have been neglected [11]. Many experts agree that development of a diverse research workforce—in basic, clinical, health services, and behavioral research—is an essential component of reducing health inequities [12, 13].

This chapter reviews the progress that has been made and discusses the continuing challenges to achieving health equity and to building a diversified research workforce.

Discussion

The Role of Research in Eliminating Health and Health Care Disparities

The goal of eliminating health disparities cannot be accomplished by a single sector or entity but the role of research and data in driving policy and interventions to address health disparities cannot be overemphasized. Research uncovers the dimensions and complexities of health disparities and provides the evidence base for actions that can be taken at multiple levels to promote health equity. It is research that identifies and measures disparities in health status, health care, and health outcomes. It is research that has revealed the multifactorial causes of health disparities and the interactions between biological, social and environmental factors [6, 7]. Research has documented the role of bias and stereotyping on the part of health care providers in contributing to unequal treatment [14]. It is research that precisely characterizes the prevalence of various diseases and their complications in specific population subgroups to allow appropriate diagnostic decision-making and research that reveals differential treatment efficacy across various racial and ethnic groups [15]. It is research that has established the linkage between health inequities and the social determinants of health (i.e., the conditions in which people are born, grow, live, work, and age) [6, 7, 13]. And it is research that formally tests effectiveness of patient-level, provider focused, systems-level, and community-based initiatives to eliminate disparities.

In 2009, the Federal Collaboration on Health Disparities Research (FCHDR) was established to increase scientific collaboration to eliminate health disparities and to explore needs and opportunities for pooling scientific expertise and resources to conduct, translate, and disseminate research to develop the evidence base for policy and practice. The objectives of the FCHDR are to explore the complexity of addressing the broad biological and nonbiological determinants of health; to develop the evidence base; to identify new or improved solutions; and to support and disseminate research. Led by the Office of Minority Health of the US Department of Health and Human Services, and the National Institute on Minority Health and Health Disparities of the National Institutes of Health, the FCHDR fosters communication, coordination, and collaboration amongst federal agencies that sponsor health disparities research and promotes continued integration of science, practice, and policy, including actions on the social determinants of health and community engagement [7].

Defining and Measuring Disparities

For many years, disparities research was hampered by a lack of consensus on how to define health disparities and how to measure them. Health disparities are more than simple differences in health. The term *disparity* connotes a difference that is inequitable, unjust, or unacceptable [6]. Observed differences in health between groups vary depending on which groups are observed and what is measured. Characterization of a difference as unjust requires a detailed understanding of the nature and etiology of the difference and is likely to involve multiple criteria such as avoidability, mutability, and detriment to groups that are disadvantaged in terms of opportunities and access to resources [6]. Groups may be described by gender, race, ethnicity, education, occupation, income, place of residence, or other characteristics chosen by the observer. The choice of group characteristics may be based on a conceptual model, observed empirical differences, or beliefs regarding what is just [6].

Additional challenges to the investigation of health disparities are presented by the requirement for accurate identification and categorization of groups. With respect to race and ethnicity, self-identification is generally considered the gold standard [16]. Often these variables are assigned by clerical, clinical, or research staff without inquiry and many authors do not indicate how information about race and ethnicity of subjects was obtained [15, 16].

The granularity used to categorize race and ethnicity is another important methodological issue. The most commonly used are those delineated by the Office of Management and Budget (OMB) which includes five race categories: (1) American Indian or Alaska Native; (2) Asian; (3) Black; (4) Native Hawaiian or Other Pacific Islander; (5) White; and two ethnicity categories: Hispanic/Latino or non-Hispanic/Latino. The OMB allows for the designation of multiple race categories by an individual but it requires that race and ethnicity be separately designated. This creates conceptual issues for those who believe that race and ethnicity should not be considered separately because these two categories overlap, as well as practical issues for researchers since many Hispanic/Latino individuals self-identify only as Latino and refuse to designate a race [17].

Data that use large groupings of race and ethnicity may fail to distinguish substantial differences in health status within some racial groups. For example, data on Asians and Pacific Islanders are often pooled, masking the persistently poorer health indicators of Native Hawaiians. Similarly, patterns are seen in some Hispanic subgroups: Puerto Ricans often have significantly poorer measures of health status and health outcomes than Mexican Americans, whose status is usually poorer than that of Cuban Americans. Presenting measures of health for “Hispanics” masks the substantial variation among Hispanic subpopulations. Blacks are also quite heterogeneous with many ethnic subgroups. There have been many calls for more granular collection of race and ethnicity data to identify important health disparities among subgroups, an issue that was partially addressed in the 2010 census [6, 18].

Socioeconomic status (SES) presents different, but equally complex, measurement issues. The concept of SES is a composite of several factors. Classically these included individual income, education, and occupation but other factors such as household income, childhood income level, parental education, and wealth have been shown to influence health status and outcomes. Unfortunately, in many research studies, this complexity is lost because only one or two of these factors are measured, rather than incorporating all SES factors relevant for the research question being studied [6]. As a result, conclusions about the relationship between SES and health vary widely in the literature, depending on which SES measures were used.

Measurement issues in studies that examine race, ethnicity, and SES must also account for the interactions between these variables. In the USA, there is a nonrandom distribution of education and income across racial and ethnic groups [6]. Characteristics such as minority racial/ethnic status and low income or less education frequently coexist within populations and may interact with one another to produce health disparities. It is well documented that the meaning of specific indicators of socioeconomic status may differ across groups [6]. At each level of income, for example, African Americans and Hispanics have lower net worth and live in worse neighborhoods than whites [19, 20]. The meaning of educational attainment also varies across groups with higher education conferring lesser health benefits on minorities and women, reflecting lower social and economic returns on education for these groups [6, 19]. Special measurement problems arise for groups that have received their education in other countries, where there are different educational systems and levels of accreditation. In many populations, the data suggest that one cannot adequately study racial and ethnic disparities in health without considering socioeconomic factors and vice versa [19, 20]. Ideally, researchers should simultaneously examine the effects of race, ethnicity, socioeconomic status, and rural or urban residence when evaluating disparities.

Health care disparities are one particular aspect of health disparities which has received substantial attention. Differences in access to health care and the quality of health care for racial, ethnic, and limited English proficiency groups have been well documented [14]. While the overall impact of these disparities is considered small relative to other determinants of health, health care disparities are of substantial interest to the medical community and may be the most amenable to changes within the health care system [14, 15].

The US Department of Health and Human Services currently defines a “health disparity” as “a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion” [5, 6].

It is now clear that many of the underlying risk factors that contribute to health disparities are the result of where we live, learn, work, and play. These factors, commonly called “social determinants of health,” interact to impact health and contribute to health disparities. According to The National Partnership for Action to End Health Disparities, eliminating health disparities will necessitate behavioral, environmental, and social-level approaches to address issues such as insufficient education, inadequate housing, exposure to violence, and limited opportunities to earn a livable wage. Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities [21].

Measuring health equity requires, at a minimum, having population-based data on health status, health care, and the social determinants of health that can be disaggregated (with adequate sample sizes for reliable estimates) by race; ethnic group; markers of socioeconomic status such as income, education, and wealth; gender; disability status; sexual orientation, and other characteristics that have been associated with social stigma. Existing routine data systems have known limitations for examining race and socioeconomic status, but are particularly inadequate for capturing these other important dimensions of equity.

Key challenges in measuring health equity that should be addressed as part of efforts to eliminate health disparities include: inadequate numbers of certain highly disadvantaged groups, such as American Indians, in many routine data sources to obtain reliable estimates regarding their health needs; a complete absence of data on some groups, such as sexual orientation minorities; and inadequate information about social and economic conditions to understand either racial and ethnic or socioeconomic disparities, often resulting in erroneous assumptions regarding underlying reasons for the disparities [6].

Inclusion of Disparities Populations in Research Studies

Despite the substantial practical and methodological challenges involved in gathering accurate individual data on race, ethnicity, language preference, and other relevant demographic and social characteristics, it is imperative that such data be routinely collected in all health care settings, all research studies and all national datasets. Culturally competent health care requires control of the health care provider's biases and prejudices; it also requires accurate group specific data on disease presentation, prevalence, and processes in minority populations [14, 15]. Lack of knowledge regarding population-specific information may adversely affect the quality of diagnostic decision making for minority patients. Collection of more granular data on race, ethnicity, language preference, socio-economic status, gender identity and sexual orientation, and disabilities in all health surveys, data sets, and public health monitoring measures would dramatically enhance the data available to clinicians and researchers. Embedding disparities research into all large studies (molecular, clinical, and epidemiological), could be achieved through the greater inclusion of appropriate measures of race, ethnicity, socioeconomic status, and the psychosocial and environmental factors that are likely to shape health disparities in the population being studied at each time point of data collection. Consistent application of a health equity lens on all types of research is needed to generate the data required to identify, monitor, and eliminate health disparities.

Diversity of the Research Workforce

It has been suggested that a diverse team of researchers will be more likely to ask and pursue the most appropriate questions in the most appropriate manner to eliminate health disparities [11–13]. According to a 2010 Census Bureau report, minorities will make up half of the US population by 2050 [18]. However, the makeup of the biomedical research workforce does not reflect the diversity of the population. According to the National Science Foundation, underrepresented minorities are less likely than whites to attend or graduate from college with a degree in science or engineering [22]. Although underrepresented minorities' share of science degrees has been rising over the past decades, only 6.9 % of doctorate degrees were obtained by Blacks, Hispanics, and Native Americans in 2010 [22]. Similarly, the number of underrepresented minorities pursuing a medical degree is lagging behind the nation's demographic shift with only 13.5 % of physicians identifying as Black or

African American, Hispanic or Latino, and American Indian or Alaska Native in 2013 [23]. Only a fraction of those obtaining science or medical doctoral degrees actually conduct research, making the underrepresentation of Blacks, Latinos, American Indians, and Alaska Natives even more pronounced.

During the first decade of the twenty-first century, increasing the diversity of the research workforce had been the focus of several federal initiatives. For example, the National Institutes of Health, the nation's premiere research agency, launched both intramural and extramural biomedical research workforce programs to increase the number of underrepresented minorities in the research workforce pipeline, to mentor underrepresented minority scientists and strengthening the infrastructure of comparatively under-resourced minority institutions. These programs include Minority Access to Research Careers, Minority Biomedical Research Support, Research Centers at Minority Institutions, and Diversity Research Supplements. Other major federal funders of pipeline programs targeting biomedical research include: the Office of Minority Health of the Department of Health and Human Services, Centers for Disease Control, and the National Science Foundation. Most of these pipeline programs target college students; less than 12 % focus on middle or high school students [24].

It has been well documented that throughout the education pipeline, Black, Latino, and Native American students are less likely to graduate from high school, less likely to attend college, less likely to major in biomedical science, and less likely to obtain a doctoral level degree [22, 23]. However, it was commonly assumed that once minority scientists advanced to the stage of faculty, their chances of obtaining funding from NIH as principal investigators would be similar to those of white faculty. In 2011, a thoughtful analysis published by Ginther and colleagues examined data for research grants submitted to the National Institutes of Health between FY 2000 and FY 2006. The study sample included 83,188 applications from 40,069 unique PhD investigators; of these, 1.4 %, self-identified as Black, 3.2 % as Hispanic, and 0.05 % as Native American. The study determined that after controlling for education and training, employer characteristics, and measures of scientific achievement such as previous grants, publications, and citations; the likelihood of obtaining NIH funding for an R01 grant application, (the most common type of investigator-initiated research project grant), black applicants were 10 percentage points less likely to receive research funding compared with whites [25].

The results of this study sparked a national debate over lack of diversity in the research workforce and the fairness of the NIH review processes. Leadership of the National Institutes of Health called the findings unacceptable and responded swiftly, affirming the "urgent need to ensure that the scientific talent which is key to our nation's success is nurtured, recognized, and supported across all demographic groups" and described multiple objectives related to increased efforts to diversify the research workforce including: (1) improving the quality of the training environment; (2) balancing and broadening the perspective in setting research priorities; (3) improving the ability to recruit subjects from diverse backgrounds into clinical research protocols; and (4) improving capacity to address and eliminate health disparities [26].

Within a year, the NIH Working Group on Diversity on the Biomedical Workforce recommended a framework for action that included: data collection/evaluation; mentoring/career preparation and retention; institutional support at universities/academic health centers, and at NIH; and bias-related research and intervention testing [8]. The following year a series of new funding initiatives were announced including the National Research Mentoring Network (NRMN), Building Infrastructure Leading to Diversity (BUILD) and the Coordination and Evaluation Center (CEC). Evaluation of the impact of these initiatives is ongoing.

Experts agree that increasing the diversity of the biomedical workforce has to begin early and continue throughout career development. Early factors cited throughout the literature needed to achieve this goal include the elimination in disparities in K-12 education and the continuation of early intervention biomedical pipeline programs. The first step is to introduce science in an engaging fashion and as a potential career path beginning in elementary school to begin to develop scientific minds. This must be accompanied by enrichment from “pipeline programs” outside of the primary and secondary educational systems to educate and groom individuals from underrepresented groups for research careers.

Conclusion

The elimination of health disparities will require the engagement of the entire spectrum of biomedical, clinical, health services and behavioral research. Despite substantial progress, significant methodological, practical, and workforce challenges remain. The collection of granular data on individual demographic and social characteristics in all research studies and in all health care settings is an essential component to overcoming these challenges. A culturally competent and diverse research workforce is critical to the elimination of health disparities.

Recommendations

- Careful collection of appropriate measures of race, ethnicity, language preference, gender identity and sexual orientation, socioeconomic status, immigrant status, residential characteristics, psychosocial data, and environmental factors should be embedded into large research studies of all types (molecular, clinical, epidemiological, and health services) to allow examination of disparities issues in the population and condition being studied.
- Differential impact of treatments and interventions on racial, ethnic, and disadvantaged population groups should be measured in all therapeutic or interventional trials.
- Investigations designed to identify or measure disparities should use the “healthiest” population subgroup as the reference group, with the disparity defined as the absolute difference between the reference group and each other subgroup.

- Trans-disciplinary research initiatives using both quantitative and qualitative approaches are needed to further advance understanding of the underlying causes of health disparities, including the biological mechanisms mediating disparities, gene–environment interactions, and social factors such as social connectivity, stress, and racial/ethnic discrimination.
- Effective targeted interventions to reduce health disparities that are tailored (clinically and culturally) for specific populations must be developed, evaluated, and disseminated.
- Established investigators and research institutions should actively seek to increase the diversity of their research trainees and facilitate their success, which will serve to improve both the diversity and the cultural competence of the research workforce.
- Innovative middle school, high school, and college programs are needed to provide Black, Latino, Native American, and disadvantaged youth with research exposure and training.

References

1. Centers for Disease Control and Prevention (CDC). CDC health disparities and inequalities report – United States, 2011. MMWR Surveill Summ. 2011;60(Suppl):1–2.
2. Centers for Disease Control and Prevention (CDC). CDC health disparities and inequalities report - United States. MMWR Surveill Summ. 2013;62 Suppl 3:9–18.
3. Heckler MM. Report of the Secretary's task force on Black and minority health. Washington, DC: United States Department of Health and Human Services; 1985.
4. Agency for Healthcare Research & Quality [Internet]. Rockville (MD): Agency for Healthcare Research and Quality; [cited 2015 Feb 18]. National Healthcare Quality & Disparities Reports; [about 1 p.]. Available from: http://www.ahrq.gov/research/findings/nhqrdr
5. Department of Health and Human Services - USA. The Secretary's advisory committee on national health promotion and disease prevention objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020. Department of Health & Human Services - USA; 28 Oct 2008.
6. Institute of Medicine (US) Committee on the Review and Assessment of the NIH's Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities, Thomson GE, Mitchell F, Williams MB, editors. Examining the health disparities research plan of the national institutes of health: unfinished business. Washington, DC: National Academies Press; 2006.
7. Gracia JN, Ruffin J. Partnership, research, and leadership to advance health equity and eliminate health disparities. Am J Public Health. 2014;104 Suppl 4:S520–1.
8. Working Group on Diversity in the Biomedical Research Workforce (WGDBRW), The Advisory Committee to the Director (ACD). National institutes of health draft report of the advisory committee to the director working group on diversity in the biomedical research workforce. National Institutes of Health; 13 Jun 2012.
9. Hong L, Page SE. Groups of diverse problem solvers can outperform groups of high-ability problem solvers. Proc Natl Acad Sci U S A. 2004;101(46):16385–9. Epub 2004 Nov 8.
10. Sessa VI, Taylor JJ. Executive selection: strategies for success. San Francisco: Jossey-Bass; 2000.
11. Leung AK, Maddux WW, Galinsky AD, Chiu CY. Multicultural experience enhances creativity: the when and how. Am Psychol. 2008;63(3):169–81.

12. Stoff DM, Forsyth A, Marquez ED, McClure S. Introduction: the case for diversity in research on mental health and HIV/AIDS. Am J Public Health. 2009;99 Suppl 1:S8–15.
13. Satcher D. Embracing culture, enhancing diversity, and strengthening research. Am J Public Health. 2009;99 Suppl 1:S4.
14. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley BD, Stith AY, Nelson AR, editors. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press; 2003.
15. Richardson LD, Irvin CB, Tamayo-Sarver JH. Racial and ethnic disparities in the clinical practice of emergency medicine. Acad Emerg Med. 2003;10(11):1184–8.
16. Dehlendorf C, Bryant AS, Huddleston HG, Jacoby VL, Fujimoto VY. Health disparities: definitions and measurements. Am J Obstet Gynecol. 2010;202(3):212–3.
17. The White House [Internet]. The White House; [cited 2015 May 5]. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity; [about 15 p.]. Available from: http://www.whitehouse.gov/omb/fedreg/1997standards.html
18. United States Census Bureau [Internet]. U.S. Census Bureau; [cited 2015 Feb 26]. 2014 National Population Projections; [about 1 p.]. Available from: https://www.census.gov/population/projections/data/national/2014.html
19. Williams DR. Race, socioeconomic status, and health. The added effects of racism and discrimination. Ann N Y Acad Sci. 1999;896:173–88.
20. Kawachi I, Daniels N, Robinson DE. Health disparities by race and class: why both matter. Health Aff. 2005;24(2):343–52.
21. National Partnership for Action to End Health Disparities [Internet]. U.S. Department of Health & Human Services; [updated 2011 Mar 4; cited 2015 May 5]. Health Equity & Disparities; [about 1 p.]. Available from: http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34
22. National Science Foundation, National Center for Science and Engineering Statistics. Women, minorities and persons with disabilities in science and engineering: 2013. Arlington, VA: National Science Foundation; 2013. Special Report: NSF 13-304.
23. Nivet MA, Castillo-Page L. Diversity in the physician workforce: facts & figures 2014. Washington, DC: Association of American Medical Colleges; 2015.
24. U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration and HHS' Office of Public Health and Science (OPHS), Office of Minority Health (OMH). Pipeline programs to improve racial and ethnic diversity in the health professions: An inventory of federal programs, assessment of evaluation approaches, and critical review of the research literature. Apr 2009.
25. Ginther DK, Schaffer WT, Schnell J, Masimore B, Liu F, Haak LL, et al. Race, ethnicity, and NIH research awards. Science. 2011;333(6045):1015–9.
26. National Institutes of Health [Internet]. Bethesda (MD): U.S. Department of Health & Human Services; [updated 2014 Oct 22; cited 2015 May 5]. Overview [about 1 p.]. Available from: https://commonfund.nih.gov/diversity/overview

Part II
Cultural Competency Case Studies: Transitional Introduction

The following cases are provided for use in teaching environments for attending physicians, nurses, residents, students, and other health care professionals. Our intention in including these case studies is to enhance the chapter material. Instructors should feel free to model additional cases on those included here for teaching purposes.

The cases were developed with a focus on the Next Accreditation System for Emergency Medicine also known as Milestones. These milestones evolved from the original Accreditation Council for Graduate Medical Education (ACGME) core competencies. The majority of our contributors have experience in Emergency Medicine, which makes the Emergency Medicine Milestones an appropriate choice for inclusion. They were designed for programs to use in semiannual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. While some of the milestones are applicable to all health professionals, these competencies were written specifically as guidelines for emergency medicine residency programs.

Emergency Medicine Milestones [1]

Emergency Stabilization: Prioritizes critical initial stabilization action and mobilizes hospital support services in the resuscitation of a critically ill or injured patient and reassesses after stabilizing intervention.

Performance of Focused History and Physical Exam: Abstracts current findings in a patient with multiple chronic medical problems and, when appropriate, compares with a prior medical record and identifies significant differences between the current presentation and past presentations.

Diagnostic Studies: Applies the results of diagnostic testing based on the probability of disease and the likelihood of test results altering management.

Diagnosis: Based on all of the available data, narrows and prioritizes the list of weighted differential diagnoses to determine appropriate management.

Pharmacotherapy: Selects and prescribes appropriate pharmaceutical agents based upon relevant considerations such as mechanism of action, intended effect, financial considerations, possible adverse effects, patient preferences, allergies, potential drug–food and drug–drug interactions, institutional policies, and clinical guidelines; and effectively combines agents and monitors and intervenes in the advent of adverse effects in the ED.

Observation and Reassessment: Reevaluates patients undergoing ED observation (and monitoring) and using appropriate data and resources, determines the differential diagnosis and, treatment plan, and disposition.

Disposition: Establishes and implements a comprehensive disposition plan that uses appropriate consultation resources, patient education regarding diagnosis, treatment plan, medications, and time- and location-specific disposition instructions.

Multitasking (Task Switching): Employs task switching in an efficient and timely manner in order to manage the ED.

General Approach to Procedures: Performs the indicated procedure on all appropriate patients (including those who are uncooperative, at the extremes of age, hemodynamically unstable and those who have multiple comorbidities, poorly defined anatomy, high risk for pain or procedural complications, sedation requirement), takes steps to avoid potential complications, and recognizes the outcome and/or complications resulting from the procedure.

Airway Management: Performs airway management on all appropriate patients (including those who are uncooperative, at the extremes of age, hemodynamically unstable and those who have multiple comorbidities, poorly defined anatomy, high risk for pain or procedural complications, sedation requirement), takes steps to avoid potential complications, and recognize the outcome and/or complications resulting from the procedure.

Anesthesia and Acute Pain Management: Provides safe acute pain management, anesthesia, and procedural sedation to patients of all ages regardless of the clinical situation.

Other Diagnostic and Therapeutic Procedures: Goal-Directed Focused Ultrasound (Diagnostic/Procedural): Uses goal-directed focused ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance.

