Virtual Mentor
American Medical Association Journal of Ethics

December 2001, Volume 3, Number 12: 425-459

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 427-430.

FROM THE EDITOR
Dr. Counter-Diversity
Audiey Kao, MD, PhD

According to the 2000 US Census, Asians make up less than 4 percent of the nation's population[1]. I am counted as a member of this racial and ethnic group, in which the Census Bureau includes Chinese, Korean, Japanese, and others (but not those of Middle Eastern descent even though they also originate in the Asian continent). Yet, Asians and Pacific Islanders comprise nearly 20 percent of the more than 65,000 US medical students[2]. Given that many leaders in medicine advocate educating and training physicians who look more like their patients and thus represent America more accurately, my being a physician can be viewed as running counter to the goal of achieving representative diversity in the nation's physician workforce.

The debate raging over the means to and ends of diversity extends far beyond its implications for our health care system. Advocates for affirmative action see the promotion of diversity in education and the workplace not only as being in society's present and future interest, but also as a means to correct past social injustices. Opponents view diversity-promoting mechanisms as nothing more than reverse discrimination through the establishment of quotas that are blind to merit. As this debate about diversity rages on, it is critical that all discussants have greater clarity and understanding of several key questions: (1) How do we define diversity? (2) Given an accepted definition of diversity, what is its value to society? (3) If society deems diversity of substantial value, how do we achieve this goal?

Without a reasonable working definition of diversity, it will be impossible to measure and therefore know whether diversity in the physician workforce has been achieved. At first glance, the definition appears to be black and white. Many of the headline-grabbing court cases focus exclusively on the color of a plaintiff's skin[3, 4]. Yet, defining diversity simply by race is too narrow, especially given the growing ethnic and cultural heterogeneity of American society. While characterizing diversity by race alone is insufficient, it is difficult to determine what other factors need to be considered. Most would say that gender and cultural and religious background at least should be part of our conception of diversity. But what about age, socioeconomic status, physical disability, sexual preference, and rural background? I would argue that the definition of diversity as it applies to the physician workforce should be linked to its value in promoting the practice of good medicine. In other words, what aspects of difference or concordance between patient and physician can be shown to affect quality of care and patient outcomes?

Diversity's value in medicine can be examined from a symbolic perspective as well as from this instrumental perspective. Some consider diversity to be intrinsically valuable—diversity for the sake of diversity. As a person with progressive attitudes and ideologies, I find this symbolic argument for diversity appealing. But, as one who also considers the consequences of human actions and choices to be particularly relevant, I am left wanting greater proof of diversity's tangible value than this symbolic argument supplies.

What is the available proof of the value of diversity? From a social policy perspective, promoting greater diversity in school and at work provides previously disadvantaged groups an opportunity to enter respected professions and advance up the socioeconomic ladder. While diversity-promoting policies have contributed significantly to the socioeconomic advancement of minority groups[5, 6], those remedies are meant in part to correct past social injustices and have been challenged as acts of "reverse discrimination." Several lower court rulings have struck down race-based scholarship programs, employment practices, and university admissions processes[7-12], thus leaving the value of current diversity-promoting policies as a means of social advancement in some doubt.

According to Lee Bollinger, the recently named president of Columbia University, "People learn more and learn better in an environment where they are part of a mix of people . . . not like themselves"[13]. From an educational policy perspective, promoting greater diversity in medical school is designed to create a learning environment that helps students develop the skills to better care for an increasingly diverse patient population. The opportunity for increased interactions with diverse groups is meant in part to promote greater awareness, understanding, and tolerance of different cultures. However, conclusive evidence that exposure increases understanding and tolerance is lacking. Some studies suggest that students are better learners in a diverse student body context[14, 15], while others find no direct link between such variables[16]. If we are to continue to focus on teaching "cultural competence" in medicine, the educational value of such instructional efforts requires serious scientific examination.

From a health policy perspective, many argue that having more minority physicians translates into better care for underserved or minority patients. Studies show that minority physicians are more likely to practice in rural and inner city communities[17-19]. In addition, numerous studies on disparities of care suggest that the care that physicians provide is not color blind [20-23]. To counter physician bias, some advocate for greater matching of race and ethnicity between patients and their physicians. This matching, however, would be impractical to say the least, given the opportunity constraints of pairing patients with physicians. More importantly, the implications of this "dating service" approach run counter to the educational goal of diversity-promoting policies: that students and physicians will be better able to care for an increasingly diverse patient population because they have been exposed to a diverse learning environment.

Finally, if we were to agree on a definition of diversity that had symbolic and practical value in promoting the practice of good medicine, we would still be left with the critical question of how to achieve the correct mix of physicians. Currently available means for promoting diversity—such as race-based affirmative action—face severe constitutional challenges to their legal integrity. Initiatives such as the Association of American Medical Colleges' 3000 by 2000 Initiative have met with mixed success; the targeted number of 3000 medical students from underrepresented minority groups by the year 2000 was not fully achieved. As a member of a minority group that is overrepresented in medicine, I have personal as well as theoretical reservations about efforts to reengineer the physician mix for the sake of greater diversity. At the same time, given the disparities of and unequal access to medical care, proposed efforts that are designed to address such important problems require serious consideration.

In the December 2001 *Virtual Mentor*, the issue of diversity in medical education and practice is explored from many different perspectives. I hope that our analyses and subsequent discussion of this pressing and relevant topic in medicine provide our readers with a greater understanding of its diverse complexities.

References

1. U.S. Census Bureau. United States Census 2000. Available at: https://www.census.gov/. Accessed November 26, 2001.
2. Brotherton S, Simon F, Etzel S. US graduate medical education, 2000-2001. *JAMA*. 2001;282(9):1056-1060.
3. Affirmative Action: Piscataway Board of Education v. Taxman, Sharon. *Washington Post* [serial online]. Available at: https://www.washingtonpost.com/wp-srv/national/longterm/supcourt/1997-98/piscataway.htm. Accessed November 28, 2001.
4. Clayton M. Michigan affirmative action case will reverberate widely. *The Christian Science Monitor* [serial online]. Available at: https://www.csmonitor.com/2001/1023/p14s1-leca.html. Accessed November 28, 2001.
5. Bruno A. *Affirmative Action in Employment: Background and Current Debate.* Washington, DC: Congressional Information Service, Inc; 1998.
6. Holzer H, Neumark D. Assessing affirmative action. *J Economic Lit*. 2000;38(3):483-568.
7. *Podberesky v Kirwan*, 38 F.3d 147 (4th Cir. 1994), cert denied, 115 S. Ct. 2001 (1995).
8. *Hopwood v Texas*, 999 F. Supp 872 (1998).
9. *Sarah P. Wessmann, p.p.a. Henry R. Wessmann v Robert P. Gittens, chairperson of the Boston Latin School Committee, et al*., U.S. Court of Appeals for the First Circuit, No. 98-1657, November 19, 1998.
10. *Grutter v Bollinger*, 137 F. Supp. 2d 821 (E.D. Mich. 2001).
11. *Gratz v Bollinger*, 122 F. Supp. 2d 811 (E.D. Mich. 2000).

12. SUNY Brockport. Affirmative Action Decisions. Available at: http://www.brockport.edu/~affirm/supremecourt.htm. Accessed November 28, 2001.
13. Editorial. A bidding war for presidents. *New York Times* [serial online]. Available at: http://college3.nytimes.com/guests/articles/2001/10/10/873033.xml. Accessed November 28, 2001.
14. The University of Michigan. Expert report of Patricia Gurin. Available at: http://www.umich.edu/~urel/admissions/legal/expert/gurintoc.html. Accessed November 28, 2001.
15. Elam CL, Johnson MM, Wiggs JS, et al. Diversity in medical school: perceptions of first-year students at four southeastern U.S. medical schools. *Acad Med*. 2001;76(1):60-65.
16. Astin A. *What Matters in College?* Four Critical Years Revisited. San Francisco: Jossey-Bass; 1993.
17. Komaromy M, Grumbach K, Drake M, et al. The role of black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med*. 1996;334(20):1305-1310.
18. Xu G, Fields SK, Laine C, et al. The relationship between the race/ethnicity of generalist physicians and their care for underserved populations. *Am J Public Health*. 1997;87(5):817-822.
19. Nickens HW. The rationale for minority-target programs in medicine in the 1990s. *JAMA*. 1992;267(17):2390-2391.
20. Gemson DH, Elinson J, Messeri P. Differences in physician prevention practice for white and minority patients. *J Community Health*. 1988;13(1):53-64.
21. Kogan MD, Kotelchuck M, Alexander GR, Johnson WE. Racial disparities in reported prenatal care advice from health care providers. *Am J Public Health*. 1994;84(1):82-88.
22. Kahn KL, Pearson ML, Harrison ER, et al. Health care for black and poor hospitalized Medicare patients. *JAMA*. 1994;271(15):1169-1174.
23. Shi L. Experience of primary care by racial and ethnic groups in the United States. *Med Care*. 1999;37(10):1068-1077.