Other Diagnostic and Therapeutic Procedures: Wound Management: Assesses and appropriately manages wounds in patients of all ages regardless of the clinical situation.

Other Diagnostic and Therapeutic Procedures: Vascular Access: Successfully obtains vascular access in patients of all ages regardless of the clinical situation.

Medical Knowledge: Demonstrates appropriate medical knowledge in the care of emergency medicine patients.

Patient Safety: Participates in performance improvement to optimize patient safety.

Systems-Based Management: Participates in strategies to improve health care delivery and flow. Demonstrates an awareness of and responsiveness to the larger context and system of health care.

Technology: Uses technology to accomplish and document safe health care delivery.

Practice-Based Performance Improvement: Participates in performance improvement to optimize ED function, self-learning, and patient care.

Professional values: Demonstrates compassion, integrity, and respect for others as well as adherence to the ethical principles relevant to the practice of medicine.

Accountability: Demonstrates accountability to patients, society, profession, and self.

Patient-Centered Communication: Demonstrates interpersonal and communication skills that result in the effective exchange of information and collaboration with patients and their families.

Team Management: Leads patient-centered care teams, ensuring effective communication and mutual respect among members of the team.

Reference

1. ACGME. http://www.acgme.org.

Chapter 19
Case 1: African-American Infant and Family

Sheryl L. Heron and Lynne D. Richardson

Case Scenario

A 3-year-old African-American infant is brought to the Emergency Department by her 19-year-old mother and her 55-year-old grandmother. The infant is febrile to 104.2 °F and is inconsolable, pulling on her left ear and clinging to her mother. The infant is wrapped in several blankets and dressed in flannel long-sleeved pajamas. In the patient treatment area, the resident, a young white man, undresses the infant to examine her. The exam is remarkable for a dull left tympanic membrane with decreased movement on pneumatoscopy: the rest of the physical exam is unremarkable. The doctor, believing the child to be overdressed, prevents the mother from replacing all of the layers of clothing and blankets. The infant's grandmother becomes so hostile that she has to be removed by security.

Review of Symptoms

Per Mother: The infant has been febrile, inconsolable, and pulling on her left ear. She has been drinking fluids but has decreased intake of solid foods. She denies rhinorrhea, cough, and abdominal pain. All other systems are reported negative.

S.L. Heron, M.D., M.P.H. (✉)
Department of Emergency Medicine, Emory University School
of Medcine and Grady Memorial Hospital, Atlanta, GA, USA
e-mail: sheron@emory.edu

L.D. Richardson, M.D.
Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai,
New York, NY, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_19

Past Medical History

None, normal spontaneous vaginal delivery at full-term and immunizations are up-to-date

Family History

Diabetes only. No hypertension, cancer, or other illnesses

Social History

The mother and grandmother live together in the same home with the infant. No history of tobacco or drug use reported in the home. The infant's father is not with the family.

Physical Exam

Vital Signs: Temp: 104.2 °F, Pulse: 120, BP: 90/60, Respirations: 20, O_2 Sat 99 % on room air

General: Healthy appearing infant, inconsolable

Cardiovascular: Tachycardia with no murmurs, gallops, or rubs

Respiratory: No use of accessory muscles, clear breath sounds

ENT: Dull left tympanic membrane with decreased movement on pneumatoscope, nose clear, throat clear, no erythema, uvula midline

Abdomen: Nondistended, nontender with normal bowel sounds, no hepatosplenomegaly

Extremities: No cyanosis, no edema

Skin: No rashes or lesions

Neuro: Grossly intact, moves all four extremities, no obvious sign of deficit

Neck: Supple, non-tender, no adenopathy, no meningismus

Questions for Discussion

1. Why did the grandmother become hostile?

   Attitudes/assumptions: the physician

   (a) Medical science is the correct approach to treating this infant.
   (b) I am the physician caring for the patient and I believe I know what's best for my patient.
   (c) This woman (the grandmother) has an eighth grade reading level and she does not understand what needs to be done to care for the infant.
   (d) This woman (the grandmother) is interfering with the care of my patient.
   (e) This woman (the grandmother) is ignorant and of lower socioeconomic status. Because of this, I will not take the time to educate her on my management recommendations.

   Attitudes/assumptions: the grandmother

   (a) I've raised six children and four grandchildren, I know about babies and fever. This doctor thinks I am ignorant just because I'm black and poor.
   (b) My daughter can't handle this situation. She's young and it's up to me to make sure these people treat my granddaughter right.

   Gaps in Provider Knowledge

   (a) Lack of knowledge of health beliefs/customs by provider including: Folk medicine/home remedies. Hot and cold illnesses/hot and cold remedies.
   (b) Lack of knowledge regarding this specific community: Beware of stereotyping. Learn/understand the family dynamic, i.e., patterns of housing with grandmother serving as primary caretaker while daughter works at her various jobs.
   (c) Lack of knowledge of disparities/discrimination: African-American people have been subject to discrimination in this country. African-Americans may be distrustful of authority including medical authority due to a history of misuse by researchers (e.g., Tuskegee experiments, HeLa Cells).

2. What actions could have been taken by the doctor to avoid/prevent this unfortunate outcome?

   Cross-Cultural Tools and Skills

   (a) Assume the grandmother loves her grandchild and wants what is best for her.
   (b) Assume that if you communicate with her effectively, she will recognize that you also want what is best for the child.
   (c) Acknowledge the grandmother's experience with children.
   (d) Ask the grandmother what she thinks is wrong with the child, and how she has been treating the fever at home.

3. What medical issues concern you about this case?
   (a) The resident should discuss the treatment of fever, the physiologic difference between fever and hyperthermia (which supports the “sweat a fever” approach) in terms the grandmother and mother can understand.
   (b) The resident should collaborate with the grandmother and mother on a treatment plan.
4. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

   Patient Centered Communication: Demonstrates interpersonal and communication skills that result in the effective exchange of information and collaboration with the patient.

   Professional values: Demonstrates compassion, integrity, and respect for others as well as adherence to the ethical principles relevant to the practice of medicine [1].

Case Outcome

Diagnosis Left Otitis Media

Disposition Home

After an appropriate history is obtained utilizing the principles above, the patient is treated for her fever, the patient is given antibiotics for her otitis media, a discussion occurs between the physician, the mother, and the grandmother on medical instructions on how to care for the infant as well as appropriate follow-up with the child’s pediatrician. The family was given the time to ask additional questions and was further instructed to return to the Emergency Department if the infant did not improve.

Reference

1. The Emergency Medicine Milestone Project [Internet]. Chicago: The Accreditation Council for Graduate Medical Education and the American Board for Emergency Medicine; c2012 [cited 5 Aug 2014]. Available from: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/EmergencyMedicineMilestones.pdf

Chapter 20
Case 2: Cambodian Refugee

Erika Phindile Chowa and Christian Arbelaez

Case Scenario

A 58-year-old Cambodian male presents to the emergency room with the complaint of fatigue. He is approached by a resident physician who notes that the patient appears thin, disheveled, and unkempt. His English is minimal and his affect flat. He came alone today. He reports that he has struggled with feelings of fatigue for years now but has been strong enough to overcome such feelings. Over the last few months, he feels "weak and without power" and has been unable to overcome these feelings. Confused as to why this patient is presenting to the emergency room for such complaints, the resident poses a few questions [1–4].

Physician: So Sir, you presented to the emergency room because you are weak and tired? Have you seen your primary care doctor?

Patient: I don't have a primary care doctor. I have not been to see a doctor for years. In Cambodia years ago I may have seen a traditional healer, but nothing recently. I had to come today, Doctor. I can barely sleep and I keep waking up. I am not sure I can fight these feelings any longer. I tried taking herbs and coining but it has not helped. I also have bad dreams.

Physician: What kind of dreams do you have?

Patient: Evil things. Spirits coming after me or I am running for my life. Can you help me take away these dreams?

E.P. Chowa, B.A., M.D. (✉) • C. Arbelaez, M.D., M.P.H.
Department of Emergency Medicine, Brigham and Women's Hospital, Boston, MA, USA
e-mail: echowa@partners.org

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_20

Physician: Have you ever had any bad things happen to you?

Patient: In my youth, I spent time in a labor camp. Bad things happened, but that is the past.

Physician: Sir, are you depressed?

Patient: Depression?! Oh no, me? Many things have happened in my life, but I don’t believe in such illnesses.

Physician: Do you lose interest in the things that you used to do?

Patient: Yes.

Physician: Have you lost weight?

Patient: Yes, but I eat all the time. I don’t understand.

Physician: Do you ever think about taking your life?

Patient: Life has been tough, but I would never take my life, Doctor. I am stronger than that.

Review of Symptoms

Patient denies any headache, chest pain, shortness of breath. No fever/chills. He reports 20 lb. weight loss. No cough, or upper respiratory symptoms. No hematochezia or melena. Has nightmares. He has had polyuria and polydipsia.

Past Medical History

Denies any medical history.

Family History

Father had problems with his heart. No other history.

Social History

Patient has been living alone for some years now. He is a refugee from Cambodia and reports having spent some time in a labor camp in the past. He lost his family during that stay. He denies tobacco use. He drinks about five beers a day and has tried to cut down. He is married, but his wife left him a few years ago to stay with her family. He thinks it may be because of his drinking problem. He is a factory worker currently and makes a little above minimum wage.

Physical Exam

Vital signs: Temp: 98.2 °F, Pulse: 90, BP: 180/72, Respirations: 18, O_2 Sat 99 % on room air

General: Thin, disheveled, poor eye contact, no acute distress

Cardiovascular: Regular rate and rhythm, no murmurs, no gallop

Respiratory: No respiratory distress, bronchi noted bilaterally

ENT: Unremarkable

Abdomen: Soft, non-distended, non-tender, normal bowel sounds

Extremities: Warm and well-perfused.

Skin: Areas of ecchymosis over back

Neuro: Alert, answers questions appropriately, motor and sensory grossly intact

Psych: Flat affect, no SI/HI, no hallucinations
After completing the evaluation, the physician informs the patient that his symptoms may be concerning for depression or posttraumatic stress disorder. He does however recommend that basic blood work be drawn given the patient has not seen a doctor in years and there are some concerning symptoms on his review of systems. Patient agrees to blood work, but he is very upset that the doctor thinks he has a mental condition. The physician tries to explain what this means to the patient and that it does not make him weak, but the patient refuses to understand. While blood work is being drawn, the physician consults the psychiatrist for further evaluation, given concern for the patient's ability to take care of himself due to severe depression. He tells the patient that he has asked another doctor to help him figure out exactly what is going on.

Questions for Discussion

1. What factors contribute to the difficult H&P?

   Attitudes/assumptions: the physician

   (a) The patient is wasting emergency medicine resources and should have seen his primary care doctor.
   (b) His English is good enough. No need to get an interpreter.
   (c) This patient is not very intelligent.

   Attitudes/assumptions: the patient

   (a) The doctor thinks I am crazy.
   (b) He does not understand me.
   (c) I am only here because I feel weak and need help. I would not have come if I did not need help.

Gaps in Provider Knowledge

(a) Lack of knowledge of health beliefs/customs: There are multiple barriers to obtaining an adequate and efficient history in Cambodian patients or any patient from another culture.
(b) Language Barriers: Obtain a professional interpreter whenever possible. Sometimes when the patient speaks a little English, we get comfortable, but we will miss key elements of the history. Keep in mind that even with an interpreter there may be miscommunication if the patient is not comfortable with the sex, age, or social status of the interpreter. Patients may also feel that they cannot accurately communicate their problems and needs even with an interpreter because of complexity, cultural differences, or other factors.
(c) Lack of knowledge of historical experiences: Prior experiences can lead to fear and mistrust. Cambodian refugees may have experienced detailed interrogations where their life was dependent on the content and/or consistency of what they said. This may result in discomfort during the history taking or reluctance to offer extensive detail in their answers.
(d) Lack of knowledge of stoicism: In general, the Cambodian culture, particularly the older generation, places pride on stoicism. There is a reluctance to complain and patients may downplay or deny symptoms. There is also a desire not to be a burden on family or health professionals.

2. How could the doctor have improved communication with his patient?

(a) Cross-Cultural Tools and Skills:

- Whenever possible, use a professional interpreter, preferably one who is not only bilingual but bicultural as well. Ask the patient if there is any reason they are uncomfortable providing a history via this interpreter and/or if there is someone else they would prefer to have interpret for them.
- With patients who are not forthcoming, ask specific questions. Keep in mind that patients are rarely intentionally keeping information from you. Use family to obtain additional history when you feel the patient may not be fully disclosing the extent of their illness.
- Try not to anchor on a diagnosis right away. It may be difficult to gauge why patient has presented to the emergency room through their history, but make sure your review of systems is thorough and detailed.
- Often a lack of familiarity with western medicine and the chaos of most emergency departments are very overwhelming and cause patients to withdraw. Take time to put the patient at ease and guide them through the process. Show respect for the patient and acknowledge their stoicism but remind them that you are there to help them and that they are not a burden to you.
- Attempt to understand the illness as the patient does. Ask the patient specifically what they think is causing their illness and what they have done to heal themselves thus far. Inquire about visits to Cambodian healers, home remedies and spiritual interventions. By asking about alternative healing methods, you will convey an appreciation and acceptance of other forms of health care that will help build trust between you and your patient.

3. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

   Patient Safety: Through history taking, the emergency medicine physician realizes that the patient may not be safe going home given his symptoms. He calls in for help from a psychiatrist. Before patient is discharged from the hospital, he is set up with a social worker, a therapist, and case management.

   Systems-based Management: The patient not only has medical problems, but the physician realizes that he also has psychosocial problems such as depression, family social support, and substance abuse. The utilization of laboratory analysis, psychiatrist, and social workers in the treatment of this patient demonstrates this milestone. Additional resources such as alliances with community health programs would also be useful in this case.

   Professional Values: Professionalism was exemplified in this case by the resident's commitment to understanding and addressing the reason why the patient came in. He demonstrated the appropriate decision making in a difficult patient interview. He realized the cultural factors impacting this patient's care.

   Patient Centered Communication: Approaching the patient with attitudes that reflect cultural sensitivity, utilizing linguistic and cultural interpreters when necessary and making appropriate medical decisions that account for both the patient's and bio-medical explanatory models of disease all demonstrate competency in patient care. The resident was initially upset when the patient presented to the emergency room with weakness, but as he continued to speak to the patient, he realized that the patient did have some problems that need to be addressed. The resident has an appreciation of the cultural factors affecting this patient–physician interaction, but still could have called in for help with an interpreter or someone in the family for more assistance.

Case Outcome

Diagnoses: Adult Onset Diabetes and Kidney Disease

Disposition: Admitted and was started on insulin and linked up with primary care physician, social workers, therapists, and community programs for refugees.

When the patient's laboratory results came back with blood glucose in the 500's and signs of renal failure, the resident realized that this was likely contributing to the patient's weakness and not so much posttraumatic stress or depression (although he does have an element of this). The resident realized that he may have missed key parts in the patient's history given cultural and language barriers and wanted to be sure the patient understood what was going on. He called for a Cambodian interpreter who explained everything to the patient. The patient was very grateful that the resident took time to find out exactly what was going on with him. He also says that he does get upset about his former experiences and would appreciate more community support, especially to help stop drinking and get his family back. The resident made sure to notify the inpatient team about this.

References

1. Muecke MA. Caring for Southeast Asian refugee patients in the USA. Am J Public Health. 1983;73(4):431–8.
2. Eisenbruch M. From post-traumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. Soc Sci Med. 1991;33(6):673–80.
3. Marcucci J. Sharing the pain: critical values and behaviors in Khmer culture. In: Ebihara MM, Mortland CA, Ledgerwood J, editors. Cambodian culture since 1975: Homeland and exile. Ithaca, NY: Cornell University Press; 1994.
4. Wong EC, Marshall GN, Schell TL, Elliott MN, Hambarsoomians K, Chun CA, et al. Barriers to mental health care utilization for U.S. Cambodian refugees. J Consult Clin Psychol. 2006;74(6):1116–20.

Chapter 21
Case 3: Sickle Cell Crisis

Bernard L. Lopez, Heather Hollowell Davis, Traci R. Trice, Leigh-Ann Jones Webb, and Marcus L. Martin

Case Scenario

A 22-year-old African American male with sickle cell disease (SCD) comes to the emergency department (ED) with pain in all of his extremities typical of his vaso-occlusive crisis (VOC) and requests pain medicine. He has never come to this ED before—he "usually goes to the one across town but [he] won't go back there because they never give enough pain medicine." When asked how much pain he has, he states "it's a 15." The patient is in obvious distress, writhing in pain. The doctor assesses the patient and addresses the need for pain control.

B.L. Lopez, M.D., M.S. (✉)
Department of Emergency Medicine, Thomas Jefferson University Hospital,
Philadelphia, PA, USA
e-mail: Bernard.lopez@jefferson.edu

H.H. Davis, M.D.
Department of Emergency Medicine, Medstar Southern Maryland Hospital,
Clinton, MD, USA

T.R. Trice, M.D.
Department of Family and Community Medicine, Thomas Jefferson University Hospital,
Philadelphia, PA, USA

L.-A. J. Webb, M.D.
Department of Emergency Medicine, New York-Presbyterian Hospital, Columbia University
Medical Center, New York, NY, USA

M.L. Martin, M.D.
Department of Emergency Medicine, School of Medicine, University of Virginia,
Charlottesville, VA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_21

Review of Symptoms

Painful extremities, no fever, no chest pain, no cough, no respiratory distress.

Past Medical History

Sickle cell disease, pneumonia. No known drug allergies.

Family History

Sickle cell trait, hypertension.

Social History

Drinks alcohol socially, no smoking or recreational drug use.

Physical Exam

Vital Signs: Temp: 98.6 °F, Pulse: 110, BP: 135/80, Respirations: 20, O_2 Sat 98 % on room air

General: Patient writhing in pain

Cardiovascular: Sinus tachycardia, normal S1/S2, no murmurs, rubs, or gallops

Respiratory: Clear to auscultation bilaterally

ENT: Extra-ocular muscles intact, pupils equal and reactive, tympanic membranes normal

Abdomen: Soft, non-distended, mild diffuse tenderness, no guarding or rebound tenderness.

Extremities: No clubbing/cyanosis/edema, no tenderness to palpation

Skin: Flushed, diaphorectic, otherwise within normal limits.

Neuro: Cranial nerves intact, motor and sensory exam normal

ED Course

An IV was started, IV morphine was promptly ordered by the doctor and administered by the nurse. The patient's pain was adequately controlled during his 2-h stay in the ED. No labs or radiographs were ordered.

Questions for Discussion

1. What would prevent cross-cultural communication?

Attitudes/Assumptions: the physician

(a) Administering high doses of opioids for sickle cell pain crisis will create an addiction and a crossover effect of illicit drug use [1].
(b) The patient is overestimating his pain because he's an addict and he wants more medicine.
(c) The patient does not have "real" pain and is simply seeking narcotics.

Attitudes/Assumptions: the patient

(a) These doctors never give enough pain medication. They're not taking care of me. I have to emphasize how much pain I'm in so they will give me enough medicine for pain relief.
(b) The doctor and nurses are not the same race/ethnicity as me and therefore don't understand my pain. They may not even care about me as much as other patients.

Gaps in Provider Knowledge

(a) Lack of knowledge of community: beware of stereotyping. Learn/understand more about the unique nature of this disease, how to best treat pain, and that treating acute exacerbation of pain does not necessarily lead to drug addiction [2].
(b) Lack of knowledge of cultural disparities/discrimination: African American people have been discriminated against in this country. African American people may be mistrustful of the medical profession [3]. Microaggressions or recurrent injustices experienced over years of interactions with the health care system may further contribute to patients' ill perceptions [4]. Additionally, differences in race and ethnicity may influence the way patients express their symptoms (physicians may not understand a patient's expression of his or her symptoms [5].
(c) Lack of knowledge of unconscious bias: understand that people view the world based on the knowledge and experiences gained during life. These views may conflict and cause a less than optimal interaction. Recognition that unconscious bias exists will lessen potential conflict.
(d) Lack of knowledge of language barriers: The physician's level of fluency in patients' primary language and comfort with utilizing interpretive resources is an important factor in effective physician–patient communication. This is essential to assessing pain. Additionally, recognition of patients' varying literacy and specifically, health literacy levels is important [5].

2. What barriers to care do sickle cell patients have?

Although pain medicine prescribing rates for patients presenting to the ED with a chief complaint of pain have markedly increased since 2001, physicians still, in general, undertreat pain. More specifically, there has been no narrowing in the racial/ethnic disparity in opioid prescribing across all types of chronic pain [1]. This is important as the vast majority of SCD patients are African American. Physicians may underestimate the amount of pain that a patient may have. Perceived discrepancies between patient behavior and patient behavior/body language and pain score may lead to mistrust between both parties. Physicians may have conflicting responsibilities (i.e., duty to the patient and duty to protect the public from opioid diversion) [4].

During busy times in the ED, sickle cell pain is often given a lower priority and patients may not receive timely analgesic administration. Thus, prolonged time between doses of pain medication may occur. There is a fear that opioid administration will create drug addiction and a crossover effect of illicit drug use [6]. Healthcare workers may not believe that the patient is truly in pain and that they have presented to the ED to simply obtain opioids. In addition, most sickle cell patients are African American; most emergency physicians and nurses are not African American, and there is mistrust from the patients. Patients may also present melodramatic in order to receive the pain medications that they need. Concerns about drug abuse, physician reluctance to prescribe opioids, and disbelief of patients' report of pain severity are barriers to effective sickle cell pain management. Lastly, patients may be uninsured or underinsured and thus may not have a primary care physician or hematologist to manage their chronic pain in the outpatient setting. This lack of continuity of care lends itself to variations in pain management and potential dissatisfaction.

3. What actions should be taken by the doctor to avoid/prevent stereotyping in this situation?

Treat this patient in a kind and caring manner like you would any other patient. Obtain a good history and do a thorough physical exam. Be knowledgeable about the pathophysiology of this unique disease with special attention to the issues surrounding inadequate analgesic treatment. Moreover, education with regard to cultural competence and its effect on the patient–doctor relationship is equally important. Lastly, be aware of one's own unconscious biases.

4. What medical issues concern you about the case?

Pain (and its relief) is the primary concern for this patient. Vaso-occlusive crisis (VOC) is the most common condition in adult patients with SCD presenting to the ED [7]. Severe pain is a medical emergency that requires prompt treatment.