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 431-432.

CASE AND COMMENTARY

Are There Limits to Honoring Diversity?

Commentary by Faith Lagay, PhD

Case

Dr. M was a first-year resident in a family practice program. An Islamic woman, Dr. M intended to limit her practice to primary care of children, adolescents, and adult women. Because of her future practice plans and her religion, Dr. M stated that she would not participate during her residency training in procedures that required her to examine or treat genitorectal areas of males—procedures such as circumcision, urethral swabs, testicular exams, and digital prostate exams. Dr. M lived, and intended to practice, in a large US city. She maintained that her decision not to perform this limited set of procedures would not cause harm to any individual because those in need of these medical services would be able to secure them elsewhere without undo burden.

The residency program director, Dr. R stood firm on the requirements. He argued that satisfactory completion of his program was taken as certification that all residents had performed and mastered the required procedures. Dr. R. believed he was justified in specifying professional qualifications for that certification. He was not curtailing Dr. M's rights; he was setting professional standards. Dr. R contended that if he were to let Dr. M complete the program without experience in all required procedures, his family practice residency program would no longer certify that all graduates were experienced in all procedures they may be called upon to perform. Furthermore, he said, this exception would open the door to other exclusions. Individuals might ask to be exempted from learning any procedure that they attested they would not have to perform in the course of their practice.

In pursuing her case, Dr. M said that the door to exceptions was already opened. Physicians opposed to abortion were excused from performing them. Indeed, she argued, most residencies did not require or even teach physicians how to perform abortions, out of deference to strong religious antipathy to abortion prevalent in the US. She also pointed out that in most places Jehovah's Witness surgeons were exempted from giving blood transfusions. Dr. R's decision in this case, she alleged, was solely one of indifference to the tenets of her particular religion—Islam.

Questions for Discussion

1. The AMA's "Principles of Medical Ethics" state that, in non-emergency situations, physicians may choose whom to serve. Since the procedures Dr. M wishes not to perform are not life-saving procedures, she may ethically

choose not to perform them. Does this also mean that she need not be expected to learn about them in her training?
2. Is Dr. R justified in saying that certification in a given residency should guarantee uniform competency among all graduates? If Dr. R decided to honor Dr. M's wishes, how might he indicate that her qualifications differ from those of other program graduates? Is it necessary to so indicate?
3. Would Dr. R's policy, if enforced in other family practice residency programs, mean that women who share Dr. M's interpretation of Islamic principles could not become family practice physicians in America? If personal moral values are at odds with professional ethics, and one is acting in a professional role, what should one do?
4. Does commitment to diversity mean that every educational and professional opportunity must be designed to accommodate individuals of every race, creed, ethnicity, sex, type of physical disability, sexual preference, and age? Are there differences in the weight of these various aspects of diversity? How can religion-based exceptions be honored without opening the door to honoring all closely held, non-reason-based values?
5. Patients are free to seek or reject treatment from physicians of a given ethnicity, race, or religion, or of one or the other sex. Should physicians have the same latitude in choosing patients that patients enjoy in choosing physicians?

Faith Lagay, PhD is managing editor of *Virtual Mentor*.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 433-434.