Patients with SCD are at high risk for serious complications of disease. Numerous organ systems can be affected by sickle cell disease: pulmonary (intrapulmonary shunting, embolism, infarct, pneumonia), vascular (anywhere), liver (hepatic infarct, hepatitis secondary to transfusion), gallbladder (gallstones), spleen (acute sequestration crisis), urinary (infection, hematuria), genital (decreased fertility, impotence, priapism), skeletal (bone infarcts, osteomyelitis, aseptic necrosis), cardiovascular (congestive heart failure), central nervous system (stroke), skin (stasis ulcer), eye (retinal hemorrhage, retinopathy) [8].

Ancillary testing should, as is the case with any ED patient, be guided by the history and physical examination. Given the risk of significant complications of the disease, a low threshold for ordering tests should exist, especially if the patient is unknown to the hospital or ED. In this case, the patient typically seeks care at another institution and is not known to the hospital. The most useful tests in the case of VOC are the complete blood count (CBC) and reticulocyte count as these demonstrate the level of anemia and red blood cell (RBC) production. This should be obtained in the case of atypical presentation of VOC, pain refractory to analgesia, or evidence of complications.

5. How should you manage this patient's pain?

While a wide variety of analgesics may be used, parenteral opioids represent the most common and most effective treatment for sickle cell crisis pain. Adequate analgesia with opioids may be achieved with intravenous (intermittent via IV push, continuous via infusion, patient-controlled analgesia) or intramuscular injection. While its effectiveness is unclear, practitioners may choose to add adjuvants such as an H-1 histamine antagonist such as diphenhydramine. A nonsteroidal anti-inflammatory medication such as ketorolac has been used effectively. If ED management is successful, the patient may be discharged to home with oral narcotics such as hydromorphone or oxycodone. In cases of inadequate analgesia in the ED, the patient should be considered for inpatient analgesic therapy.

6. Which cross-cultural skills could the physician use with this patient?

Treat this patient no differently than you would any other patient. Obtain a good history and do a thorough physical exam in a compassionate manner.

Communicate effectively to the patient that you want the best for him and that you want to work with him to get his pain under control.

In collaboration with the patient, determine the goal of treatment. Reiterate that pain will be eased, not eliminated.

7. What components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

Diagnosis: Based on all of the available data, narrows and prioritizes the list of weighted differential diagnoses to determine appropriate management and demonstrates cross-cultural clinical skills by recognizing the severity of pain in patients with vaso-occlusive crisis with sickle cell disease

Pharmacotherapy: Understands the choice of proper analgesics for acute vaso-occlusive crisis pain

Anesthesia and Acute Pain Management: Provides safe, acute pain management regardless of the clinical situation

Professional values: Demonstrates compassion, integrity, and respect for others as well as adherence to the ethical principles relevant to the practice of medicine by demonstrating sensitivity to patient's distress rather than stereotyping or making assumptions of drug-seeking behavior.

Patient Centered Communication: Demonstrates interpersonal and communication skills that result in the effective exchange of information and collaboration with the patient.

Case Outcome

Diagnosis: Sickle cell vaso-occlusive crisis.

The patient's painful crisis was treated in a timely fashion with adequate doses of intravenous opioid. The history and physical examination revealed no evidence of a complication of SCD. As the patient's pain was typical for his prior VOC, no tests were obtained. The patient was discharged home on oral pain medication and told to follow-up with his primary care physician. While the patient was new to this ED, both the physician and the patient interacted well and a satisfactory outcome was achieved.

References

1. Pletcher MJ, Kertesz SG, Kohn MA, Gonzales R. Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. JAMA. 2008;299(1):70–8.
2. Murray Jr RF, Soble A. Case studies in bioethics. Drug treatment or drug addiction? Can a physician differentiate between true sickle cell crisis and iatrogenic narcotic addiction? Hastings Cent Rep. 1974;4(3):10–2.
3. Clark PA. Prejudice and the medical profession. Racism, sometimes overt, sometimes subtle, continues to plague U.S. health care. Health Prog. 2003;84(5):12–23. 70–78.
4. Zempsky WT. Treatment of sickle cell pain: fostering trust and justice. JAMA. 2009;302(22):2479–80.
5. Bonham VL. Race, ethnicity, and pain treatment: striving to understand the causes and solutions to the disparities in pain treatment. J Law Med Ethics. 2001;28(s4):52–68.
6. Shapiro BS, Benjamin LJ, Payne R, et al. Sickle cell-related pain: perceptions of medical practitioners. J Pain Symptom Manage. 1997;14:168–74.
7. Ballas SK, Gupta K, Adams-Graves P. Sickle cell pain: a critical reappraisal. Blood. 2012;120:3647–56.
8. Lovett PB, Sule HP, Lopez BL. Sickle cell disease in the emergency department. Emerg Med Clin North Am. 2014;32(3):629–47.

Chapter 22
Case 4: Mongolian Spots

Heather Hollowell Davis, Leigh-Ann Jones Webb, and Marcus L. Martin

Case Scenario

A 16-year-old Latino female presents to the emergency department (ED) with her 6-month-old baby boy. She states that she was working much of the weekend and the child was under the direct care of her boyfriend. Mother states that today she noticed some bruising on the back and buttocks of the child that do not seem to bother him (see Fig. 22.1). Mother's boyfriend is in the waiting room.

Review of Symptoms

Per mom: No fussiness, no vomiting or diarrhea, no fever, eating and drinking normally.

H.H. Davis, M.D. (✉)
Department of Emergency Medicine, Medstar Southern Maryland Hospital,
Clinton, MD, USA
e-mail: hnhdavis@gmail.com

L.-A. J. Webb, M.D.
Department of Emergency Medicine, New York-Presbyterian Hospital, Columbia University
Medical Center, New York, NY, USA

M.L. Martin, M.D.
Department of Emergency Medicine, School of Medicine, University of Virginia,
Charlottesville, VA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_22

Fig. 22.1 Child with Mongolian Spots. With permission from Hackbart BA, Arita JH, Pinho RS, Masruha MR, Vilanova LC. Mongolian spots are not always a benign sign. J Pediatr 2013;162(5):1070. © Elsevier. [10]

Past Medical History

Normal vaginal delivery with uncomplicated birth. Full-term. Immunizations are up to date. No significant medical history.

Family History

A 2-year-old sibling was recently evaluated in the ED for a left humerus fracture, reportedly sustained after a fall while at the playground.

Social History

Lives with mom, older sibling, and grandmother. No smokers in the household. Mom works at a local restaurant. The patient attends daycare during the week. He has “a lot of babysitters who chip in with him and his brother” on weekends.

Physical Exam

Vital Signs: Temp: 98.6 °F, Pulse: 130, BP: 90/60, Respirations: 24, O_2 Sat 97 % on room air, Weight: 7.5 kg

General: Alert and playful, drinking milk and sitting on mother’s lap, no acute distress

Cardiovascular: Regular rate, normal S1/S2, no murmur, rubs, gallops

Respiratory: Clear to auscultation bilaterally, no wheezes

ENT: Clear tympanic membranes bilaterally, nares unremarkable, normal oropharynx

Abdomen: Soft, non-tender, non-distended, normal bowel sounds, no rebound or guarding

Extremities: Moving all extremities symmetrically, no clubbing/cyanosis/edema, no tenderness

Skin: Hyperpigmented, non-tender, irregularly shaped bluish gray to deep brown, macular lesions of varying sizes on buttocks and sacrum

Neuro: Grossly intact, acting appropriately for age, able to sit independently

Eyes: Normal appearing, pupils equal and reactive bilaterally, extra-ocular movements intact, no retinal hemorrhages

Questions for Discussion

1. How should you obtain the history?

   It is important to be sensitive to the needs of the patient and the family. Approach the family objectively and nonjudgmentally. Obtain history from both sources: the patient's mother and the boyfriend. Interviews should be separate and carefully scrutinized for consistency. In addition, the history should include any medical history of the child and family. Special attention should be given to any bleeding disorders, psychosocial history and review of systems [1]. If possible, elicit more information regarding the sibling's recent injury. Discussing both the patient as well as family dynamics with the pediatrician or family physician may be helpful in obtaining collateral information. Often, the child's previous exam is well documented in both the inpatient (routine newborn exam) as well as the outpatient setting. The child's primary doctor will have important records regarding growth, milestones, and any potential patterns of suspicious injury for which the child presented for evaluation.

   Attitudes/assumptions: the physician

   This young mother is inexperienced and may not be providing an appropriate history. The boyfriend, mother, or both may be abusing the child. The mother may have animosity against the boyfriend and may be trying to teach him a lesson.

   Attitudes/assumptions: the mother

   The doctor should believe the history I am providing since I'm the mother. Doctors think that all teenage mothers are alike and that we don't take good care of our children.

2. What physical findings are suggestive of child abuse?

Providers must maintain a high level of concern for cases of non-accidental trauma. In a retrospective analysis studying a cohort of patients over 7 years, Thorpe et al. demonstrated that approximately one third of children with healing abusive fractures in the study had presented in various care settings previously with trauma related complaints [1]. Health care providers are increasingly relied upon to diagnose whether an injury is secondary to abuse. A misdiagnosis of child abuse can have serious repercussions on the child and family. Alternatively, a missed detection of abuse can have lethal consequences for the child [2]. A thorough evaluation including physical exam and imaging can provide corroborative evidence to support clinical suspicions of abuse [2–4]:

General: poor feeding, failure to thrive, evidence of poor care
HEENT: boggy scalp hematoma, step off/deformity of skull, bruising of ears or neck, hemotympanum, Battle's sign, retinal hemorrhage
Extremities: circumferential burns
Skin: ecchymosis, especially in varying stages of healing or bruises in protected areas (back, genitals, chest, abdomen, thighs), human hand marks and other patterned markings, bite marks, burns
Neuro: irritability, listlessness
Imaging: intracranial hemorrhage, skull fractures (abuse more likely bilateral, comminuted, depressed), fractures in multiple stages of healing, bucket-handle fracture, scapular fracture, posterior rib fractures, spinous process fractures, sternal fractures, rupture of liver/spleen, ruptured viscous, duodenal hematoma

3. What do findings on the physical exam of this patient suggest?

The child appears to be well cared for. The physical exam shows that the lesions of concern are well defined and in the typical distribution suggestive of Mongolian spots. Extensive presence of Mongolian spots should raise suspicion for concomitant inborn errors of metabolism [5]. In addition to non-accidental trauma, the differential diagnosis includes other dermatological conditions involving dermal melanocytosis, which can be differentiated largely by clinical history and will not be discussed in this chapter.

ED Course

Upon further questioning of the mother, she noticed the bruising a few months ago shortly after birth and they have gotten more bluish/black. The patient does not seem to be affected by the areas and there is no discomfort. Mother states she has never hit her child nor has witnessed any type of physical abuse. Patient is attempting to crawl, but mother does not remember her son falling down. They do not have steps in the home and both parties suggest that the child is very closely supervised at all times. Mom feels safe at home and around her boyfriend. The boyfriend states that he "loves the little man" and would never hurt him. He remembers the bruising always being there although they have gotten a little bigger over the last few months.

Gaps in Provider Knowledge

Congenital dermal melanocytosis, more commonly referred to as Mongolian spots, are flat birthmarks with wavy borders and irregular shapes that appear at birth or shortly after birth. They may occur in up to 80 % of Asian, African, Native American, and Latino heritage, while seen in less than 10 % of Caucasians. There have been reports that a patient can have a Mongolian spot superimposed on another Mongolian spot, which commonly looks like a bruise [6]. Mongolian spots appear bluish gray to deep brown or black. They often appear on the base of the spine, on the buttocks and back and even sometimes on the ankles or wrists [7]. They are typically referred to as aberrant Mongolian spots if they occur near the occiput, temple, shoulders, and limbs. Skin texture is classically normal. Although these spots can last into adulthood, most resolve by 6 years of age [8]. According to one study, more than 40 % of infants with Mongolian spots had complete resolution at one year. Multiple patches, extrasacral position, size larger than 10 cm and dark-colored lesions were markers of persistence after a year [9]. For persistent lesions, cosmetic treatment may include laser therapy, bleaching creams, and cosmetic camouflage creams. Routine labs are usually not indicated.

4. What components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

Diagnosis: Based on all available data, narrows and prioritizes the list of weighted differential diagnoses to determine appropriate management and appropriately concludes that the skin findings are not the result of non-accidental trauma.

Medical Knowledge: Demonstrates appropriate medical knowledge in the care of emergency medicine patients. Demonstrates cross-cultural clinical skills by recognizing that Mongolian spots are a benign non-traumatic lesion found in some populations and applies this knowledge to patient care.

Professional Values: Demonstrates compassion, integrity, and respect for others as well as adherence to the ethical principles relevant to the practice of medicine, including diverse populations.

Patient Centered Communication: Demonstrates interpersonal and communication skills that result in the effective exchange of information and collaboration with patients and their families across a broad range of socioeconomic and cultural backgrounds. Exercises nonjudgmental, appropriate, compassionate communication and care to both patients and their families.

Case Outcome

Diagnosis: Mongolian Spots

The physician spoke with both the mother and boyfriend separately and did not obtain a history of abuse. The physician realized that the lesions had been present since birth, not in various stages of healing; thus, not consistent with child abuse. The provider was able to verify the child's baseline exam with his pediatrician, who noted no previous concerns for abuse in the outpatient setting. The mother and boyfriend were educated on Mongolian spots and the likelihood that they would fade over time. In addition, they were informed on child safety and childproofing the home.

Disposition: The patient was discharged home with mom to follow up with his pediatrician. The mother was instructed if new lesions appeared, or if she had any concerns to return to the emergency department in a timely manner.

References

1. Thorpe EL, Zuckerbraun NS, Wolford JE, Berger RP. Missed opportunities to diagnose child physical abuse. Pediatr Emerg Care. 2014;30(11):771–6.
2. Harris TS. Bruises in children: normal or child abuse? J Pediatr Health Care. 2010;24(4):216–21.
3. Lane W. Diagnosis and management of physical abuse in children. Clin Fam Pract. 2003;5(2):493–514.
4. Pressel DM. Evaluation of physical abuse in children. Am Fam Physician. 2000;61(10):3057–64.
5. Gupta D, Thappa DM. Mongolian spots: how important are they? World J Clin Cases. 2013;1(8):230–2.
6. Leung AK, Robson WL. Superimposed Mongolian spots. Pediatr Dermatol. 2008;25(2):233–5.
7. Morelli JG. Diseases of the neonate. In: Kliegman RM, Stanton BF, St Geme JW, Schor NF, Behrman RE, editors. Nelson textbook of pediatrics. 19th ed. Philadelphia, PA: Elsevier Saunders; 2011.
8. Sorhaindo L, Rossi A, Alexis A, Silverberg NB. Hot topics in pediatric dermatology. Expert Rev Dermatol. 2010;5(3):259–67.
9. Gupta D, Thappa DM. Mongolian spots—a prospective study. Pediatr Dermatol. 2013;30(6):683–8.
10. Hackbart BA, Arita JH, Pinho RS, Masruha MR, Vilanova LC. Mongolian spots are not always a benign sign. J Pediatr. 2013;162(5):1070.

Chapter 23
Case 5: Death Disclosure

Tammie E. Quest

Case Scenario

A 46-year-old African American woman presents to the emergency department in cardiac arrest. The patient is known to be on hospice care for metastatic cancer. The patient is pronounced dead in the emergency department 15 min after arrival in asystole. The emergency physician pronounces the patient dead and he informed the patient's immediate and extended family of her death. The patient's sisters tell the physician that the patient is not actually dead and state that Lazarus rose from the dead and they refuse to believe that she is dead. They report that Jesus told Martha, "Your brother will rise again." The sisters assert that the patient will in fact rise again and that they insisted on waiting for 5 days before death is declared stating that Jesus came on the fourth day and they need to wait a minimum of 4 days. The physician is not of Christian faith and is unfamiliar with this idea and explains the hospital protocol and the state law to the family. The family refuses to select a funeral home and request the patient be allowed to stay at the hospital for the 4 days while they wait for Jesus to resurrect her.

The family tells the physician that he is not a "believer" and they don't expect him to understand. They ask to see another physician that is of Christian faith.

T.E. Quest, M.D. (✉)
Emory University School of Medicine, Atlanta, GA, USA
e-mail: tquest@emory.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_23

Past Medical History

Metastatic lung cancer for the last 18 months with brain metastasis. Has been receiving home hospice care for the last 4 months. Despite multiple discussions the patient and family would not agree to non-resuscitation despite recommendation by primary oncologist, palliative care physician and hospice team. The patient and family reported great faith in God to control the destiny of the patient's course of illness and received intensive support by the hospice chaplain.

Family History

Brother died of gun violence at the age of 20.

Parents are deceased—mother due to end stage renal disease and father due to myocardial infarction.

Social History

The patient's son is incarcerated on drug charges. The patient has never been married and her only caregivers are her sisters. Her sisters throughout her care have sustained the view that she would be healed by Jesus Christ despite her decline from cancer.

Physical Exam

The patient is moved to a quiet room, the patient family is allowed to view the deceased patient. The patient's skin becomes cold and mottled in the hour after her death.

Questions for Discussion

1. Why did the family not accept the declaration of death by the physician?

   Attitudes/Assumptions: The physician

   (a) Medical science determines death
   (b) Family in denial and not accepting of reality.

(c) This family is impeding the after death care process in the emergency department
(d) This family is ignorant of medical science and the certainty of medical death
(e) Assumption that the family is requesting the patient to stay in the ED

Attitudes/Assumptions: The family

(a) The doctors have done what they can, but God is in control
(b) God can perform miracles and man cannot
(c) What doctors say is not always what the outcome will be

Gaps in Provider Knowledge:

(a) Lack of knowledge of how spiritual beliefs effect medical decision making
(b) Lack of knowledge of how to reconcile the family's spiritual beliefs with medical facts
(c) Lack of knowledge regarding negotiation of how to handle the after death process in a way that allows for respects of values and beliefs while caring for a deceased patient in the hospital setting.

2. What actions could have been taken by the doctor to avoid/prevent this unfortunate outcome?

Cross-Cultural Tools and Skills

(a) Involve the hospital chaplain in the care of the patient and family
(b) Involve the family's spiritual counselor/advisor in an acceptable spiritual and medical outcome
(c) Discuss with the family what next steps typically are (movement to the morgue) and what might be acceptable within hospital protocol.

3. What medical issues concern you about this case?

(a) Incorporation of faith and family values in end of life care is common and complex. There is often a need to involve other disciplines when situations arise that clinicians may be uncomfortable with.

4. Which competencies of the Emergency Medicine Milestones of the ACGME competencies are incorporated into the case?

Professional Values: Demonstrating behavior that conveys caring, honesty, genuine interest and tolerance when interacting with a diverse population of patients and families and demonstrating an understanding of the importance of compassion, integrity, respect, sensitivity, and responsiveness, and exhibiting these attitudes consistently in common/uncomplicated situations and with diverse populations.

Patient-Centered Communication: Effectively communicates with vulnerable populations, including both patients at risk and their families.

Team Management: Leads patient centered care teams that ensures effective communication and mutual respect amongst members of the care team.

Case Outcome

The patient's family was allowed to spend time with her in the emergency department for several hours with prayer rituals and services held. After meeting with the hospital chaplain and the arrival of their family's clergy, the family agreed to allow the patient to be moved to the morgue but requested that the patient stay in the morgue until 5 days after death and on the fifth day they would return to reassess her status in the morgue. At the end of 5 days, the patient's family, allowed for release of the patient to the funeral home that they chose, proclaiming her death at this point and that "Jesus' will has been done." The hospice chaplain continued to support the family post-death. The patient's family thanked the clinical caregivers in her case for "doing everything" to care for her [1–11].

References

1. Shoenberger JM, Yeghiazarian S, Rios C, Henderson SO. Death notification in the emergency department: survivors and physicians. West J Emerg Med. 2013;14(2):181–5. doi:10.5811/westjem.2012.10.14193.
2. Quest T. The hardest news: death disclosure in the emergency department. Medscape J Med. 2008;10(8):194. Epub 2008 Aug 18.
3. Bhuvaneswar CG, Stern TA. Teaching cross-cultural aspects of mourning: a Hindu perspective on death and dying. Palliat Support Care. 2013;11(1):79–84. doi:10.1017/S1478951512000946. Epub 2012 Nov 22.
4. Hardy-Bougere M. Cultural manifestations of grief and bereavement: a clinical perspective. J Cult Divers. 2008;16(2):66–9.
5. Quest TE, Franks NM. Vulnerable populations: cultural and spiritual direction. Emerg Med Clin North Am. 2006;24(3):687–702.
6. Lobar SL, Youngblut JM, Brooten D. Cross-cultural beliefs, ceremonies, and rituals surrounding death of a loved one. Pediatr Nurs. 2006;32(1):44–50.
7. Warren BJ. The cultural expression of death and dying. Case Manager. 2005;16(1):44–7.
8. Komaromy C. Cultural diversity in death and dying. Nurs Manag (Harrow). 2004;11(8):32–6.
9. Mazanec P, Tyler MK. Cultural considerations in end-of-life care: how ethnicity, age, and spirituality affect decisions when death is imminent. Am J Nurs. 2003;103(3):50–8. quiz 59.
10. Clements PT, Vigil GJ, Manno MS, et al. Cultural perspectives of death, grief, and bereavement. J Psychosoc Nurs Ment Health Serv. 2003;41(7):18–26.
11. McQuay JE. Cross-cultural customs and beliefs related to health crises, death, and organ donation/transplantation: a guide to assist health care professionals understand different responses and provide cross-cultural assistance. Crit Care Nursing Clin North Am. 1995;7(3):581–94.

Chapter 24
Case 6: Coin Rubbing

Matthew M. Leonard, Bryant Cameron Webb, Adetolu Olufunmilayo Oyewo, and Marcus L. Martin

Case Scenario

A young Asian mother brings her 5-year-old daughter to the Emergency Department (ED) for evaluation of a fever and cough. As you introduce yourself, the mother smiles and maintains little eye contact. The mother and patient speak very little English and most of the history is obtained from a family friend. The family friend informs you that the patient has been sick for a long time. When you ask if she has taken any medicine for the fever, the friend replies "yes, pills." Despite further questioning, you are unable to obtain any history regarding the identity or quantity of pills.

Review of Systems

Positive for fever and cough, negative for nausea, vomiting, diarrhea, all other review of systems are negative.