ART OF MEDICINE
The Face of Contemporary Medicine: Is It Diverse?
Sam Huber

When the first AMA House of Delegates convened in 1901, its membership was largely homogeneous. It is no surprise that most American physicians were white males, and after the emergence of medicine as a profession these gentlemen were, on the whole, financially secure. Neither should it be a surprise that the demographics of today's delegates and of the profession are vastly different. One could say that the profession has achieved diversity relative to its composition 100 years ago. Some would argue that this is not enough. They would argue for categories of difference in addition to color, gender, and financial status in the name of improved patient care. Although the causal link between a diverse physician population and quality of patient care seems intuitively correct, it remains tenuous and unproven.

A recent study defined diversity for medical school students along 9 population characteristics: age, sex, race, ethnic background, physical disability, religious affiliation, sexual orientation, socioeconomic status, and rural background (town population of < 5000)[1]. AAMC data on medical school applicants and matriculates tracks sex, race or ethnic background[2]. A cursory examination of these data suggests that these demographics have not changed appreciably over the past 10 years.

As we stretch the collective discussion of diversity to include more characteristics, the broader categories become divided into more specific descriptions. Narrowing the categories of diversity to gain specificity increasingly detaches these subgroups from reality and from the realistic goal of improving patient care. The danger is that skepticism and subdivision can rapidly collapse into individualism, the notion that everyone is distinct or (even worse) unique, and that categories don't work for anyone. For example, if the only means to the end of better patient care becomes one-to-one physician/patient concordance and familiarity, the ideal paradigm would be a physician treating family members, an untenable and unethical position. In seeking concordance, the opposite of diversity is achieved if the discussion results in individualized and segregated sameness.

Yet, despite the above stretching and dividing process, it is important to assert that some differences matter. (Sometimes, the lack of differences matters, too, as in treatment protocols or standards of care.) In the presence of similarity, differences become defining and distinguishing characteristics. Human functioning is in large

part based on the recognition of such differences. The difficulty is in assessing which differences are useful in a certain situation. A medical approach to variation often assesses symptoms or differences on the basis of functionality. Such a distinction applied to statements about diversity informs a process of heuristic management, wherein a heuristic is a generalization that is functional, and a stereotype, one that is not.

The questions to be asked are which differences matter enough to receive a privileged (or perhaps protected) place in American medicine and medical education, and to whom these differences matter, be they actual patients, potential patients, or physicians in training in an attempt to foster habits or virtues. Perhaps race and gender are no longer the differences that matter the most. Surely, they were paramount issues in the history of medical demographics, and they may still be important to consider. It is also important to consider what differences need to be protected because respect for them is not intuitive. The reason to protect or ensure that a category of difference will be present in medicine or medical school is that it stretches our understanding and capacity to connect with people and their ideas. If diversity is a dialectic growth process and not a battle, perhaps we should consider where next to grow, rather than considering whether one group has won some sort of battle for inclusion.

References

1. Elam CL, Johnson MM, Wiggs JS, et al. Diversity in medical school: perceptions of first-year students at four southeastern U.S. medical schools. *Acad Med*. 2001;76(1):60-65.
2. AAMC Data Warehouse. Available at: https://www.aamc.org/data/facts/start.htm. Accessed November 26, 2001.

Sam Huber is a research assistant in the AMA Ethics Standards Group.

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 435-437.

PERSONAL NARRATIVE

Who Am I, and Why Am I Different?

Robert Davidson, MD, MPH

"Hey Daktari, they need you over in medical right away." This, thankfully, pulled me from a staff meeting on budgets to take care of a volunteer who had been assaulted and had a head laceration. The story behind this unfortunate event started me thinking about the subject of diversity in Africa.

The volunteer was a 25-year-old African American woman. She had been in downtown Nairobi on a Friday and happened to be near a mosque as the mid-day prayers finished and a group of men emerged into the street. She was wearing a hat that she had purchased in Africa, one traditionally worn by men of the Islamic faith. Several of the men approached her and started shouting to her to take off the hat. One of them grabbed it from her, and she got into a tug-of-war with him. She began yelling for him to stop and leave her alone. One of the other men picked up a board lying nearby and struck her over the head causing the laceration. As she let go of the hat to defend herself, the men ran off shouting back to her that she needed to learn her place. She was not badly hurt and was not knocked out. She got a ride to our office holding her head to stem the blood flow. After calming her and anesthetizing the laceration, we had the chance to talk as I cleaned and sutured the wound.

As we began to talk, the tears swelled in her eyes. "Doc, this happens all the time. Who am I and why am I different?" In my best open-ended question style, I prodded her to discuss the problem openly with me. Out came a poignant story of why she had chosen the Peace Corps and her experiences as an American with dark skin in Africa.

She had grown up in a predominately black community, gone to a prominent university dedicated to the education of black Americans, studied African American history, and was looking forward to working in Africa with "her people." Her actual experience was quite unexpected. She came to realize that she was much less African and much more American than she had thought. She related the experience of talking with a group of educated Africans in the school in her community. She told them she felt she was having difficulty being accepted as a friend and colleague and asked them why. They responded that she was a "Mzungu." She was shocked. Mzungu is roughly translated from Kiswahili to mean "European." It has taken on a much greater connotation, however, and is applied in a semi-derogatory manner to refer to the colonialists from Europe and developed nations and is applied to all ex-

patriots working in eastern Africa. It was a difficult realization for her that she had so much more in common with Europeans and with the other Peace Corps volunteers than with the Africans who looked much more like she did. She felt she was being discriminated against in Africa in a manner much more virulent than she had experienced in the United States as a black American.

A few days later, I was sitting in on a committee of volunteers called the "Diversity Committee" that had been formed to look at ways to attract a more diverse group of volunteers to Africa to better represent the many cultural groups of the United States. The same black American volunteer, stitches still in her scalp, addressed the group. I want to quote her as closely as I remember. "Diversity should not be a goal in and unto itself," she began. "If you work toward diversity, you are admitting that there is still discrimination. The goal should be to do away with any biases and allow true equal opportunity for all and then let what happens happen. I want to work with people who I care for and respect and who feel the same way about me. It has been very hard for me to admit that I am more comfortable working and relating with other volunteers, most of whom are white, than with the Africans I thought I identified with. I am also coming to the reluctant conclusion that I am probably better off as the descendant of slaves brought to America than I would be if my ancestors had remained in Africa. Do not get me wrong; I hate the whole idea of slavery more than anyone else does in this room. However, I am so glad that I have the opportunity in the US to accept people for who they are and not get hung up on the color of their skin."

As she finished, there was a stunned silence in the room. It had taken great courage for this young women to express her feelings openly with the group. She had become the teacher on what diversity is all about. It had taken pain and incredible insight for her to come to this conclusion. I left the meeting with a good feeling that we will continue to advance in the US in our understanding and intolerance of racism and bias. We will be led in this process by young women and men of diverse backgrounds willing to explore and express their feelings.

So what does this have to do with diversity in the medical profession? For 22 years before coming to Africa, I was on the faculty of the University of California, Davis, School of Medicine. For 12 of those years, I served on the admission committee. Each year the committee struggled with the issue of diversity of the incoming class. There was almost universal agreement among committee members that there was a positive value in having an ethnically diverse class. What we differed on, often precipitating lengthy discussions late into the evening, was what criteria we should use in the selection process. It was seductively easy to fall back on the objective data supplied by the MCAT and undergraduate GPA. How could we measure our success in achieving diversity? We talked in terms of overcoming barriers as a measure of accomplishment, diverse language skills, and commitment to underserved communities. For some applicants, these notions helped us to see their potential value as future physicians and to secure them a place in the entering class. However, this did not address the applicant from a minority race or culture who was

not disadvantaged. If diversity itself was the goal, we should give preference to all members of a minority race or culture. It is clear that we were not seeking diversity alone, but the added value brought to the education process and to the future profession of a class that reflected the rich cultural diversity of California.

Just as the young black American volunteer's experiences enriched all of us, a diverse profession can do the same. She was able to define the meaning of diversity in a way that was impossible for someone who had not shared her experiences, and she was willing to impart this to the group.