M.M. Leonard, M.D.
Emergency Department, Suburban Hospital, Bethesda, MD, USA

B.C. Webb, M.D., J.D.
Department of Internal Medicine, NewYork-Presbyterian Hospital, New York, NY, USA

A.O. Oyewo, M.D.
Department of Emergency Medicine, Emory University, Atlanta, GA, USA

M.L. Martin, M.D. (✉)
Department of Emergency Medicine, School of Medicine, University of Virginia, Charlottesville, VA, USA
e-mail: mlm8n@virginia.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_24

Past Medical History

No previous hospitalizations, immunizations up to date per the family friend, no medications, no known drug allergies.

Family History

None

Social History

Patient lives with both parents, two younger siblings, and grandparents. Patient's family members are immigrants from Vietnam. Patient does not attend school or daycare.

Physical Exam

Vital signs: Temp: 100.1 °F, Pulse: 90, BP: 100/70, Respirations: 20, O_2 Sat 98 % on room air

General: Anxious, alert, thin female in no apparent distress

Cardiovascular: Regular rate and rhythm, no murmur, rubs, or gallops

Respiratory: Clear to auscultation bilaterally, no wheezing or crackles

ENT: Pupils equal and reactive to light, mildly injected conjunctiva bilaterally, mild rhinorrhea, nasal mucosa is edematous, moist oral mucosa, tympanic membranes are clear bilaterally, oropharynx is erythematous without exudates, no tonsillar enlargement.

Abdomen: Soft, non-tender, non-distended, bowel sounds present throughout, no hepatosplenomegaly

Extremities: No clubbing, cyanosis, or edema

Skin: Multiple ecchymotic lesions on chest and back in angular, descending pattern bilaterally, with well-demarcated margins (see Fig. 24.1). No petechiae noted, no lesions on extremities

Neuro: Alert and appropriate for age, interactive and playful, deep tendon reflexes 2+ in upper and lower extremities

Genitourinary: Normal female genitalia, Tanner stage 1

Neck: Supple, without rigidity, mild cervical lymphadenopathy

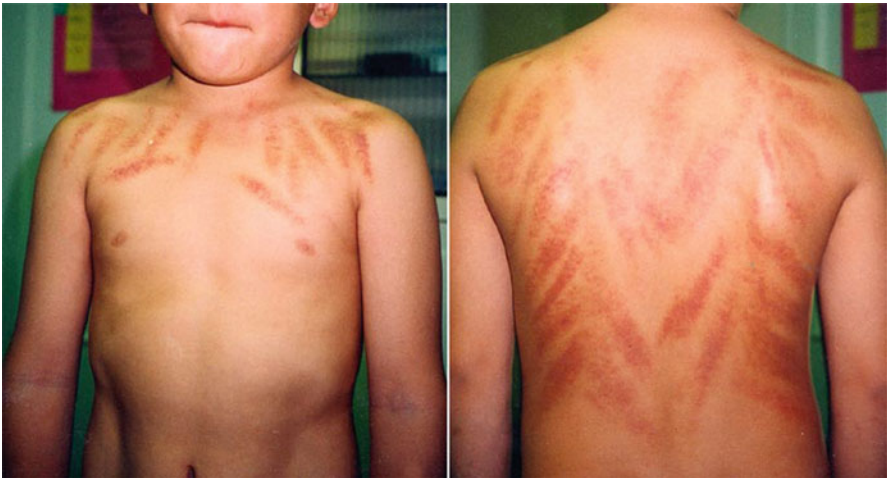


Fig. 24.1 Child with lesions from coin rubbing. With permission from Kurth H, Wilke N, Gehl A, Sperhake J. Cao Gio ("coin rubbing"). Monatsschrift Kinderheilkunde 2008;156(10):1004–1007. © Springer 2008 [8]

Questions for Discussion

1. What can you do to obtain a thorough history in this case?

   Interpreters can improve communication between the physician and the family. Although patients may come with a friend or family member who is bilingual, the use of family members and friends as interpreters compromises both the accuracy of the patient's reported history and the explanation of medical terminology. The duration of fever, characteristics of cough, previous medical interventions, sick contacts, and any other constitutional symptoms are important points in the history. In this case, the history is limited because the family friend who is bilingual cannot provide further history. Also, the family friend did not try to ask the mother further history. The history obtained is limited to the family friend's knowledge of the situation.

2. What are barriers to effective communication in this case?

   The language barrier will limit the utility of a history and physical exam. The mother does not speak English and it is possible that the family friend cannot communicate using medical terminology. Southeast Asians rely heavily on traditional medicine and culture in the healing process but this does not prevent them from seeing a Western medicine physician [1]. Asian culture emphasizes the avoidance of eye contact and politeness as a sign of compliance to medical treatment [2]. A friendly tone, appropriate eye contact, and positive hand gestures establish verbal and nonverbal trust and rapport in such cases.

3. How do you interpret your physical exam findings?

   This is a febrile, female child who appears healthy and in no acute respiratory distress. She is saturating well on room air, her head, eyes, ears, nose, and throat (HEENT) exam does not favor a bacterial cause for her symptoms, and she displays no meningeal symptoms. Her chest and lung exam is non-concerning for pneumonia. The lesions on her back are concerning for either intentional burns/rubs from child abuse or cultural practices such as coining, common in the Asian culture.

4. What is your differential diagnosis for the patient's rash?

   Differential diagnosis for the patient's rash includes: coining, child abuse, idiopathic thrombocytopenic purpura, hemophilia, Vitamin K deficiency, Henoch–Schönlein purpura, and Mongolian spots [3].

5. What is the appropriate next step in management?

   Historically, many physicians reported cases like this to child protective services as child abuse [4]. The proper procedure in this case would be to obtain a full historical account of the markings from both the parent and the child, separately if appropriate. As more history is obtained, it will be discovered that the skin findings are a cultural way of treating the sick. In cases of suspected child abuse, the location, time, and mechanism of injury need to be documented [3].

6. Could anything have been done differently to facilitate this encounter?

   Understanding and acknowledging cultural differences without being judgmental towards cultural practices or expression of disapproval of cultural practices is the key. Consider asking patients for their opinion on their understanding of the illness, their understanding of causes of the illness, and their expectations. These suggested strategies for dealing with significant cultural differences between physician and patient can improve communication, patient satisfaction, and outcomes [5]. Many patients will not volunteer that they have sought alternative medical help for fear of disapproval, of offending a Western doctor, or of embarrassment [2].

7. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

   Performance of Focused History and Physical Exam: When an interpreter is used, more history is obtained that helps clarify that patient had viral illness that began to improve but then patient started having a fever again, prompting the parent to seek medical care. A focused history in a Non-English speaking patient requires the use of a medically trained interpreter.

   Diagnosis: An appropriate workup to include the differential of coining, bleeding disorders and child abuse. The correct diagnosis can be made by using all of the available data to narrow and prioritize the list of weighted differential diagnoses

Medical Knowledge: This case demonstrates cross-cultural clinical skills by recognizing the use of coining in the Asian population in the United States

Patient Centered Communication: This case demonstrates the importance of effective information exchange between physician, patient, and families by utilization of interpreter services. Friendly tone, appropriate eye contact, and positive hand gestures establishing verbal and nonverbal trust between physician and patient

Professional Values: This case shows how to collaborate with other medical personnel when the skills of the physician are limited in order to provide sensitive and ethical care to diverse populations

Case Outcome

Diagnosis: With the aid of a trained interpreter, you are able to discern that the family arrived in the country 18 months ago and has visited a traditional Asian healer in their community who has practiced coining on the young female. She has been sick on and off for the past year with upper respiratory symptoms and has had multiple visits to the ED for similar presenting complaints. Each time, she has been evaluated and felt to have upper respiratory infections and allergies. Otherwise, she has been meeting all of her developmental goals and seems to be quite happy in her new country. In general, there is little danger involved in cultural practices such as coin rubbing, also known as *cao gio*, *gua sha*, or coining. There have been rare case reports of minor and major burns associated with individuals catching fire during coining [6].

Disposition: The patient was discharged with her mother from the ED with a follow-up appointment in the pediatric allergy and immunology clinic. She was advised to rest, drink lots of fluids, and take acetaminophen or ibuprofen for fever and analgesia. She was subsequently evaluated in the allergy clinic and does well on a low-dose, non-sedating antihistamine.

Every year, nearly three million suspected cases of child abuse are reported to Child Protective Services (CPS) [6]. Clinicians must be aware of practices such as coining, where hot coins and warm oil are rubbed on the backs of the chronically ill to release the “bad wind” [7]. In addition to the recognition of different cultural practices, clinicians must be aware of the difficulties faced by those patients who do not speak English. Non-English speakers are more likely to be dissatisfied with their care, less willing to seek care until a true emergency exists, and have more undiagnosed health problems than their English-speaking counterparts [5]. As a medical community, we must acknowledge the significance of linguistic barriers on patient care, and be committed to using properly trained interpreters and dedicating resources for our growing ethnic populations.

References

1. Jenkins CNH, Le T, McPhee SJ, Stewart S, Ha NT. Health care access and preventive care among Vietnamese immigrants: do traditional beliefs and practices pose barriers? Soc Sci Med. 1996;43(7):1049–56.
2. Moy JA, McKinley-Grant L, Sanchez MR. Cultural aspects in the treatment of patients with skin disease. Dermatol Clin. 2003;21(4):733–42.
3. Christian C. Assessment and evaluation of the physically abused child. Clin Fam Pract. 2003;5(1):21–46.
4. Keller EL, Apthorp J. Folk remedies vs child battering. Am J Dis Child. 1977;131:1173.
5. Rodriguez M. Cultural and linguistic competence: improving quality in family violence health care interventions. Clin Fam Pract. 2003;5(1):213–35.
6. Amshel CE, Caruso DM. Vietnamese "coining": a burn case report and literature review. J Burn Care Rehabil. 2000;21(2):112–4.
7. Berstein E, Bernstein J, James T. Multiculturalism and care delivery. In: Marx JA, Hockberger RS, Walls RM, Adams JG, Barsan WG, Biros MH, et al., editors. Rosen's emergency medicine: concepts and clinical practice. 6th ed. Philadelphia: Mosby; 2006. p. 3107–18.
8. Kurth H, Wilke N, Gehl A, Sperhake J. Cao Gio ("coin rubbing"). Monatsschrift Kinderheilkunde. 2008;156(10):1004–7.

Chapter 25
Case 7: Toxic Ingestion

Claire Plautz and Marcus L. Martin

Case Scenario

A 3-year-old Asian boy is brought into the Emergency Department (ED) by emergency medical services (EMS) in respiratory distress. In broken English, his grandmother reports finding him in the living room about 20 min ago with labored breathing and making “wheezing” noises. She also found her pouch of “nganga” on the floor. It appeared to have been opened. She is concerned the boy may have ingested this substance.

Review of Symptoms

Positive for: Dyspnea, audible wheezing
Negative for: Fever, cough, rhinorrhea, vomiting, diarrhea

C. Plautz, M.D.
Emergency Department, Sentara RMH Medical Center, University of Virginia
Medical Center, Charlottesville, VA, USA

M.L. Martin, M.D. (✉)
Department of Emergency Medicine, School of Medicine, University of Virginia,
Charlottesville, VA, USA
e-mail: mlm8n@virginia.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_25

Past Medical History

Reactive airway disease, immunizations are up to date
Medications: none
Allergies: None known

Family History

Father with asthma

Social History

The child lives with his parents and a school-aged sibling. The grandma is visiting from the Philippines and has been staying with the family for the last 2 weeks; she is babysitting for her daughter and son-in-law who both work.

Physical Exam

Vital Signs: Temp 98.6 °F, Pulse: 155, Respirations: 35, BP 130/70, O_2 Sat 90 % on room air

General: Mild respiratory distress, crying child on grandmother's lap

Cardiovascular: Regular rate and rhythm, tachycardic at 150 bpm with a very active precordium. Normal S_1=S_2 with no murmur, rubs, or gallops.

Respiratory: Diffuse wheezing throughout, no crackles or rhonchi. Breath sounds equal bilaterally, subtle intercostal retractions noted.

ENT: Constricted, but reactive pupils bilaterally, slight nasal flaring, no rhinorrhea. Tympanic membranes are clear, non-erythematous. Oropharynx shows non-enlarged tonsils, moist oral mucosa, brown bark-like material present on tongue and buccal mucosa.

Abdomen: Soft, non-tender, non-distended. Normoactive bowel sounds present throughout.

Extremities: No clubbing, cyanosis, or edema. Cap refill less than 2 s.

Skin: No rashes. Moist, cool skin is noted.

Neuro: Alert and awake, moving all extremities, 2+ deep tendon reflexes symmetrically.

Neck: No cervical lymphadenopathy.

Questions for Discussion

1. What other historical questions would you ask?

   Ask questions about the circumstance where the patient was found, i.e., small toys in the area, any potential foreign bodies, which could have been ingested. You may want to inquire about recent history of URIs, coughing, or fevers, or other history of sick contacts or previous episodes.

2. How would you approach a patient (or family member) when there is a language barrier?

   In cases where an interpreter is not immediately available, it will be difficult to get an adequate history. Your facial expression and open body language are your tools, i.e., do not cross your arms; do not raise your voice. Speak calmly and clearly, using simple terminology when possible. When available, interpreter services using CyraCom phone or help from hospital staff should be considered. Often, the hospital has a list of native language speakers available to be contacted for interpreter services in person or over the telephone.

3. How would you approach this possible ingestion?

   In any patient with respiratory distress, always address the ABCs (Airway, Breathing, and Circulation) first. Once assured that he is able to protect his airway, breathing adequately and is well-perfused (or have taken steps to ensure that intubation, nebulizer treatments, and supplemental O_2 are available), you may proceed with obtaining more history.

4. How do the findings on the physical exam help your management?

   The patient appears to be in some respiratory distress, as shown by his tachypnea, accessory muscle use, and nasal flaring. He also has acute constriction of his lower airways (bronchi, bronchioles) as he is wheezing on the lung exam (as opposed to stridor seen in obstruction of the upper airways). He is afebrile, not coughing and has no other signs of an active respiratory infection. He is also tachycardic with a mildly increased blood pressure.

5. What do you make of the bark-like substance found in this boy’s mouth?

   Consider that this child may have eaten something he shouldn’t have! You ask the grandma to look in his throat and she promptly tells you that it looks like her “nganga” chew. She pulls out a small pouch with a brown substance inside.

6. How would you go about researching what this unknown substance is?

   Your local Poison Information Center is a wonderful resource and a consultation with your resident toxicologist may be helpful.

7. Does the fact that the grandma is from the Philippines have any significance?

   Yes! She knows the name of the substance in her own language and researching names will be far more expedient than having this substance sent to the lab for analysis.

   Together with the toxicologist, you find that "nganga" is also called *betel nut* in western countries. It is a common masticatory drug used by up to 600 million people in south-east Asia, India, and the South Pacific. Arecoline, the active ingredient in betel nut (*Areca catechu*), has stimulatory effects similar to that of nicotine and has effects consistent with cholinergic (muscarinic and nicotinic) activation. Symptoms include tachycardia, lacrimation, salivation, dizziness, nausea, euphoria, weakness, hypertension, urinary incontinence, and diarrhea [1]. Betel chewing also increases plasma concentrations of epinephrine and norepinephrine, as well as inhibits GABA uptake [2–4]. The structure of arecoline is closely related to that of the substance, methacholine, used by pulmonologists as an inhalational provocative test to confirm asthmatic tendencies. Thus, betel nut may also cause bronchospasm and asthma exacerbations.

8. What do you do now?

   Treatment is supportive: careful airway and respiratory care, cardiac and hemodynamic monitoring, and fluid resuscitation, if needed. In known overdoses, atropine may be used as an antagonist and gastrointestinal decontamination with activated charcoal may be necessary. After he is stabilized, the grandma approaches you, somewhat anxious, stating that she loves her grandchild and would never be this careless. She begs you not to tell the authorities because they might come and take him away from his mommy and daddy.

9. How would you handle the grandma's request not to tell authorities?

   Many third world countries do not have Child Protective Services as we do in the USA. The myth of children being disciplined by their parents, then being taken away from their homes, remains a fear by those who do not understand the law. Carefully explain this to the grandma and use your best judgment to decide whether neglect was a factor in this incident.

10. What components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

    Performance of Focused History and Physical: A thorough history and physical would have elucidated grandma's betel nut chew as a potential etiology for this child's asthma exacerbation.

    Medical Knowledge: Betel nut, though rarely used in western civilization, is common in developing countries and remains a daily practice in many immigrant households. With the growing immigrant population in the USA, we, as emergency practitioners, need to be more aware of these practices.

    Systems-based Management: Use of local resources such as Poison Control, Language Line interpretation services, and Child Protective Services is helpful in a case such as above.

Patient Centered Communication: An interpreter would have been necessary to communicate with the grandma in this case. Also, good communication is paramount to the social aspects of this case, especially if there might be potential for Child Protective Services' involvement.

Case Outcome

Disposition: The patient was admitted to the pediatric inpatient floor for close observation. This 3-year-old Asian boy's symptoms improved after treatment with Albuterol/Atrovent nebulizer. The admitting team added steroids, 1 mg per kg orally to his regimen. After a 2-day stay, he was discharged home. The boy's mother, father and grandmother were all observed to interact in an appropriate manner with the child while he was in the hospital. There was no need in this case to contact Child Protective Services.

References

1. Deng JF, Ger J, Tsai WJ, Kao WF, Yang CC. Acute toxicities of betel nut: rare but probably overlooked events. J Toxicol Clin Toxicol. 2001;39(4):355–60.
2. Chu NS. Effects of betel chewing on the central and autonomic nervous systems. J Biomed Sci. 2001;8(3):229–36.
3. Kagawa-Singer M, Kassim-Lakha S. A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. Acad Med. 2003;78(6):577–87.
4. Post DM, Cegala DJ, Marinelli TM. Teaching patients to communicate with physicians: the impact of race. J Natl Med Assoc. 2001;93(1):6–12.

Chapter 26
Case 8: Adolescent Indian Male Sikh

Sybil Zachariah and Swaminatha V. Mahadevan

Case Scenario

A 17-year-old Indian male presents to the emergency department (ED) with his mom stating that he had been beaten up while walking home from school. Initially, the young man refuses to discuss what had happened. You note that the child is of Indian origin and is wearing a small turban-like headdress. A small portion of the turban is blood-soaked suggesting an underlying scalp injury. On removing his headdress, you note that the child's hair is very long. You find a superficial 3 cm laceration over the crown, which has stopped bleeding. After examining the wound, you determine that cutting some hair would facilitate closure of the wound. When the patient's mother finds the physician trimming back the child's hair she becomes extremely irate, saying, "What are you doing? Why are you cutting my son's hair? Don't you know we are Sikhs?"

The physician apologizes and pauses. The young man finally opens up and explains: "I was walking home from school like I always do. Then these kids came up to me and were shouting 'Rag head, go back to Afghanistan' and 'You'll pay for September 11th.' I tried to keep walking and ignore them but they jumped me and starting punching and kicking me." The child and mother both burst into tears. He continues, "I was so angry I almost pulled out my kirpan (see Fig. 26.1) to take care of those bullies. They are going to pay for this if it's the last thing I do."

S. Zachariah, M.D.
Department of Surgery, Division of Emergency Medicine, Stanford Hospital and Clinics,
Stanford, CA, USA

S.V. Mahadevan, M.D. (✉)
Department of Emergency Medicine, Stanford University School of Medicine,
Stanford, CA, USA
e-mail: s.mahadevan@stanford.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_26

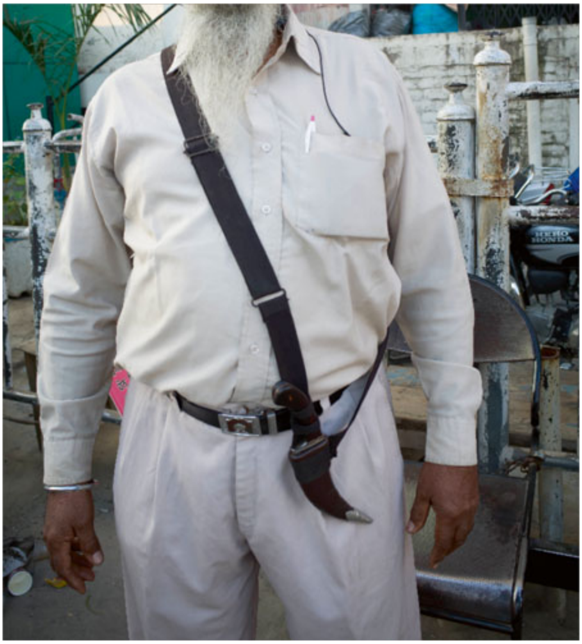


Fig. 26.1 Sikh man wearing kirpan

Review of Symptoms

Patient complains of headache and cut to his scalp.

Past Medical History

None

Family History

None

Social History

Denies alcohol, drug use, or tobacco use.

Physical Exam

Vital signs: Temp: 98 °F, pulse: 75, BP: 118/70, respirations: 20, O_2 Sat 98 % on room air

General: Healthy male wearing a small turban headdress, which is blood-soaked

Cardiovascular: Regular rhythm, no murmurs or gallops. No edema, capillary refill less than 2 s

Respiratory: Regular, unlabored breathing. Clear to auscultation bilaterally.

ENT: Upon removing his headdress, you find a superficial 3 cm laceration to the frontal area, no active bleeding

Abdomen: Bowel sounds normal in all four quadrants. Soft, non-distended

Extremities: Warm, well perfused, intact

Skin: Warm, dry, clean, appropriate for ethnic background. Significant for superficial 3 cm laceration

Neuro: Pupils equally round and reactive to light. Cranial nerves intact

Neck: Soft, nontender. No lymphadenopathy

Questions for Discussion

1. What are some ways of getting this patient to open up?
    (a) Showing empathy, being compassionate, being patient, building trust, and making it clear that you are there to help.
2. How often are adolescents the victims of violence?
    (a) Violence disproportionally affects children, adolescents, and young adults, with youth having the highest rate of victimization of any age group. In 2009, nearly 500,000 children and youth sought care for nonfatal violent injuries, and 6 % of these were hospitalized. Children often initially experience or witness violence at home; this can increase their predisposition to violence along with exposure from school, media, sports, and peer violence [1].
3. Is school violence common?
    (a) Many adolescents report that their greatest fear is school violence. In a 2011 national school survey, 5.9 % of students missed school because they felt unsafe at school or traveling to or from school, and 7.4 % of kids had been threatened or injured with a weapon while on school property. The survey also revealed that 32.8 % of high school students had been in a physical fight

and 16.6 % carried a weapon to school (e.g., gun, knife, or club) [2]. Bullying is becoming recognized as an important part of school violence, consisting of the repeated and intentional intimidation, harassment, or physical harm toward an individual or group. Up to 54 % of students report being victims of bullying within the past year [1].

4. Why would the mother become hostile as the patient needs the hair to be trimmed to facilitate wound closure?

Attitudes/assumptions: the physician

In medical practice, the cutting of the hair to facilitate wound closure is standard of care.

Attitudes/assumptions: the mother

Sikhs are forbidden from cutting their hair or their beards.

Gaps in Provider Knowledge

(a) Lack of knowledge of health beliefs/customs: Sikh religion was created 500 years ago in Punjab, India, and there are 20 million Sikhs worldwide. Although people of many religious and ethnic backgrounds wear head coverings, Sikh men are mandated to wear them as commanded by one of their spiritual leaders. Sikhs are also forbidden from cutting their hair or their beards [3].

(b) Lack of knowledge of this community: As part of their sacred religious beliefs, Sikhs are required to wear a ceremonial sword or *kirpan*. The kirpan can be a few inches in length to over 3 ft long and is usually kept sheathed (see Fig. 27.1). It is worn as a religious symbol and is not intended for use as a weapon [3].

(c) Lack of knowledge of disparities/discrimination: The Department of Justice defines hate crimes as “the violence of intolerance and bigotry, intended to hurt and intimidate someone because of their race, ethnicity, national origin, religion, sexual orientation, or disability. The purveyors of hate use explosives, arson, weapons, vandalism, physical violence, and verbal threats of violence to instill fear in their victims, leaving them vulnerable to more attacks and feeling alienated, helpless, suspicious and fearful” [4].

Hate crime data is collected by the FBI per the Federal Hate Crimes Statistics Act. Prior to 2001, hate crimes due to bias against Islam were relatively rare. The September 11th terrorist attacks spawned a backlash of hate crimes against many US residents who were felt to be associated with the terrorists based on appearance, ethnicity, or religion, peaking within the year after the attacks to nearly 500. The incidents then decreased but have held steady at 100–200 a year, however, never returning to the low rates prior to 2001 [5]. A study done in 2010 demonstrated that 43 % of Americans hold at least “a little” prejudice toward Muslims, with 53 % having an unfavorable view of the Islamic faith [6]. Many Sikhs and Sikh organizations have organized nationwide campaigns to educate Americans about their religion.

5. What actions could have been taken by the doctor?

   (a) Express empathy for what has happened. Allow the victim to ventilate feelings about the crime, and validate those feelings by expressing your personal concern for the victim and what he or she has experienced.
   (b) Inform the victim that he or she may experience a range of normal emotional responses due to the victimization (e.g., anger, sadness, emotional numbness) and that these responses may manifest themselves immediately following or any time after the incident. Do not attempt to diminish the impact of the crime in any way.

6. What should the ED physician do regarding the child's statement of retaliation?

   (a) The ED physician should take all threats of physical harm or violence seriously, and victims should be counseled by either healthcare providers or social services while in the ED. Determine the victim's plans to seek revenge and counsel the patient, emphasizing a cooling-off period to prevent further acts of violence. The risk of criminal prosecution, re-injury, or death to the patient or others should be discussed with the patient.
   (b) Emergency physicians and other healthcare providers may be legally bound to report a patient to law enforcement officials if a patient threatens a specific individual.

7. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

   General Approach to Procedures: Showing empathy, being compassionate, being patient, and building trust by suturing the laceration without cutting the patient's hair.

   Professional Values: Cross-cultural inclusion of the patient and his mom in understanding the Sikh belief of not cutting hair before closing of a laceration.

   Patient-Centered Communication: Allowing the victim to ventilate his feelings about the crime and validating those feelings by expressing personal concern for the victim. If you cannot communicate in the language of the victim, arrange for an interpreter. Be sensitive and respectful.

Case Outcome

Diagnosis: Scalp laceration
Disposition: Home

The patient's scalp laceration is cleaned, explored, and closed without cutting the patient's hair. His mother is relieved and grateful. After being counseled by the ED physician and social worker, the child acknowledges that he was just angry and really does not intend to harm his assailants. The ED physician suggests that he and his mother meet with the school principal to discuss the events of the day.

References

1. Strote J, Hutson HR. Youth, violence, and street gangs. In: Marx JA, Hockberger RS, Walls RM, editors. Rosen's emergency medicine: concepts and clinical practice. 8th ed. Philadelphia: Elsevier; 2013. p. e1–7.
2. Youth violence: facts at a Glance [Internet]. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; c2012 [cited 2014 October 22]. Available from: www.cdc.gov/ViolencePrevention/pdf/YV_DataSheet_2012-a.pdf
3. Sikhs.org [Internet]. c2011 [cited 2014 Sep 6]. Available from: www.sikhs.org/topics.htm
4. The United States Department of Justice [Internet]. Washington, DC: The United States Department of Justice; [updated 2014 Jun 23; cited 2014 Sep 6]. Community Relations Service: Hate Crime; [about 26 p.]. Available from: http://www.justice.gov/crs/hate-crime
5. The Federal Bureau of Investigation [Internet]. Washington, DC: The Federal Bureau of Investigation; [cited 2014 Sept 6]. Uniform Crime Reports; [about 1 p.]. Available from: http://www.fbi.gov/about-us/cjis/ucr/hate-crime/
6. Morgan GS, Wisneski DC, Skitka LJ. The expulsion from Disneyland: the social psychological impact of 9/11. Am Psychol. 2011;66(6):447–54.

Chapter 27
Case 9: Intimate Partner Violence in the Gay Community

Simiao Li, Jason Liebzeit, and Michael A. Gisondi

Case Scenario

A 19-year-old male presents to the emergency department with a complaint of painful rectal bleeding. The triage note is otherwise blank. The patient enters the examination room alone, appearing sullen and withdrawn. A young male resident assigned to his care becomes frustrated during multiple attempts at a history and a physical. The patient is quiet, slow to answer questions, and offers little detail. The resident makes several requests for the patient to fully undress. Physical examination is remarkable for a bloody laceration extending close to the ventral aspect of the anal sphincter. Multiple bruises are noted on the extremities. After the examination, the physician shakes his head and asks, “How did all this happen?” The patient starts to cry and states, “I can’t believe my life has gotten so out of control.”

S. Li, M.D., M.S. (✉)
Department of Emergency Medicine, Northwestern University Feinberg School of Medicine,
Chicago, IL, USA
e-mail: simiao.li@gmail.com

J. Liebzeit, M.D.
Department of Emergency Medicine, Emory University School of Medicine,
Atlanta, GA, USA

M.A. Gisondi, M.D.
Department of Emergency Medicine, Northwestern University Feinberg School of Medicine,
Chicago, IL, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_27

Review of Systems

The patient also reports nausea and anorexia, as well as painful defecation. He denies fever, cough, vomiting, headache, weight loss, and rash. All other systems are negative.

Past Medical History

Environmental allergies. No medications/allergies.

Family History

No history of inflammatory bowel disease or cancer.

Social History

The patient lives with his 34-year-old boyfriend. He denies tobacco use, but drinks alcohol heavily each weekend and uses illicit drugs: “My boyfriend gives me T to use sometimes.”

Physical Exam

Vital signs: Temp*:* 99.3, pulse 105, RR 22, BP 125/55, O_2 Sat 100 % on room air

General: Awake and alert, appears uncomfortable, poor eye contact

Cardiovascular: Tachycardic and regular; S_1 and S_2 normal, no murmurs

Respiratory: Breathing comfortably with good aeration, clear in all fields

ENT: Normocephalic, atraumatic; pupils equally round and reactive to light and accommodation, extraocular movements intact, anicteric; moist mucosa

Abdomen: Non-distended; normal bowel sounds; mild, diffuse tenderness to palpation without guarding; no peritoneal signs; no organomegaly or masses

Extremities: Warm, well perfused, full active range of motion; non-tender

Skin: Multiple areas of ecchymosis at bilateral wrists, proximal arms, and medial thighs

Neuro: Alert and oriented; cranial nerves 2–12 intact; strength and sensation 5/5 × 4; reflexes 2+ × 4; cerebellar and gait exams normal

Rectal: Tender 2.5 cm perianal laceration at 6 o'clock position; external sphincter tone intact; a small amount of fresh blood is present; vault empty, prostate non-tender

Questions for Discussion

1. Why wasn't the patient immediately forthcoming about the nature of his injuries?

   Attitudes/Assumptions: The physician

   (a) I know that there is something wrong, but how can I help him if he won't tell me what happened? This patient is wasting my time.
   (b) I'm not surprised he's such a mess. I don't even know what drugs he is using … what does "T" even mean?
   (c) I don't have time for something he brought on himself. If he is being abused by his partner, why doesn't he just leave?

   Attitudes/Assumptions: The patient

   (a) This doctor is going to judge me. I bet he is a conservative.
   (b) If I tell the doctor that I'm using meth, he will report me and I will get arrested.
   (c) I can't tell them that my boyfriend is beating me up. Men don't allow themselves to be beaten.
   (d) If I tell them my boyfriend is beating me up, my boyfriend will get arrested.
   (e) My boyfriend will really hurt me if he finds out I tried to get help.

   Gaps in Provider Knowledge

   (a) Lack of knowledge of health beliefs/customs: Drug use and depression are often associated with intimate partner violence (IPV) [1]. Methamphetamine, a highly addictive illicit drug, is associated with increased sexual drive and unsafe sexual practices [2]. "T" is one of the street names used for the drug [3].
   (b) Lack of knowledge of community: Relative lack of awareness of IPV in general, particularly among same-sex couples. Gay men experience IPV at rates similar to or higher than those among heterosexual women [4], but can be hesitant to disclose due to social pressure [5]. The rates of IPV for women with same-sex partners and transgender individuals are even higher [5].
   (c) Lack of knowledge of disparities/discrimination: Gay patients may be reluctant to discuss their sexual orientation or practices, given prior negative experiences with family and/or healthcare providers.

2. How could the physician more sensitively obtain a sexual history?

   Cultural Tools and Skills to Improve Communication

   (a) Questions about sexual orientation should be direct and free of judgment [6].
   - "Do you have sex with men, women, or both?" Do not assume heterosexuality.
   - Avoid labeling a patient as gay, lesbian, bisexual, or transgender, unless prompted by the patient. Some patients may avoid self-identification with a particular group and the term "men who have sex with men" (MSM) is more inclusive.

   (b) Sexual practices should be discussed in a "matter-of-fact" tone that conveys understanding: "There seems to be a tear at the opening to your rectum. Such injuries are commonly the result of trauma during anal sex or from the use of sex toys. Was anything put in your rectum that could have caused the cut I noticed?"

   (c) Details of possible IPV should similarly be solicited in a direct, yet supportive manner [6, 7]:
   - "Does your partner ever hit, kick, hurt, or threaten you?"
   - "Do you feel unsafe in any of your relationships?"
   - "Does anyone hurt you or force you to have sex?"
   - "Do you have a safe place to stay?"

3. What medical issues concern you about this patient?

   (a) Intimate partner violence, substance abuse, possible depression and/or suicidal ideation, anal laceration

4. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

   Medical Knowledge: The comprehensive care of this patient would require that the resident is well versed in the following topics: anorectal emergencies, substance abuse and addiction, depression and self-harm, IPV, and cultural competence with LGBT (lesbian, gay, bisexual, transgender) health issues.

   Patient Safety: Cases of IPV often require providers to address psychosocial issues as well as medical emergencies. This scenario tests the resident's ability to identify and manage cultural, psychiatric, and medical challenges in concert.

   Systems-Based Management: This case may require a resident provider to utilize multiple referrals for potential outpatient care (general surgery, addiction counselor or program, psychiatrist, STI clinic, shelter). Residents should become familiar with referral systems to such agencies in their communities.

   Professional Values: Providers often encounter patients with social or cultural practices that may conflict with the provider's own beliefs or values. It is imperative that residents learn skills to care for patients in a manner that respects perceived differences and engenders a therapeutic environment.

Patient-Centered Communication: A professional and nonjudgmental approach is essential when obtaining a sexual history or eliciting experiences with IPV. The skilled resident would be able to tailor their questioning to the challenges of the case while ensuring a comfortable and trusting patient-physician interaction.

Case Outcome

Diagnoses: Anal laceration; IPV; substance abuse; depression
Disposition: Discharge with a supportive friend

The details of the patient's injuries are obtained in a supportive manner. As a result, the patient is comfortable relaying the details of his troubled home life to an understanding healthcare provider. The physician discusses the increased risks of self-injurious behavior, substance abuse, and partner violence among young gay men. The patient affirms that he is not suicidal and agrees to speak with a social worker regarding his partner's violence and unsafe living environment. He takes an outpatient mental health referral for possible depression. He receives appropriate STI screening and empirical treatment. A rapid HIV test is negative. The anal laceration will heal by secondary intention. The physician prescribes Augmentin, stool softeners, Sitz baths, and an outpatient surgery referral. The patient is given return precautions and is discharged in the care of a close friend.

References

1. Buller AM, Devries KM, Howard LM, Bacchus LJ. Associations between intimate partner violence and health among men who have sex with men: a systematic review and meta-analysis. PLoS Med. 2014;11(3):e100109.
2. Vosburgh HW, Mansergh G, Sullivan PS, Purcell DW. A review of the literature on event-level substance use and sexual risk behavior among men who have sex with men. AIDS Behav. 2012;16(6):1394–410.
3. Stonewall Project, San Francisco AIDS Foundation. Tweaker. 2015 [cited 2015 Feb 2]. Available from: http://www.tweaker.org.
4. Finneran C, Stephenson R. Intimate partner violence among men who have sex with men: a systematic review. Trauma Violence Abuse. 2013;14(2):168–85.
5. Finneran C, Chard A, Sineath C, Sullivan P, Stephenson R. Intimate partner violence and social pressure among gay men in six countries. West J Emerg Med. 2012;13(3):260–71.
6. Ard KL, Makadon HJ. Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. J Gen Intern Med. 2011;26(8):930–3.
7. Hellinger MD. Anal trauma and foreign bodies. Surg Clin N Am. 2002;82:1253–60.

Chapter 28
Case 10: West Indian/Caribbean

Heather M. Prendergast

Case Scenario

A 65-year-old male presents to the emergency department with his wife. From the triage assessment, you learn that the husband recently emigrated from Jamaica, West Indies, to join his wife in the USA. Per his wife, the patient has been losing weight and seems to be "more tired." She reports that the patient has been self-medicating with a variety of "herbal remedies" which seemed to have helped. The patient is a healthy, well-groomed male with shoulder length hair (dreadlocks) who appears older than his stated age.

You are unable to obtain any meaningful additional information concerning the chief complaint from the patient, and his wife is unable to provide the necessary specifics. Multiple attempts at a dialogue with the patient yield only one-word or vague answers. The doctor, believing the patient to be arrogant and disinterested in seeking medical attention, focuses on the patient's use of "herbal remedies," and assumes that these "herbal remedies" the patient has been using are "ganja" (also known as marijuana); therefore he is dismissive of the wife's concerns. The doctor unintentionally minimizes the severity of the complaints based on the general appearance of the patient and preconceived stereotypes about Jamaicans with dreadlocks and the perceived widespread use of marijuana among this group of individuals. The doctor suggests to the family that the patient's complaints are not emergent and instructs the wife to make a clinic appointment for an outpatient evaluation. Specifically, the dialogue is as follows:

Physician (enters the room and immediately begins with his questioning): "Sir, when did your symptoms first begin?"
Patient: "Well, some time now."

H.M. Prendergast, M.D., M.S., M.P.H. (✉)
Department of Emergency Medicine, University of Illinois, Chicago, IL, USA
e-mail: hprender.heather@gmail.com

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_28

Physician: “Approximately how much weight have you lost?”

Patient: “Quite a bit.”

Physician: “Have you noticed any changes in your appetite since coming to the United States?”

Patient: “No.”

Physician: “Have you experienced any of the following: fevers, blood in your stools, headache, and abdominal pain?”

Patient: “Well, it’s hard to say.”

Physician: “Your wife mentioned that you have being trying some herbal remedies. Can you tell me more about what you have been using?”

Patient: “Well, not per se. You can’t buy them in stores. It’s a homemade thing.”

Physician: “Well, sir, what would you like me to do for you today?”

Patient: “I don’t know, you are the doctor and I am the patient.”

Physician: (appears a bit frustrated and sighs) “Sir, correct me if I am wrong. These symptoms have been occurring for some time now and nothing new has happened recently that precipitated your presence here today. Do you share the same concerns as your wife, or are you here for her benefit?”

Patient: “Well doctor, this is the hospital and you must tell me if something is wrong.”

Physician: “Sir, I believe that you can best benefit from an outpatient evaluation. Based upon our conversation, I don’t see any reason to do any expensive laboratory testing from the Emergency Department, and your chronic complaints can be addressed in a less costly environment.”

Review of Symptoms

Provided by the wife: The patient has experienced weight loss, frequent loose stools, and urinary frequency sometimes with difficulty. There is no history of vomiting.

Past Medical History

Hypertension controlled with herbal preparations

Family History

Father died of cancer. Mother with a history of diabetes.

Social History

Smokes tobacco, occasional alcohol, no illicit drug use

Physical Exam

Vital signs: Temp: 98.7 °F, pulse: 86, respirations: 20, BP: 146/92, O_2 Sat 98 % on room air

General: Well-developed and well-nourished male, appears healthy

Cardiovascular: Regular rate and rhythm, S1, S2 normal

Respiratory: Occasional rhonchi at bases, otherwise clear

ENT: Pupils equal and reactive, extraocular movements intact, neck: supple, mucous membranes moist

Abdomen: Soft, flat, normal bowel sounds, no rebound, no guarding

Extremities: Well perfused. Capillary refill <2 s. No edema. No clubbing of nails.

Skin: Warm, dry, intact, clean.

Neuro: Alert and oriented ×3. Cranial II-XII intact.

Rectal: Enlarged prostate, firm, brown stool, heme occult positive

Questions for Discussion

1. Why did the physician-patient relationship suddenly change to an adversarial one?

   Attitudes/Assumptions: The physician

   (a) I am the doctor, I know best. I am here to help you, but do not waste my time.
   (b) Based upon the patient's vague and one-worded responses, the patient is not really interested in being a partner in his medical care.
   (c) Patients with dreadlocks and of West Indian descent tend to use marijuana recreationally and marijuana use may be a part of his "herbal remedies."
   (d) The patient looks relatively healthy and is probably here at the urging of his wife.

   Attitudes/Assumptions: The patient

   (a) The doctor assumes that I am uneducated and may not understand English well.

(b) The doctor is disrespectful and feels I am not worthy of respect by not introducing himself and addressing me by my last name.
(c) The doctor is arrogant and believes I am wasting his time.
(d) Americans in general are impatient.
(e) The doctor does not understand Jamaican culture and attitudes—he probably thinks I am stupid.

Gaps in Provider Knowledge

(a) Lack of knowledge of health beliefs/customs by provider: In general, Jamaicans tend to self-medicate and exhaust every possible home remedy before seeking professional medical assistance. However, once seeking professional medical attention, there is a sincere belief in the physician or medical providers to cure the illness. Herbs are also used for health maintenance. Elders within the family are repositories of herbal wisdom. Popular home remedies included senna, Epsom salt, or castor oil to cleanse the bowel of worms and purify the body.
(b) Lack of knowledge of community: Jamaicans see themselves as independent thinkers. They take pride in controlling their destiny. Most reject authority when they believe that their intellectual ability is being disregarded or when the authority figure is perceived to be condescending. The strong sense of person and family is often misconstrued. Many Jamaicans are perceived as stubborn or intolerant of authority and authority figures. Women tend to take the leadership role in securing medical services for themselves and their families. Women often accompany men to doctor's appointments and may tend to do most of the talking. Jamaicans are very proud and try to maintain dignity at all cost. This leads to stoic behavior and should not be misinterpreted as unfeeling or uncaring.
(c) Lack of knowledge of disparities/discrimination: There is a misbelief that most Jamaicans do not speak English and therefore have difficulty understanding English. In addition, there is the stereotype that marijuana or "ganja" use is widespread in Jamaica, especially among Rastafarians and dreadlocks are stereotypical of affiliation with Rastafarian beliefs.

2. What actions could have been taken by the physician to avoid/prevent this negative exchange?

Cross-Cultural Tools and Skills

(a) Greetings or acknowledgement of an individual's presence is an important cultural value. Absence of the greeting implies a failure of interest in the well-being of the individual.
(b) Listen carefully to understand what is being said. Many Jamaicans may speak with an accent. Simply clarify what has been said in order to prevent any misunderstanding on your part or the part of the patient. Make sure that efforts to achieve clear communication and dialogue are not conveyed in a condescending manner.

(c) Remember that Jamaicans bring with them a cultural history and that "one size does not fit all" when it comes to culture.
(d) Be understanding of cultural norms and tendencies without imposing judgment.

3. What medical issues concern you about this case?

(a) The patient presents with concerning symptoms (weight loss and fatigue); however it is difficult getting a good history from the patient. The patient provides one-word answers and seems uninterested.
(b) Systematically go through your medical differential by focused questioning and really engage the patient in the process.
(c) Discuss or explain the reasoning behind your questions. This may help improve the quality of the patient's responses. For example, explaining why the types of herbal regimens used by the patient may be important in formulating a thorough differential diagnosis. Many herbal preparations may contain mild diuretics or laxatives, etc.

4. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

Patient care: Establishes and implements a comprehensive disposition plan that uses appropriate consultation resources; patient education regarding diagnosis; treatment plan; medications; and time- and location-specific disposition instructions.

Patient-centered communication: Demonstrates interpersonal and communication skills that result in the effective exchange of information and collaboration with patients and their families. Taking the time to introduce or greet the patient can serve to set the tone for a good physician-patient relationship and a potentially positive service outcome. Ask when in doubt. Most Jamaicans are proud of their country and are happy to talk about it.

Professional values: Demonstrates compassion, integrity, and respect for others as well as adherence to the ethical principles relevant to the practice of medicine.Listen carefully to the wife's concerns. Communicate openly in a nonjudgmental manner and do not minimize the patient's presentation to the ED.

Case Outcome

Diagnosis: Symptomatic anemia probable due to chronic blood loss from the gastrointestinal tract

Disposition: Home

After an appropriate history and physical examination is obtained utilizing the principles above, screening laboratory studies revealed hemoglobin of 10 with no previous baseline. Based upon the heme-positive stools, you conclude that it is most likely an iron-deficiency anemia. You send blood to the lab for iron studies to be followed up during a future clinic appointment. You explain your concerns to the family, and explore the correlation with the patient's symptoms and your findings. The patient is encouraged to take a multivitamin in addition to the iron tablets that you prescribe. You learn of the family's deep religious beliefs and concerns about cancer. You discuss a management plan with the couple stressing the importance of avoiding a presumptive diagnosis. You communicate your concerns about the continued use of herbal remedies in addition to the multivitamins and iron supplements. You ask that the patient refrain from use of those products until a diagnosis is made. You instruct the family that they may return to the emergency department should there be any change in his symptoms or condition [1–9].

References

1. Miller D. An introduction to Jamaican culture for rehabilitation services providers [Internet]. Buffalo, NY: Center for International Rehabilitation Research Information and Exchange at the University of Buffalo State University; 2002. [cited 2014 Jul 8], Available from: http://cirrie.buffalo.edu/culture/monographs/jamaica/.
2. Black CV. History of Jamaica. Kingston: Longman; 1997.
3. Kleier JA. Prostate cancer in Black men of African-Caribbean descent. J Cult Divers. 2003;10(2):56–61.
4. Hickling FW, Paisley V. Issues of clinical and cultural competence in Caribbean migrants. Transcult Psychiatry. 2012;49:223–44.
5. Wafula EG, Snipes SA. Barriers to health care access faced by black immigrants in the US: theoretical considerations and recommendations. J Immigr Minor Health. 2014;16:689–98.
6. Hickling FW. Understanding patterns in multicultural settings: a personal reflection on ethnicity and culture in clinical practice. Ethn Health. 2012;17:203–16.
7. Eldemire-Shearer D. Jamaica, Intra II: Perceptions of health care providers--the training issue [Internet]. Bronx, NY: Monroe College [cited 12 Apr 2015]. Available from: https://www.monroecollege.edu/uploadedFiles/_Site_Assets/PDF/alc_intra2_specialreport_jamaica.pdf
8. Archibald C. Cultural tailoring for an Afro-Caribbean community: a naturalistic approach. J Cult Divers. 2011;18:114–9.
9. The Emergency Medicine Milestone Project [Internet]. Chicago: The Accreditation Council for Graduate Medical Education and the American Board for Emergency Medicine; c2012 [cited 12 Nov 2014]. Available from: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/EmergencyMedicineMilestone.pdf.

Chapter 29
Case 11: American Indian

Diane Rimple

Case Scenario

An 84-year-old American Indian woman is brought to the emergency department at a tertiary care hospital by Advanced Life Support ambulance from an Indian Health Services clinic on a Pueblo approximately 2 hours away. She is accompanied by her daughter, who brought her to the clinic from home due to cough and fever. She is a frail-appearing older woman in a hospital gown, lying under a traditional blanket. She is on oxygen by non-rebreather. The patient is somnolent but easily arousable to voice. She speaks some English, but Navajo is her primary language. The resident has difficulty understanding her responses and is not certain that the patient understands her questions.

The clinic chart reports that a chest radiograph was obtained, which revealed a right middle lobe pneumonia. Labs were obtained, which were remarkable for an elevated white count and elevated blood urea nitrogen (BUN) with normal creatinine. The clinic gave the patient 1 liter of normal saline IV fluid and antibiotics appropriate for community-acquired pneumonia. Copies of the medical record, laboratory results, and radiologist's read of the X-ray are included.

The resident asks the patient's daughter about the patient's history and review of systems. She explains that the patient will be admitted to the hospital for antibiotics, oxygen, and IV hydration. She asks the patient's daughter if she has any questions. The daughter says, "No." The resident exits the room to begin the treatment and admission of the patient.

D. Rimple, M.D. (✉)
Department of Emergency Medicine, University of New Mexico, Albuquerque, NM, USA
e-mail: DRimple@salud.unm.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_29

Review of Symptoms

According to the clinic chart and the patient's daughter, the patient ordinarily is ambulatory and independent in the activities of daily living. She lives with her daughter and the daughter's family. The daughter said that she hasn't been eating well for about a week. She has been in bed for 2 days and seemed to be having trouble breathing this morning. No other symptoms were recorded.

Past Medical History

Right hip fracture 2 years ago. Repaired.
Per clinic chart: Influenza vaccine this year and has never received a pneumovax

Family History

Children with diabetes and hypertension, parents died of "old age"

Social History

No alcohol or tobacco use by the patient, patient worked at home as a weaver

Physical Exam

Vital signs: Temp: 101.3 °F, pulse: 104, BP: 90/55, respirations: 24, O_2 Sat 90 % on 10 liters by non-rebreather mask

General: Thin, frail-appearing older American Indian woman, somnolent but arousable to voice

Cardiovascular: Tachycardia in regular rhythm, with no murmurs, gallops, or rubs, palpable radial pulses

Respiratory: Tachypnea, shallow respirations, crackles in the bilateral lower lung fields; coarse breath sounds on right

ENT: Pupils round, reactive to light, arcus senilis, conjunctiva normal, mucous membranes dry, poor dentition

Abdomen: Soft, non-tender, non-distended, no organomegaly

Extremities: No edema, 4+ strength throughout, no cyanosis, arthritic changes to hands

Skin: No rash

Neuro: Grossly intact, no focal deficits

Neck: No jugular venous distention, bruits, no stridor

Questions for Discussion

1. Why is communication with the patient difficult?

   Attitudes/assumptions: The physician

   (a) The patient does not speak English well.
   (b) The patient does not understand my questions.
   (c) The patient may have dementia or other memory loss.
   (d) The patient is uneducated and wouldn't be able to give a medical history.
   (e) The patient's daughter can speak for her and will make health decisions for her.
   (f) The clinic's record is adequate because that is where the patient gets her primary care.

   Cross-Cultural Tools and Skills: Language

   (a) Commercial interpretation services often do not include American Indian languages.
   (b) Institutions taking care of populations speaking American Indian languages often have interpreter services available.
   (c) Younger family members are often bilingual. Elder American Indians will often be accompanied by family members who wish to help with their care. This raises the ethical issue of using family members as interpreters.
   (d) In some American Indian communities, asking questions is a sign of disrespect. Simply asking if a patient or family member has any questions may not be adequate to explore their understanding.

   Cross-Cultural Tools and Skills: Patient Autonomy

   (a) Elders are considered autonomous and make their own health decisions if they are able.

2. How should the physician approach issues of code status and goals of care?

   Attitudes/assumptions: The physician

   (a) The patient won't understand or be able to make her own decisions regarding her goals of care or code status.
   (b) She and her family will be offended if code status or goals of care are brought up.

   Gaps in Provider Knowledge

   (a) Lack of understanding of elders' autonomy.
   (b) Lack of knowledge regarding this specific community: Learn the family dynamic of elders living with extended family and expectation regarding elders' participation in decision making.

(c) Lack of knowledge of disparities/discrimination: American Indians may be distrustful of western medicine and the healthcare system, both internal and external to the Indian Health Service, due to a long history of misuse by researchers and transient healthcare workers with little understanding of their culture [1].
(d) Lack of knowledge of health beliefs/customs by provider including traditional medicine and the importance of medicine men.

3. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case? [2]

Patient Safety: Participating in an institutional process improvement plan to optimize emergency physician practice and patient safety.
Systems-Based Management: Recommending strategies by which patients' access to care can be improved.
Professional Values: Demonstrating behavior that conveys caring, honesty, genuine interest, and tolerance when interacting with a diverse population of patients and families and demonstrating an understanding of the importance of compassion, integrity, respect, sensitivity, and responsiveness, and exhibiting these attitudes consistently in common/uncomplicated situations and with diverse populations
Patient-Centered Communication: Effectively communicates with vulnerable populations, including both patients at risk and their families.

Case Outcome

Diagnosis: Right middle lobe pneumonia and sepsis.
Disposition: Patient was made full code and admitted to the intensive care unit (ICU), where she initially deteriorated and required bilevel positive airway pressure (BiPAP). The family requested that their medicine man be able to visit. He performed several healing ceremonies. The patient made a slow recovery, complicated by a troponin leak and deconditioning. She was discharged to a rehabilitation facility 21 days after admission.

References

1. US Commission on Civil Rights. Broken promises: evaluating the Native American health care system. Washington, DC: US Commission on Civil Rights; 2004.
2. The Emergency Medicine Milestone Project [Internet]. Chicago: The Accreditation Council for Graduate Medical Education and the American Board for Emergency Medicine; c 2012. Available from: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/EmergencyMedicineMilestones.pdf

Chapter 30
Case 12: Spiritualism in the Latino Community

Lisa Moreno-Walton, Marcus L. Martin, Leslie Uldine Walker, Ruth E. Wong-Pérez, and Janene Hecker Klein

Case Scenario

Mr. Cruz is a 43-year-old Puerto Rican male unrestrained driver of a pickup truck brought to the emergency department (ED) in the middle of the night after a motor vehicle collision. Paramedics wheel the stretcher through the door and tell a Caucasian male physician that the patient ran a red light at a low rate of speed and collided with a vehicle which was coming through the intersection. There was no reported loss of consciousness. He is immobilized in the usual manner on a long backboard and cervical collar. His left hand appears injured. He is asked to remove a ring from his left hand but he refuses.

ED physician:	"Hello, Mr. Cruz, I am Dr. Jones. What happened?"
Patient:	"I don't know. I looked both ways, but it was dark."
ED physician:	"Did you lose consciousness or pass out?"

L. Moreno-Walton, M.D., M.S., M.S.C.R. (✉)
Professor of Emergency Medicine, Director of Research, Director of Diversity,
Department of Medicine, Section of Emergency Medicine, Louisiana State University Health Sciences Center – New Orleans, New Orleans, LA, USA
e-mail: doctormoreno@gmail.com

M.L. Martin, M.D.
Department of Emergency Medicine, School of Medicine, University of Virginia, Charlottesville, VA, USA

L.U. Walker, B.A.
Office for Diversity and Equity, University of Virginia, Charlottesville, VA, USA

R.E. Wong-Pérez, M.D.
Emergency Department, Heritage Valley Health System, Beaver, PA, USA

J.H. Klein, M.D.
Heritage Valley Health System, Sewickley, PA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_30

Patient: “No, no.” (The patient appears more upset than would normally be expected.) “I should have known this was going to happen.”
ED physician: “Did you hit your head?”
Patient: “No, I should have known. No, I did not hit my head.”

Obviously puzzled, the doctor looks at the nurse, a Latina, who is obtaining vital signs. She just smiles back at him. The patient notices the interaction between the doctor and nurse and becomes agitated. He addresses the nurse in Spanish, “Señorita, you understand what I’m talking about. My cousin, he is a *santero*. He told me this afternoon that someone who is jealous of my family business put a spell on me.”

Nurse (to doctor in English): “He is worried that the collision was the result a spell someone put on him. His cousin is a santero, and they believe someone who is jealous of his family wishes him harm.”
Doctor (to patient): “I’m going to take you into the trauma bay so that I can do a full physical examination.”
Patient: “I don’t want to go into that room. I’m gonna die! So many people have died in there. I see them all over the place.”
Nurse: “Yes, but a lot of people have survived in this room also, and you will be just fine, sir. Just fine.”

Review of Symptoms

Laceration on dorsum of his left hand and an abrasion to the left side of his forehead

Past Medical History

Fractured left arm resulting from an injury during early childhood

Family History

Hypertension, diabetes mellitus

Social History

Patient lives with his wife, their three children, and cousin Don Jose.

Physical Exam

Vital signs: Temp: 98.6 °F, pulse: 105, BP: 160/90, respirations: 18, O_2 Sat 100 % on room air

General: Well-developed, well-nourished male, in no respiratory distress

Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops

ENT: Normocephalic, abrasion to the left side of his forehead, pupils equal, round, and reactive to light and accommodation (PERRLA), no evidence of papilledema, tympanic membranes clear, oropharynx clear

Respiratory: Clear to auscultation bilaterally, no wheezes, rales, or rhonchi

Abdomen: Bowel sounds normal in all four quadrants. Soft, non-distended, no tenderness to palpation

Extremities: Dorsum left hand, 4 cm stellate laceration, no tendon or muscle involvement, no motor or sensory deficits

Neuro: Awake, alert and oriented ×3, no focal deficits

Questions for Discussion

1. The physician does not seem to know about *Santería* (an Afro-Caribbean belief system) or why the patient believes that the collision is related to this. How could the patient's care be affected by the physician's lack of understanding?

   Attitudes/Assumptions: The physician

   (a) Any apparent agitation on the part of the patient is probably due to head trauma.
   (b) The patient is probably paranoid and does not know what he is saying.
   (c) The patient is agitated. He believes that the collision was caused by a spell, but he may also have a head injury or may be intoxicated. The patient senses that the physician is judgmental or dismissive of his fears, jeopardizing further communication with physician and staff.
   (d) The patient's paranoia must be dealt with immediately as opposed to finding out what is causing the paranoia.
   (e) The patient's ring must be removed no matter what the symbolism in order for the X-ray to be taken.

   Attitudes/Assumptions: The patient

   (a) My cousin, a *santero*, informed me today that my neighbors, the Mercados, are jealous of the success of my family's bodega, and that Mr. Mercado has consulted with someone and purchased items at the *botanica* to bring bad luck to me so that I will not be able to work at my bodega.

(b) I made sure to check the road both ways and didn't see anyone; therefore it must be the curse that has harmed me.

(c) I know that the doctor does not believe me, and I have witnessed the interaction between him and the nurse. The doctor's lack of knowledge about *Santería* is evident.

2. How can the physician gain more information about Puerto Rican cultural belief systems?

Gaps in Provider Knowledge

(a) Lack of knowledge of health beliefs/customs: Religious practices are an extremely significant component of the Latino cultural system [1]. Like members of many faith groups globally, some Latinos attribute health problems to supernatural causes or interpersonal conflicts and seek the guidance of spiritual healers within their own culture [2]. *Santería*, literally "worship of the Saints," is an Afro-Caribbean belief system that is a hybrid of the Yoruba religion brought by slaves from the area of Africa that is now Nigeria and the Catholic faith brought to the Caribbean by Spanish colonialists. The religion of enslaved peoples was illegal in many parts of the colonized New World, but the Yoruba faith, which includes a belief in a supreme creator and many spirits, or *orishas*, was readily adapted to the Catholic belief in God and the Saints. *Santería* embraces harmony with nature, homeopathic healing, worship of the Saints, divination of the future, and the interaction between the living and the dead. This interaction is viewed as a form of ancestor worship, and is one of the persistent cultural practices that continue to infuse an African world view into the larger Puerto Rican community [3, 4].

(b) *Santería* focuses on bringing good to the individual. Specific rituals and *orniero* (herbal medicines) are used for the healing of physical, mental, and emotional illness. In almost all modern Afro-Caribbean societies, these are used as an adjunct to Western medicine. *Santeros* are often consulted by patients after they have seen their physicians, and if consulted first, it is not uncommon for *santeros* to refer patients to doctors' offices, emergency departments, and mental health clinics while continuing to pray for and minister to their patients. Prayer and sacrifice are made to the Saints for the purpose of *ashe* (the power to make things happen or to create), sometimes to fulfill the wishes of the petitioner for love, good health, or good luck, and sometimes for protection of the petitioner or his loved ones. Interaction between the living and the dead is not only a comfort and a part of the grieving process for the living; it sustains memory and cultural continuity. This was exceedingly important to the enslaved and remains important today. *Palo mayombe,* or the practice of black magic according to traditions that originate in the Congo, also came to the New World with the slaves. This practice is disdained by many *santeros*. Its practitioners are called *mayomberos,* or more colloquially, *brujos*, or witches. Although not all Puerto Ricans use the terminology of *brujería* (witchcraft), some do believe that certain individuals have the power to cause negative effects through magical practices [5]. The patient in this case presentation fears the power of el brujo, and believes that his bad luck (the motor vehicle collision) is a direct result of the curse that el brujo placed on him. It should be noted that some who practice this religion consider the term *Santería* to be derogatory since it is often perceived as including *palo mayombe*, and therefore prefer the names *La Regla de Ocha* (The Rule of the Orishas) or *La Religión Lucumí* (*Lucumí* is the Yoruba dialect used in the liturgy) [6].

(c) In the nineteenth century, European and white American culture was influenced by the writings of Franz Mesmer and Allan Kardac (the pen name of Hippolyte Leon Rivail), and Spiritism, communication with the dead through the use of mediums during séances, became popular. The worldwide spiritist movement affected *Santería*, and séances and possession by spirits became a part of some Afro-Caribbean rituals. For those not involved in *Santería*, the words *espiritista* (spiritist) and *santero* are often used interchangeably, but they are not the same thing. Although not all Puerto Ricans may participate in *Santería* or *espiritismo*, the cultural constructs are very much embedded in their collective memory [4].

(d) Lack of knowledge of community: Learn/understand (from the nurse possibly) the concepts inherent in Afro-Caribbean religious culture and how removing the ring would negatively affect the disposition of the patient. Ask the patient to explain his fear and find other ways to overcome having the ring on his finger (for example, move it to another finger or the other hand, or put it on a chain around his neck).

(e) Simply asking the patient may result in knowledge about this cultural issue that impacts medical care. Validating the patient's beliefs may lead the physician toward techniques likely to result in cooperation of the patient. Additionally, the nurse appears to know something about *Santería*. Staff members, family members, and friends of the patient and translators may have knowledge of this cultural entity.

3. What are the medical priorities and treatment plan for this patient?

Beyond airway, breathing, and circulation, the patient needs to be assessed for head injury, intoxication, and mental status. He needs to have his laceration repaired and underlying foreign body or orthopedic injury ruled out.

After the primary and secondary survey, the doctor concludes that the patient's injuries consist of a laceration on his left hand and possibly a closed head injury. He walks out to the nurses' station to write his assessment and plan.

ED physician: "Well, we will x-ray his left hand for foreign body. He needs a tetanus shot. He will also need a urine drug screen and some electrolytes. I will repair his laceration after his head CT (Computed Tomography scan)." He pauses. "It's a bit unusual. I don't see significant evidence of head trauma, but he is so paranoid and incoherent. Either he hit his head or he took something.”

Nurse: “He does seem a bit frazzled about this whole accident, but I don’t think he is incoherent. He believes he has been placed under a spell which caused his accident.”

ED physician: “What makes you think that?”

Nurse: “My husband’s friend Ramon is a ‘Santero’. It is a religion or a belief system where if you wrong someone or if they have ill will towards you, they can put a spell on you and cause something bad to happen to you.”

ED physician: “Oh. Well, I saw he wears a rosary around his neck and I presumed he was a good Catholic boy like me.”

Nurse: “Well, he may identify with that belief system also.”

ED physician: “Really? But what about the dead people he sees? He seems to be hallucinating about that, don’t you think? Maybe this guy’s problem is organic.”

Nurse: “Maybe, but many Santeros see dead people. I just know that Ramon wears that same ring on his left ring finger that Mr. Cruz did not want me to take off and put with the rest of his belongings.”

ED physician: “Yes, that reminds me, I have to get that thing off before he goes to x-ray. What is that? Some kind of Indian with ruby eyes?”

Nurse (smiling): “Yes. And good luck trying to get him to take it off.”

4. Should the physician try to take off the patient’s ring? What could happen if it is forcibly removed?

   If indicated (swelling, potential vascular compromise, etc.), the physician can ask the patient to remove the ring. If he refuses and it is imperative that it be removed, using information gained as above, the physician might be able to come up with a solution acceptable to the patient, such as on another finger or on a chain. The physician needs to understand that the ring offers spiritual protection. If it is removed, the patient may suffer a poor outcome despite “appropriate medical care.”

5. How can the physician gain compliance with his treatment and aftercare plans?

   The physician should ask the patient what he believes he can do to “get better” after having a spell put on him. As long as no harm can be done by the cure, it too should be incorporated into the treatment plan. The physician must fully understand what that entails before endorsing it. In many hospitals, the physician can work with the *santeros* to insure the patient’s positive outcome.

6. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

   Professional Values: Physician should practice virtues such as understanding, compassion, and open-mindedness.

   Medical Knowledge: Do not assume that there is a medical etiology for the patient's anxiety. What the doctor perceives as paranoia and confusion may be culturally syntonic responses.

   Patient-Centered Communication: After explaining the medical necessity for the ring to be removed from the left hand, ask respectfully for the patient to remove ring to the other hand or to a neck chain until the X-ray has been taken. Respect patient's autonomy despite lack of physician understanding.

   Accountability: Provides sensitive, ethical, accountable care.

Case Outcome

Diagnosis: Laceration on left hand
Disposition: Home

After an appropriate history is obtained utilizing the principles above, the laceration is repaired and the patient is given analgesia. A discussion with the doctor allows the patient to recognize his good intentions and allows the doctor to comprehend the importance of the ring within the patient's cultural construct. The patient is given time to talk with the doctor about issues related to *Santería* and its role in patient management or outcome. The patient leaves satisfied that the doctor is indeed on his side. Indications for return to the ED are explained to the patient. He is assured that his physicians will work with him and his *santero* if he has concerns about wound healing or the resolution of his symptoms.

References

1. Cruz S. Religion: recent publications on religion among Puerto Ricans and in the Caribbean. Cent J. 2006;18(1):276–85.
2. Altarriba J, Bauer LM. Counseling the Hispanic client: Cuban Americans, Mexican Americans, and Puerto Ricans. J Couns Dev. 1998;76(4):389–96.
3. Moreno VM. Espiritismo in the Puerto Rican community: a new world recreation with the elements of Kongo ancestor worship. J Black Stud. 1999;29(3):325–53.
4. Romberg R. Whose spirits are they? The political economy of syncretism and authenticity. J Folklore Res. 1998;35(1):69–82.
5. Jacobson Jr GJ. "Espiritus? No. Pero la maldad existe": supernaturalism, religious change, and the problem of evil in Puerto Rican folk religion. Ethos. 2003;31(3):434–67.
6. Perez y Mena AI. Cuban Santería, Haitian Vodun, Puerto Rican Spiritualism: a multiculturalist inquiry into syncretism. J Sci Study Relig. 1998;37(1):15–27.

Chapter 31
Case 13: Islamic Patient

Tareq A. Al-Salamah and Lisa Moreno-Walton

Case Scenario

A 25-year-old female of Middle Eastern origin arrived at the emergency department (ED) accompanied by her father and her sister. She appeared to be in moderate pain, with her hands pressed to her right lower quadrant (RLQ). The patient looked slightly anxious when the male resident walked into the room. During the interview, her father seemed to answer most of the questions for her. When her father and sister were asked politely to step out of the room, her father became agitated, but stepped out. The patient became more anxious. When the resident began to examine her, she pushed his hand away and requested to be examined by a female physician.

Review of Symptoms

The patient complained of sharp RLQ pain which first started that morning. Pain had worsened throughout the day. She had two episodes of vomiting, though she denied having any fever, chills, diarrhea, urinary symptoms, vaginal bleeding, or discharge. Her last menstrual period was 1 week ago.

T.A. Al-Salamah, M.B.B.S., M.P.H. (✉)
Department of Emergency Medicine, University of Maryland Medical Center,
Baltimore, MD, USA

King Saud University, Riyadh, Saudi Arabia
e-mail: Tareq.Salamah@gmail.com

L. Moreno-Walton, M.D., M.S., M.S.C.R.
Professor of Emergency Medicine, Director of Research, Director of Diversity,
Department of Medicine, Section of Emergency Medicine, Louisiana State University Health
Sciences Center – New Orleans, New Orleans, LA, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_31

Past Medical History

She had a urinary tract infection over a year ago and a tonsillectomy as a child. She has no known drug allergies and takes ibuprofen as needed.

Family History

Her father has hypertension. No known diabetes, cancer, or other diseases.

Social History

Patient has never been married. She denies smoking, drinking, or drug use, although she looked uncomfortable answering those questions. Even though her family members were not present in the room during this interview, her discomfort became overtly apparent when asked if she was sexually active. She forcefully denied it. She works in her father's convenience store. She lives at home with her parents and younger siblings.

Physical Exam

Vital signs: Temp: 98.6 °F, pulse: 104, respirations: 18, O_2 Sat 98 % on room air.

General: She looks anxious, uncomfortable in bed and in mild-moderate pain.

Cardiovascular: Tachycardic with a regular rhythm, no murmurs, rubs, or gallops.

Respiratory: Equal breath sounds bilaterally, no wheezes, rales, or rhonchi.

ENT: Head atraumatic, pink mucous membranes, nose clear, throat clear, no erythema, uvula midline.

At this point, per the patient's request, a female resident continued the physical exam.

Abdomen: Soft, non-distended, RLQ tenderness, no rebound, normoactive bowel sounds.

Extremities: Well perfused. Capillary refill <2 s. No clubbing.

Skin: Warm, dry, clean, intact. No cyanosis.

Neuro: Speech is clear and coherent, grossly intact.

Pelvic: Patient refused exam offered by female resident.

Laboratory Results

Complete blood count (CBC): Within normal range except for a white blood cell count (WBC) of 12,500.
Comprehensive metabolic panel (CMP): Within normal range.
Urinalysis: Within normal range.
Urine human chorionic gonadotropin (HCG): Negative.

The patient was referred for pelvic ultrasound. She refused a transvaginal examination, but permitted an abdominal ultrasound (US). This study demonstrated a right ovarian cyst with some free pelvic fluid. A computerized tomography (CT) scan was then ordered, which demonstrated a normal appendix and no evidence of ovarian torsion.

Questions for Discussion

1. Why did the father answer for his daughter and then become agitated when asked to step out of the room? Why was this 25-year-old woman uncomfortable and anxious?

   Attitudes/assumptions: The physician

   (a) This patient is 25 years old, of sound mind and proficient in English. She is capable of answering for herself during a medical exam.
   (b) Asking about the social history is necessary to obtain pertinent health information in order to reach an accurate diagnosis. As an adult, she shouldn't have any problems answering questions regarding sexual activity.
   (c) The resident physician knows what tests are indicated to ensure an appropriate diagnosis. In his opinion, she is not a young girl, and should have no reason to refuse a pelvic exam or transvaginal US.

   Attitudes/assumptions: The father

   (a) I will speak for my daughter. If I can answer the questions, there is no need for this male doctor to insist on addressing her.
   (b) I was not comfortable leaving my daughter; however I didn't want to cause any delay in treatment.
   (c) I need to know what's going on, so I can fully participate in her treatment.

   Attitudes/assumptions: The daughter

   (a) My father knows the details of how I feel; he can speak for me.
   (b) It is insulting to be asked such questions. It is especially offensive, insulting, and embarrassing to be asked about sexual activity. I am not married nor have I ever been.

   (c) I understand that I live in a different culture, but to be examined by a male doctor is outside of my comfort zone.
   (d) There are plenty of medical tests which can be used to determine what is wrong with me without invading my body.

   Gaps in Provider Knowledge

   (a) Lack of understanding the role of patriarch in a Middle Eastern family, regardless of the patient's age, especially with regard to a daughter.
   (b) Lack of knowledge of the culture where discussion of sex is involved, particularly premarital sex.
   (c) Lack of knowledge of the importance of virginity in religion and family honor, and anything that may be thought to endanger it.
   (d) Lack of knowledge of the importance of modesty and protection of females in the patient's culture and religion.

2. What actions could have been taken by the doctor to avoid/prevent this unfortunate outcome?

   Cross-Cultural Tools and Skills

   (a) Assume that the father is concerned about his daughter and is seeking more information to enable him to contribute to the treatment plan.
   (b) Assume that if you explain to him the best way to reach a diagnosis is to have a patient give the history in her own words, he would willingly allow this.
   (c) If available, ask if the patient and her family would be more comfortable with a female provider to care for her. If a female provider is not available, acknowledge your understanding of their preference and assure them that you will not do anything without giving a detailed explanation in advance. Inform them that you cannot ethically do anything without the patient's consent.
   (d) Acknowledge the role of the patriarch and family in the patient's care.

3. What medical issues concern you about this case?

   (a) The resident should understand and acknowledge the differences in culture and beliefs and tailor his approach to meet the patient's needs and preferences.
   (b) The resident should collaborate with the family on a treatment plan. It should be assumed that they are with her because they're concerned about her.
   (c) If the patient consents to the sharing of her protected health information with her family members, the resident should discuss his concern for appendicitis and ovarian torsion with the family and ensure that they understand the need to exclude organ-threatening conditions.

4. What knowledge is required to bridge cultural disparities?

   With increasing social integration, distinct cultures not only come into contact with one another, but they also often collide. One of the ways to address healthcare disparities among cultural and ethnic groups is to incorporate cross-cultural skills [1].

The Muslim culture is a large, diverse culture within itself, but there are general cultural competencies that can be applied. For example, Muslim women highly value modesty and would feel more comfortable seeking medical attention if the health providers understood this [2]. Although it is commonplace for women in Western culture to have gender-defining body parts examined by a male, this is regarded as a violation by Muslim females, often generating personal humiliation, anger, and resentment [2]. In order to encourage Muslim women to seek an adequate level of healthcare and to adhere to standards for screening exams, it would be expeditious to inform them to ask if it is possible to be examined by a female physician. This would eliminate possible delay and discomfort in treatment [2]. Discussion of sexual activity, most especially premarital sex, is alien to Muslim families. A Muslim woman is assumed to be a virgin until marriage, so the question of sexual activity for an unmarried woman is offensive. Virginity is prized and protected. An invasive exam such as a pelvic exam or a transvaginal ultrasound would be viewed as a violation and a possible endangerment to virginity. A physician's understanding of this reluctance would help him/her to judge how to prioritize methods of investigation and treatment.

Muslim family structure is commonly patriarchal. The father is often the spokesperson for the entire family, and is looked to for guidance and wisdom [3]. It is not an uncommon expectation that health updates be first shared with the family spokesperson, no matter the age or gender of the patient [3].

Ultimately, physicians desire that examination and treatment of their patients will promote the patients' participation in their own health care and improve compliance with treatment plans, while patients desire to be treated with understanding and respect. Bridging cultural gaps through cultural competencies instills the fundamental trust required to achieve optimal results for both.

5. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

Patient safety: Appropriately uses system resources, such as including colleagues (nurses or physicians), to improve patient care [4].

Professional values: Demonstrates behavior that conveys caring, genuine interest, and tolerance when interacting with a diverse population of patients and families [4]. He demonstrates an understanding of the importance of respect and sensitivity, and exhibits these attitudes consistently with diverse populations [4]. The provider recognizes how personal beliefs and values impact medical care, and develops alternate care plans when patients' personal decisions or beliefs preclude the use of commonly accepted practices [4].

Patient-centered communication: Listens effectively to patients and their families, manages their expectations, and uses communication methods that minimize the potential for stress, conflict, and misunderstanding [4]. The provider uses flexible communication strategies and adjusts them based on the clinical situation to resolve specific ED challenges, such as high-risk refusal-of-care patients [4].

Case Outcome

Diagnosis: Right ovarian cyst
Disposition: Home with GYN to follow up

References

1. Padela A. Can you take care of my mother? Reflections on cultural competency and clinical accommodation. Acad Emerg Med. 2007;14(3):275–7.
2. Hasnain M, Connell KJ, Menon U, Tranmer PA. Patient-centered care for Muslim women: provider and patient perspectives. J Women's Health. 2011;20(1):73–83.
3. Aboul-Enein BH, Aboul-Enein FH. The cultural gap delivering health care services to Arab American populations in the United States. J Cult Divers. 2010;17(1):20–3.
4. The Emergency Medicine Milestone Project [Internet]. Chicago: The Accreditation Council for Graduate Medical Education and the American Board for Emergency Medicine; c 2012 [cited 5 Aug 2014]. Available from: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/EmergencyMedicineMilestones.pdf.

Chapter 32
Case 14: Pediatric Pain

Kevin Ferguson and Alex Diaz

Case Scenario

A healthy 13-year-old Hispanic male is brought in by his mother to a small community ED for evaluation of right wrist pain occurring the next day following a league football game. The patient reports that the pain started after tackling someone during the game. The patient stated having 7/10 pain then but currently it is a 4/10. The patient described landing on an outstretched right hand after tackling the opposing player. The patient had no head trauma and no loss of consciousness. On physical exam the physician notes tenderness and moderate edema over the right wrist with associated pain during active range of motion. No snuff box tenderness or changes in sensation. Radial pulses were +2/4 and vitals were stable. The resident gave the patient 30 mg Toradol IM for pain relief while they waited for X-ray results.

Complete right hand X-rays were ordered and it was found that the patient had a right distal radial fracture with dorsal displacement. The resident did a closed reduction of the wrist, causing the patient's mother to become quite upset. She asked him why he did not give her son any pain medication and the resident said that he had already gave him 30 mg of Toradol.

K. Ferguson, M.D.
Emergency Department, Kaweah Delta Health Center, Visalia, CA, USA

A. Diaz, D.O. (✉)
College of Osteopathic Medicine of the Pacific, Western University of Health Sciences,
Pomona, CA, USA
e-mail: ardiaz@westernu.edu

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_32

Review of Symptoms

Per patient: Denies any chest pain, shortness of breath, headache, dizziness, or blurred vision. All other systems are reported negative as well.

Past Medical History

No significant past medical history. C-section birth at 36 weeks due to the mother developing significant preeclampsia. No significant sequelae. Up-to-date on immunizations.

Family History

The mother and father both have hypertension. The mother does not think that cancer, diabetes, or any other diseases present in their family.

Social History

The patient lives at home with his mom, dad, and three younger sisters. The mother and father both smoke at home but outdoors only. The patient denies alcohol, tobacco, or any other drug use.

Physical Exam

Vital signs: Temp: 99.0 °F, pulse: 105, BP: 110/70, respirations: 17, O_2 Sat 99 % on room air

General: Well-developed, non-obese child sitting in mild discomfort holding his right wrist

ENT: Clear tympanic membranes bilaterally, nose clear, throat clear, no erythema, uvula midline

Neck: Supple, non-tender, no adenopathy, no thyromegaly

Cardiovascular: No murmurs, gallops, or rubs. Mild increase in rate. Capillary refill less than 2 s

Lungs: Clear to auscultation bilaterally with no wheezes, rales, or rhonchi

Abdomen: Soft, non-tender, nondistended with normal bowel sounds in all four quadrants

Extremities: Tenderness and moderate edema over the right wrist. No snuff box tenderness. Radial pulses were 2+/4

Skin: No rashes or lesions

Neuro: Grossly intact, moves all four extremities, brachioradialis reflexes 2+/4, no decrease in gross sensation

Questions for Discussion

1. What other factors could affect a physician's decision to give a patient an opioid narcotic vs. a nonsteroidal anti-inflammatory (NSAID) or acetaminophen for pain relief?
   (a) Respiratory depression in a pediatric patient
   (b) Previous exposure to narcotics
   (c) NSAIDs will help with any inflammation more than a narcotic
   (d) The patient does not seem to be in much pain, so a narcotic is unnecessary
   (e) Another shot of IM medication may be just as painful as a quick reduction
   (f) The physician may have forgotten to offer more pain medication/reassess pain level after the initial dosage
2. How could have the resident prevented the mother's reaction?

   Attitudes/Assumptions: The physician

   (a) Believing the patient doesn't want or need to know the details of the procedure, including the associated pain.
   (b) Assuming the Toradol given is adequate analgesia for fracture reduction and not reassessing the degree of pain relief. Explaining the importance of the procedure and telling the mother about the expectations.
   (c) Assuming procedural sedation is not needed for the reduction to control pain.
   (d) The mother will not know the difference in pain medications and will not understand an explanation about them.

   Attitudes/Assumptions: The mother

   (a) This doctor does not care about my child. He did not even explain what is going to happen to my child's arm.
   (b) Since we are Hispanic we are getting a poorer quality of care.
   (c) I need to protect my child from even more pain and deformity.

   Gaps in Provider Knowledge:

   (a) Lack of knowledge of health beliefs/customs by provider including home remedies and homeopathic medicine.

(b) Lack of knowledge regarding this specific community: Use of some resources in certain communities can cause unjust scrutiny among peers and cause hatred or violence.
(c) Lack of knowledge of disparities/discrimination: Hispanic people have been subject to discrimination in this country. They view medical care and decisions as a family decision and may be fearful to seek help. There is concern over racial discrimination, immigration status, payer status, and language barriers.

3. What medical/ethical issues concern you about this case ?

(a) Why didn't the mother bring in the child the same day as the accident?
(b) Why didn't the physician reassess the patient before the procedure?
(c) The physician should develop a more thorough treatment plan with the mother.

4. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

Patient safety: Participates in performance improvement to optimize patient safety [1]

(a) Improved through an institutional process improvement plan
    - Early recognition of wrist deformity
    - Orders correct imaging for complete diagnosis
    - Case consultation with attending physician

Systems-based management: Physician recommends strategies by which patients' access to care can be improved [1, 2].

(a) Earlier access to care
(b) Supplemental insurance coverage
(c) Counseling on importance of primary care physicians

Professional values: Demonstrates compassion, integrity, and respect for others as well as adherence to the ethical principles relevant to the practice of medicine [1]. There is still perceived discrimination for black patients as compared to white patients and less so between Hispanics and white patients, but nevertheless this should be at least made aware to providers [3].

Patient-centered communication: This is the opportunity to communicate both the concerns and complications involved with a particular situation for patients and their families [1]. In this case, the physician did not fully indulge in the complications of the procedure (pain); therefore an unexpected complication occurred. Better communication would have prevented this. The mother and physician could have developed a more cohesive treatment plan that they both could agree on. Minority patients are thought to get less analgesia and longer wait times than white patients, so by better communicating parents will not think this is the reason as opposed to a more medically relevant cause [4].

Case Outcome

Diagnosis: Right Colles' fracture
Disposition: Home

After some talking and reassurance, the mother was able to be consoled. A cast was put on the arm and told to take over-the-counter ibuprofen or acetaminophen for the pain. Follow-up instructions were given to see the pediatrician during the next week or to return to the emergency department if any new symptoms arose.

References

1. The Emergency Medicine Milestone Project [Internet]. Chicago: The Accreditation Council for Graduate Medical Education and the American Board for Emergency Medicine; c2012 [cited 5 Aug 2014]. Available from: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/EmergencyMedicineMilestones.pdf.
2. Park C, Lee M, Epstein A. Variation in emergency department wait times for children by race/ethnicity and payment source. Health Serv Res. 2009;44(6):2022–39.
3. Hausmann L, Jeong K, Bost J, Ibrahim S. Perceived discrimination in health care and health status in a racially diverse sample. Med Care [serial on the Internet]. 2008 [cited 2014 Oct 24];46(9):905–14. Available from: CINAHL.
4. Tsai CL, Sullivan AF, Gordon JA, Kaushal R, Magid DJ, Blumenthal D, et al. Racial/ethnic differences in emergency care for joint dislocation in 53 US EDs. Am J Emerg Med. 2012;30(9):1970–80. doi:10.1016/j.ajem.2012.04.023.

Index

A
AAMC. *See* Association of American Medical Colleges (AAMC)
ACA. *See* Affordable Care Act (ACA)
Academic Emergency Medicine, 147
Access to care, 4, 6
Accreditation Council for Graduate Medical Education (ACGME), 24, 31, 36, 40, 41, 50, 206, 211, 217, 223, 227, 232, 238, 245, 250, 257, 262, 269, 280
ACGME. *See* Accreditation Council for Graduate Medicine Education (ACGME)
ACPE. *See* Association of Clinical Pastoral Education (ACPE)
Acquired Immune Deficiency Syndrome (AIDS), 12, 102, 103, 131, 138, 164
ACS. *See* Acute coronary syndrome (ACS)
Acute coronary syndrome (ACS), 142–143
Acute myocardial infarction (AMI), 13, 143
Acute myocardial infarcts/cerebrovascular, 124
Ad hoc *vs*. professional interpreters
  cost-prohibitive, 59
  doctors, 58
  errors types, 58
  family members, 58
  medical and non-medical personnel, 58
  medical problems, 59
  miscommunication, 58
  non-English-speaking patients, 58
  patient encounters, 58
  pediatric emergency setting, 58
  physicians and patients, 59
Affordable Care Act (ACA), 4, 115, 118, 137, 155, 176
African-American infant
  children in emergency department, 171
  febrile, 203
  and Hispanic children, 173
  illnesses, 204
  multivariate analysis, 173
  and non-private insurance patients, 174
  physical examination, 204
  symptoms, 203
  tympanic membrane, 203
Agency for Healthcare Research and Quality (AHRQ), 32
AHRQ. *See* Agency for Healthcare Research and Quality (AHRQ)
Alagappan, K., 55–65
Al-Salamah, T.A., 271–276
Altshuler, L., 44
American health care settings, 24
American Indian
  attitudes, 261
  cross-cultural tools and skills, 261
  Emergency Medicine Milestones, 262
  family history, 260
  Indian Health Services clinic, 259
  lobe pneumonia and sepsis, 262
  past medical history, 260
  patient autonomy, 261
  patient safety, 262
  patient-centered communication, 262
  physical exam, 260–261
  physician, 261
  provider knowledge, 261
  social history, 260
  systems-based management, 260, 262
American Medical Association (AMA), 71, 109

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2

American Sign Language (ASL), 62, 63
Analgesia, 14, 145, 146, 169, 175, 217, 233
Annals of Internal Medicine, 17
Antiretroviral treatment (ART), 106
Arbelaez, C., 207–211
ART. *See* Antiretroviral treatment (ART)
Asian American Pacific Islander (AAPI), 14
ASL. *See* American Sign Language (ASL)
Association of American Medical Colleges (AAMC), 6, 14, 31, 40
Association of Clinical Pastoral Education (ACPE), 85, 86
Asthma, 14, 144–145, 236
Attitudes, 261
Azari, R., 74

B
Baker, D.W., 57, 58
Banaji, M.R., 7
Beers, M.H., 163
Bentley, S., 55–65
Bernstein, J., 142
Bertakis, K.D., 74
Best, M.M., 83–99
Bilal, S., 55–65
Bilevel positive airway pressure (BiPAP), 262
Bilingual/multilingual physicians, 59, 60
BiPAP. *See* Bilevel positive airway pressure (BiPAP)
Blindspot: Hidden Biases of Good People, 7
Blood urea nitrogen (BUN), 259
Brach, C., 26
Brainin-Rodriquez, J.E., 44
Bruising, 219, 222
Brummer, S., 11–18
Buddhism
  Asian countries, 87
  dying process, 91
  enlightenment, 90
  factors, 90
  interwoven causes and conditions, 90
  salvation, 90
  therapeutic dynamic, 90
  traditional field, 90
  visual representations, 90
Bullying, 244
BUN. *See* Blood urea nitrogen (BUN)
Burgess, D.J., 141

C
California educational system, 15
Cambodian refugee
  coining, 207
  depression, 208, 209
  emergency, 207
  healer, 207
  labor camp, 208
  physician, 207–209
  posttraumatic stress, 209
  power, 207
  traditional, 207
Campbell, A., 44
Canopy Medical Translator, 65
Cardiovascular care, 13
Carpenter, D.-A.L., 45
Cerebrovascular accident, 124, 144
Chan, Y.-F.Y., 55–65
Chaplain care provider, 85
Chiu, D., 60
Chowa, E.P., 207–211
Christianity, 84, 87, 91, 92, 98, 182
Chun, M.B., 27, 44
Cohen, J.J., 147
Coin rubbing, 229–233
Commonwealth Fund study, 71
Communication
  American Medical Association, 71
  cross-cultural communication, 46–49, 215
  factor, 71
  LGB patients, 109
  nonverbal, 60–61
  quality of health care and health care, 24
  patient-centered communication, 24, 27, 154, 211
  patient–provider communication, 26, 29, 31, 147, 180
  physician, 5
  skills, 33
Cone, D.C., 138
Continuous quality improvement (CQI), 163
Cooper, L.A., 71, 75
CORD. *See* Council of Emergency Medicine Residency Directors (CORD)
Council of Emergency Medicine Residency Directors (CORD), 34
CQI. *See* Continuous quality improvement (CQI)
Crampton, P., 44
Cruz, S., 263, 268

Cultural awareness
  cultural blindness, 180
  definition, 179
  EDs, 180
  patients and health care providers, 179
  religion-based discrimination, 180
Cultural competence, 6, 18, 23–25, 55
  education, 41, 42
  program, 27
  techniques, 26
  training, 27
Cultural competent faculty
  academic-community partnership, 31
  clinical practice, 35
  clinical training, 34
  clinician development, 35
  community-based preceptors, 34
  cross-cultural approach, 33
  cultural diversity, 34, 35
  cultural diversity education, 36
  cultural sensitivity/awareness approach, 32
  definition, 32
  educational and governmental institutions, 36, 37
  educational interventions, 32
  EM faculty, 32
  medical education, 35
  multicenter case–control study, 35
  multicultural
    categorical approach, 33
    training, 34
  need of teaching, 33
  policies, 35
  SAEM, 34
  US population, 31
Cultural Sensitivity/Awareness approach, 27
Cultural training programs, 28
Culturally and Linguistically Appropriate Services (CLAS), 25
Culturally sensitive care
  assessment methods, 49–50
  cardiac revascularization, 39
  competence, 40
  cross-cultural communication and negotiation models, 46–49
  culturally competent health care, 40
  disparities, 39
  diversity, US population, 40
  emergency medicine, 41, 50
  IOM, 39
  lack of awareness, 40
  medical education system, 40
  Office of Minority Health, 40
  portfolio model
    immersion model, 46
    PPD, 45
  principles, 41
  professional barriers, 42
  racial/ethnic health care disparities, 40
  representative educational models
    community model, 43
    cultural competency, 43–45
    culture and diversity course model, 43–45
    PubMed search engine, 43
  surgery and emergency medicine, 40
Culture
  Commonwealth Fund study, 71
  components, 70
  factors, 70
  medical literature, 71

D
Davis, H.H., 213–224
Death-disclosure, 225, 226
Death in Islamic community, 184, 185
Department of Health and Human Services (HHS), 115
Diabetes, 12, 13
Diagnostic and Statistical Manual of Mental Disorders (DSM-V), 114, 115
Diaz, A.R., 169–177277–281
Diet, Islamic law, 183–184
Disorder of sexual differentiation (DSD), 114
Disparities
  cultural competencies, 170
  emergency department, 170
  health care, 170
  in patient access to care, 171–172
  in patient evaluation, 172–174
  in patient therapy, 174–175
  pediatric patient population, 169
  research
    approaches, 190
    biomedical research workforce, 190
    community, 189
    social, economic and demographic characteristics, 189
    workforce diversity, 190
  SCHIP, 171
DNI. *See* Do-not-intubate order (DNI)
DNR. *See* Do not resuscitate (DNR)
Do not resuscitate (DNR), 84

Do-not-intubate order (DNI), 84
DSD. *See* Disorder of sexual differentiation (DSD)
DSM-V. *See Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*
Dyspnea, 235

E
Ecchymotic lesions, 230
EDs. *See* Emergency department (ED)
Education
  chaplain care provider, 85
  competency training, 75
  professional development, 75
  script, 75
  spiritual care provider, 85
Elderly, vulnerable populations
  developing and developed countries, 161
  healthcare providers and systems, 161
  quality care, 162
Emergency department (ED), 26, 132, 156, 203, 219, 225, 235
  CQI, 163
  disparities in health care, 170
  geriatric patients, 162
  healthcare providers, 162
  insurance status and socioeconomic factors, 170
  low-income families, 170
  minority patients, 174
  physical environment, 163
  polypharmacy, 163
  profound loss of autonomy, 162
  race/ethnicity, 171, 175
  screening criteria, 163
Emergency medical services (EMS), 121, 235
Emergency medicine (EM)
  context, medical practice, 32
  and FDP, 32
  and GME, 36
Emergency Medicine Patients Access to Healthcare Study (EMPATH), 140
Emergency physicians (EP), 56
Emerging technology, 64–65
EMPATH. *See* Emergency Medicine Patients Access to Healthcare Study (EMPATH)
EMS. *See* Emergency medical services (EMS)
End-stage renal disease (ESRD), 13
EP. *See* Emergency physicians (EP)
Esfandiari, A., 44
Ethnocentrism, 51
Ezenkwele , U.A., 179–186

F
Faculty development program (FDP)
  community-based preceptors, 34
  cultural diversity, 32
  EM faculty, 32
Fair, M., 3–7
Family in Muslim society, 184
Family practice (FP), 33
Fasting, 183
Fazel, S., 152
FCHDR. *See* Federal Collaboration on Health Disparities Research (FCHDR)
Federal Collaboration on Health Disparities Research (FCHDR), 191
Federal Hate Crimes Statistics Act, 244
Ferguson, K.L., 169–177, 277–281
Fever, 229
Fine, A.G., 152
Flores, G., 58
FP. *See* Family practice (FP)
Fraser, I., 26

G
Gallagher, R.A., 57
Gates, G., 115
Gay community
  communication improvement, 250
  discharge supportive manner, 251
  Emergency Medicine Milestones, 250
  family history, 248
  lack knowledge of community, 249
  medical issues, 250
  painful rectal bleeding, 247
  past medical history, 248
  patient-centered communication, 251
  physical exam, 248–249
  physician, 249
  professional values, 250
  sexual history, 250
  sexual practices, 250
  social history, 248
  symptoms, 248
Gender dysphoria, 114, 115
Gender in Islamic community, 185–186
General medical care, 142
Gertner, E.J., 27
Ginther, D.K., 195
Gisondi, M.A., 247–251

GME. *See* Graduate medical education (GME)
Godkin, M., 44
God's will concept, 184
Gold-Gomez, 60
Goleman, M.J., 44
Gordon, J., 44
Graduate medical education (GME), 33, 35
Green, A.R., 72
Greenberg, G.A., 151
Greysen, S.R., 40, 155

H
Haley, L.L. Jr., 137–148
Hargrave, J., 55–65
Hatem, C.J., 44
Health care disparities, 3, 4, 7, 25, 26
  and barriers
    distress level, 116
    gender identity, 116
    mental health effects, 116
    Minority stress, 116
    substance abuse, 116
    suicide attempt, 116
    tobacco use, 116
Health care system
  culturally insensitive systems, 170
  disparities, 170
  emergency departments, 170
  professionals, 174
  racial/ethnic populations, 169
Health equity, 4
  American Indians, 193
  description, 193
  research community, 189
  and research workforce, 190
Health and health care disparities
  bias and stereotyping, 191
  definition, 191–194
  FCHDR, 191
  health equity, 190
  Muslim Americans
    health care providers, 181
    immigrants, 181
    religio-culturally sensitive health care, 181
  populations in research studies, 194
  research workforce, 194–196
Health Insurance Portability and Accountability Act (HIPAA), 63
Health outcomes, 51
Health system interventions, 147
Heron, S.L., 11–18, 23–29, 137–148, 203–206
HHS. *See* Department of Health and Human Services (HHS)
Hibbs, J.R., 151
Hinduism, 97
HIPAA. *See* Health Insurance Portability and Accountability Act (HIPAA)
Hispanic
  and African American children, 171
  children rates, 171
  complicated appendicitis, 173
  ethnicity, 173
Hobgood, C., 39–51
Hochberg, M.S., 44
Holden, L., 189–197
Homeless people. *See* Vulnerable populations
Howe, E.C., 155

I
ICU. *See* Intensive care unit (ICU)
Incarcerated persons. *See* Vulnerable populations
In-sha-allah (God willing), 184
Institute of Medicine (IOM), 3, 12, 24, 39, 55, 137, 138
  ED care, 142–146
  education, 147
  evidence, 138
  health system interventions, 147
  health-related beliefs, 141
  legal, regulatory and policy, 146
  lower socioeconomic factors, 140–141
  racial and ethnic disparities, 139–140
  recommendations, 146–147
  report, 70
  workforce environment and diversity, 141–142
Intensive care unit (ICU), 262
Interpreter services
  ad hoc *vs*. professional, 58–59
  bilingual/multilingual ED staff, 59–60
  cultural competence, 55
  effective communication, 56
  emergency patient, 56
  emerging technology, 64–65
  EP, 56
  financial impact, 64
  hearing-impaired patient
    ASL, 63
    deaf, 62
    face-to-face interaction, 63
    HIPAA, 63
    Language Video Interpreter, 63
    lip-reading, 62, 63

Interpreter services (*cont.*)
        medical setting, 62
        and sign language, 62
        writing, communication, 63
    language barriers, 56–58
    methods, 56
    miscommunication, 55
    non-English-speaking patients and demographics, 56–57
    nonverbal communication, 60–61
    patient care, 56
    patient follow-up and compliance, 63–64
    preventative health services, 56–57
    telephone-based interpreter systems, 61–62
IOM. *See* Institute of Medicine (IOM)
Islam, 94, 95
    and Islamic religions
        community religious leader, Imam/Shaykh, 182
        life and judgment after death, 182
        Shiite minority, 182
        Sunnah, 182
        Sunnis, 182
Islamic patient
    cross-cultural tools and skills, 274
    cultural disparities, 274
    diagnosis, 276
    family history, 272
    father, 273
    lack of understanding, 274
    medical issues, 274
    Muslim family structure, 275
    past medical history, 272
    patient-centered communication, 275
    physical exam, 272
    physician, 273
    professional values, 275
    RLQ, 271
    social history, 272
    symptoms, 271

J
James, T.L., 69–77
Jehovah's Witness, 84, 87
Jones, A.W., 23–29
Judaism
    forbids autopsies, 97
    laws, 95
    natural hindrance *vs.* hastening death, 96
    physical health and vigor, 96
    sexuality, 96

K
Kagawa-Singer, M., 45
Kamaka, M.L., 44
Kazzi, 58
Kim, S.S., 71
Klein, J.H., 263–269
Koenig, H.G., 86
Krieger, P., 101–110
Kripilani, 40
Ku, B.S., 154
Kuo, D., 59

L
Landry, A., 60
Language of attentive patient care, 154
Language Video Interpreter, 63
Larkin, G.L., 122
LCME. *See* Liaison Committee on Medical Education (LCME)
Leflore, A., 39–51
Leman, P., 58
Leonard, M.M., 229–233
LEP. *See* Limited English proficiency (LEP)
Lesbian, gay and bisexual (LGB)
    advanced age
        illness/death, 108
        Physical disparities, 107
    health care disparities
        levels, 103
        risks, 103
        stigmatization, 103
    legal barriers, 104, 105
    medical disparities
        domestic violence, 105
        HIV, 106
        physical and mental health, 105
    minority stress model, 103
    mysterious disease, 102
    people of color
        hurdles, 108
        race/ethnicity, 108
    sexual attraction, 101
    sexual behavior, 101
    societal bias, 101
    terminology, homosexual/sexual preference, 102
    youth
        ages, 107
        heterosexuals, 107
        HIV transmissions, 107
        minority stress, 106
        risk, 106
        self-awareness, 106

Lesbian, gay, bisexual and transgender (LGBT), 113, 115
LGBT. *See* Lesbian, gay, bisexual and transgender (LGBT)
Li, S., 247–251
Liaison Committee on Medical Education (LCME), 24, 32, 40
Liebzeit, J., 247–251
Lillie-Blanton, M., 140
Limited English proficiency (LEP), 24, 56, 173, 193
Long term and primary healthcare
  abuse/early institutionalisation, 165
  coordinate nursing care, 164
  depression, 165
  description, 164
  human resources, 164
  parameters, 164
Lopez, B.L., 213–218
Lowe, R.A., 138, 141, 148
Lynne, H., 189–196

M
Mahadevan, S.V., 241–245
Mainville, D., 169–177
Managed care organizations (MCOs), 141
MARC. *See* Multicenter Airway Research Collaboration (MARC) study
Martin, J.M., 83–99
Martin, M.L., 11–18, 23–29, 31–37, 55–65, 83–99, 213–224, 229–233, 235–239, 263–269
Masson, N., 152
McCormick, R.A., 93
MCOs. *See* Managed care organizations (MCOs)
Medical emergency department, 124
Medical professionals
  ACGME, 24, 25
  CLAS, 25
  cultural competence, 25
  educational models, 26, 28
  health care providers and receivers, 23
  hospital system, 27
  miscommunication, 24
  racial and ethnic disparities, 25
Medical respite care, 155
Medical Subject Headings (MESH), 43
Mentoring, 36
Mentorship, 16, 18
MESH. *See* Medical Subject Headings (MESH)
Metastatic cancer, 225, 226
Meyer, I.H., 116
Minorities and non-English speakers, 137
Misdary, J.S., 169–177
Mishler, E.G., 154
Mobile computerized technology, 64, 65
Moll, J., 101–110
Mongolian Spots, 219–222, 224
Moreno-Walton, L., 23–29, 263–269, 271–276
Morrison, T.B., 56
Motor vehicle collisions (MVCs), 143
Multicenter Airway Research Collaboration (MARC) study, 144
Muslim American population
  cultural, educational and socioeconomic backgrounds, 181
  definition, 181
  self-reporting Muslim identity, 180–181
Musolino, G.M., 45
MVCs. *See* Motor vehicle collisions (MVCs)

N
National Medical Association (NMA), 12
Nelson, M., 57
Nganga, 235
Nicholson, S.T., 93
Nivet, M., 3–7
Nonsteroidal anti-inflammatory (NSAID), 279
Nonverbal communication
  body language, 60
  crossed legs/ankles signal, 61
  direct eye contact signals, 61
  facial emotions, 60
  genuine smiles, 61
  gesture clusters, 61
  interpreter and patient, 60
  medical interpretations, 61
  misunderstandings, 60
  multicultural awareness, 60
  open and relaxed hands, 61
NSAID. *See* Nonsteroidal anti-inflammatory (NSAID)
Nunez, 45

O
Objective structured clinical exam (OSCE), 50
OSCE. *See* Objective structured clinical exam (OSCE)
Oyewo, A.O., 229–233

P
Padela, A.I., 179–186
Page, S.E., 7
Pain control, 145–146
Palepu, A., 16
Palliative care, 226
Palliative and end of life care, geriatric patients, 165–166
Panunti, B., 113–119
Pastoral care, 85, 86
Pastoral conversation, 86
Patient-centered care
  clinical outcomes, 74
  cultural competence, 73
  health-care services, 74
  IOM, 73
Patient-centered communication, 251, 262
Patient centeredness, 69
Patient-physician partnership
  clinical experience, 69
  communication, 71
  culture, 70, 71
  dialogue, 76
  education, 75
  EM, 69
  factors, 69
  IOM report, 70
  patient-centered care, 73, 74
  systemic changes and accountability, 74
  TIC, 72, 73
  treatment plans, 76–77
  unconscious bias, 72
Patient therapy, 174–175
Pediatric pain
  disparities/discrimination, 280
  Emergency Medicine Milestones, 280
  family history, 278
  health beliefs/customs, 279
  institutional process improvement plan, 280
  lack of knowledge, 279
  medical/ethical issues, 280
  mother, 279
  NSAID, 279
  past medical history, 278
  patient-centered communication, 280
  patient safety, 280
  physical exam, 278–279
  physician, 279
  professional values, 280
  right Colles' fracture, 281
  social history, 278
  symptoms, 278
  systems-based management, 280
Pentecostal, 92
Personal and professional development (PPD), 45
PES. *See* Psychiatric emergency service (PES)
Philippines, 236
Physical disability
  accessibility, 133
  activities, 132
  acute illness/injury, 133
  behavioural disturbance, 134
  complex interaction, 131
  medical illness, 131, 133
  meticulous, 133
  multidisciplinary team, 133, 134
  non-communicable chronic diseases, 132
  quality care, 131, 132, 134
  risk factor, 132
  trauma, 131
  treatment, 134
  types, 131
  wheelchair accessible, 133
Pierce, A., 151–157
Plautz, C.U., 235–239
PPD. *See* Personal and professional development (PPD)
Prayer, Islamic worship, 182–183
Prendergast, H.M., 253–258
Prince, D., 57
Psychiatric emergency service (PES), 121
Psychiatric illness, 124
Psychiatric patient
  attitude, 123
  fresh blood, 121
  mental health, 122
  mental illness, 122, 124
  mental status, 121
  myocardial infarction, 121
  overuse and underuse errors, 122
  perfect storm, 124
  pitfalls variety, 122
  stigma, 122
  test, 124
Psychological shortcut, 25

Q
Quality care, 162
  benefits of diversity, 6
  health disparities, 4
  and health equity, 3–4
  misuse, 5
  organizations, 3
  overuse, 5

- shifts, patient demographics, 4
- underuse, 5

Quest, T.E., 225–228

R

Racial/ethnic health care disparities and inequities
- AAMC, 14
- Academic Medical Faculty, 16, 17
- African Americans, 14
- blood pressure, 13
- in cardiovascular services, 13
- HeLa cells, 12
- HIV infection, 13
- US 1990 census, 11
- US medical schools, 15
- Workforce, 17

Ramalanjaona, G., 31–37
Rastafari, 97, 98
Reactive airway disease, 236
Renal disease, 13
Research funding, 195
Residency training, 45, 46
Reyes, I., 11–18
Richards, C.F., 148
Richardson, L.D., 189–197203–206
Right lower quadrant (RLQ), 271
Right ovarian cyst, 276
Rimple, D., 259–262
RLQ. *See* Right lower quadrant (RLQ)
Roman Catholic
- contraception, 93
- evaluation, 94
- medical intervention, 93
- modern medical practice, 92
- natural rhythms, 93

Roodsari, G.S., 179–186
Rosen, J., 45
Rozel, J.S., 121–127

S

SAEM. *See* Society for Academic Emergency Medicine (SAEM)
Sarvaananda, S., 83–99
Sarver, J., 64
Sawning, S., 39–51
SCD. *See* Sickle cell disease (SCD)
School violence, 243
Self stigma, 123
SES. *See* Socioeconomic status (SES)
Sexual orientation, 193, 194, 196
Sexual reassignment surgeries (SRS), 117
Shapiro, J., 44
Sickle cell disease (SCD), 213
Sikhism
- adolescent victims of violence, 243
- disparities/discrimination, 244
- ED, 241, 245
- Emergency Medicine Milestones, 245
- family history, 242
- mother, 244
- past medical history, 242
- patient-centered communication, 245
- physical exam, 243
- physician, 244
- scalp laceration, 245
- school violence, 243
- Sikh man wearing kirpan, 241, 242
- social history, 242
- systems, 242
- wound closure, 244

Smith, A.B., 131–135, 161–167
Social justice, 26
Society for Academic Emergency Medicine (SAEM), 34
Socioeconomic status (SES), 140, 192–194
Southern Baptists, 91
Spiritual care services
- Buddhism, 87, 90
- Christianity, 91, 92
- cultural values and traditions, 84
- definition, 83
- emergency departments, 85
- health care provider knowledge, 84, 85
- health-related beliefs, 84
- Hinduism, 97
- Islam, 94, 95
- Judaism, 95–97
- knowledge and education, 85
- pastoral conversation, 86
- patients need, 86, 87
- Pentecostal, 92
- Rastafari, 97, 98
- religious/medical points, 88–89
- Roman Catholic, 92–94

Spiritualism in Latino community
- diagnosis, 269
- family history, 264
- health beliefs/customs, 266
- lack of knowledge of community, 267
- medical priorities and treatment plan, 267
- paramedics, 263
- past medical history, 264
- patient, 265
- physical exam, 265
- physician, 265

Spiritualism in Latino community (*cont.*)
  professional values, 269
  social history, 264
  symptoms, 264
  treatment and aftercare plans, 268
SRS. *See* Sexual reassignment surgeries (SRS)
Stettner, E., 137–148
Stigma and diagnostic overshadowing, 123
Street medicine, 155
Street, R.L. Jr., 71
Strict scrutiny, 15
Systematic disparity, 123–124
Systems-based management, 250, 262

T
TACCT. *See* Tool for Assessing Cultural Competency Training (TACCT)
Takayama, J.I., 44
Telephone-based interpreter systems, 61, 62
Thrombo-embolic disease and decubitus ulcers, 133
TIC. *See* Trauma informed care (TIC)
Tool for Assessing Cultural Competency Training (TACCT), 40
Toxic Ingestion, 235, 236
Transgender patient
  birth anatomy, 117
  block androgen receptors, 117
  cross-dressing, 114
  drag queens, 114
  gender identity, 115
  gender minority, 113
  gender nonconforming, 113
  gender variant behavior, 114
  hormonal and surgical therapies, 117
  injectable silicone, 117
  legal issues, 118
  mental illness, 114
  psychological distress, 114
  sexual characteristics, 114
  sexual minority, 113
  sexual orientation, 113
Transvestism, 114
Trauma, 143–144
Trauma-informed care (TIC)
  advantages, 72
  medical education, 73
  neurobiological and psychosocial effects, 73
  patients, 72
Trice, T.R., 213–218

U
Unconscious bias, 72
Underrepresented minorities (URM), 17, 18, 195
University of Massachusetts Medical School, 43
University of Sydney, 45–46
URM. *See* Underrepresented minorities (URM)
US 1990 census, 11
US health care system, Muslim Americans, 182
US medical school, 16

V
Vaso-occlusive crisis (VOC), 213
VOC. *See* Vaso-occlusive crisis (VOC)
Vulnerable populations, 154
  alcohol dependence/misuse, 152
  attitudes and beliefs, 152
  chronic and acute medical problems, 151
  chronic illnesses, 152
  clinical decision-making, 153
  communication barriers and foster, 153, 157
  comprehensive discharge planning, 154
  culturally competent care, 156
  discourse strategies, 153
  ED, 156
  empathy and interest, 152
  epidemiological studies, 152
  explicit discourse, 154
  health care providers and workers, 155
  health care system and shelters, 155
  health disparities, 151, 152
  health status, 156
  hepatitis B and C infections, 152
  homelessness, 151
  homeless people, 152, 154
  incarcerated persons, 152, 155
  intensive case management, 156
  language and power, 153
  language of attentive patient care, 154
  medical respite care, 155
  mental illness, 152
  non-sterile injecting equipment, 152
  parameters
    attentiveness, 154
    collaboration, 154
    facilitation, 154
  physical and psychiatric disease, 156
  physician–patient relationship, 156
  physicians, 153, 157
  prejudices, 153
  prisoners, 152
  psychiatric illness and substance abuse, 154
  quality care, 156

  - self-empowering language, 154
  - shelter-based patient navigators, 155
  - street medicine, 155
  - systematic review and meta-analysis, 152
  - targeted interventions, 155
  - underserved patients, 153

W

Wake Forest University, 43–45
Walker, L.U., 11–18, 23–29, 263–269
Webb, B.C., 229–233
Webb, L.-A.J., 213–224
Weissman, J.S., 39
Wellington School of Medicine and Health Sciences, 46
West Indian/Caribbean
  - cross-cultural tools and skills, 256
  - Emergency Medicine Milestones, 257
  - family history, 254
  - herbal remedies, 253
  - medical issues, 257
  - past medical history, 254
  - patient care, 255, 257
  - patient-centered communication skill, 257
  - physical exam, 255
  - physician, 255
  - professional values, 257
  - provider knowledge, 256
  - social history, 255
  - symptoms, 254

Wheezing, 235, 236
White, P.G., 83–99
Wilper, A.P., 153
Wong-Pérez, R.E., 263–269
Workforce environment and diversity, 141–142

Z

Zachariah, S., 241–245
Zun, L.S., 121–127