We would not need to worry about the concept of diversity in the profession if the opportunity for admission were equal among all. The goal is finally doing away completely with bias by race or ethnicity. Then, as the volunteer said, "Let what happens happen." *We are not there yet*. We must continue to work toward this goal and, in the interim, be willing to accept that diversity in the profession has an added value both in the education process and in serving our patients.

Robert Davidson, MD, MPH is professor in the Department of Family and Community Medicine at University of California, Davis, where his interests include both rural health and the organization and financing of health care systems. In the past few years, he has served as both the director of Rural Health and earlier as the medical director of Managed Care for the UC Davis Health System. *Out of Africa* is an on-line journal of his odyssey in the US Peace Corps as the area Medical Officer in Eastern Africa.

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 438-443.

VIEWPOINT
Recommendations for Culturally Competent End-of-Life Care
Ronald Keith Barrett, PhD

There is general agreement among researchers and caregivers that rapport is an essential ingredient in, and the virtual foundation of, an effective patient-caregiver relationship. Differences in race, ethnicity, and cultural background of caregivers and their patients can be one of the most challenging aspects of end-of-life care. Yet, while the effects of caregiver race and ethnicity have been studied and are regarded as the most important characteristics in the patient-caregiver relationship, they have seldom been looked at in combination with end-of-life care giving[1, 2].

The role of racial and ethnic differences in the patient-caregiver (or therapist) relationship has been particularly well studied in both the mental health[3, 4] and physical health[5, 6] of people of color. Racism is *itself* often the cause of mental and physical health problems and, along with stereotyping and discrimination, is believed to influence the under utilization of health services by people of color and the high attrition rates of those who do enter into care.

There is a general consensus among behavioral scholars that the culturally congruent patient-caregiver relationship (i.e., one in which patient and caregiver share the same racial or ethnic background) is ideal[7]. In such relationships the quality of the rapport and the communication process (e.g., openness, empathy, disclosure, and trust) are improved, and the feeling that caregiver and patient can relate "on common ground" is maximized[8].

Conversely, in culturally incongruent patient-caregiver relationships there is a greater probability that the caregiver will lack essential understanding of the patient's culture or background, a fact that increases potential for cultural misunderstandings and decreases the probability that the caregiver will be able to relate to the patient's dilemma. Such basic cultural misunderstanding can erode the all too fragile patient-caregiver relationship. For example, a study of caregivers' interpretation of nonverbal communication and facial affect revealed that culturally congruent caregivers were significantly better in interpreting facial affect and nonverbal signals than culturally incongruent caregivers[9]. The communication disadvantage is most evident in cross-racial pairings where the patient and caregiver do not speak the same language. Basic language differences, which include street slang in many urban subcultures, can hamper communication and rapport. In many cases, the cultural differences can also be the basis for mistrust, lack of empathy, muted speech in culturally alienated and disenfranchised patients, inhibitions of

disclosure, and defensiveness, as well as a lack of patient compliance in end-of-life care. While cultural mistrust is likely in any culturally incongruent patient caregiver relationships, the most common aspect of cultural mistrust is the mistrust of Euro-Americans by ethnic minorities or people of color[10]. These factors can serve to undermine a meaningful quality and level of rapport that is essential to an effective patient-caregiver relationship in end-of-life care.

On the other hand, cultural congruence between patient and caregiver minimizes misunderstandings about attitudes, beliefs, and values regarding end-of-life issues, such as individual versus collective decision making, distinctive cultural meanings of death and dying, and the importance of collective psychosocial support in end-of-life care in some cultures, as well as the cultural regard for funeral rites and culturally sensitive approaches to aftercare.

Another literature supports the position that matters of race, ethnicity, and cultural congruence are less important than more individual, interpersonal caregiver traits such as genuineness, warmth, acceptance, and empathy, which are crucial to establishing a bond and meaningful rapport with patients at the end of their lives. Most important, on this view, is the caregivers' willingness to become acquainted with aspects of their patients' culture, social class, and spirituality as they affect attitudes, beliefs, values, and traditions about death and dying. By so doing, caregivers build confidence, credibility, cultural trust, competence, and professional effectiveness and skills[11, 12]. The ultimate goal in culturally sensitive care giving is to "move beyond the initial issue of . . . racial (and sociocultural) difference[s] to focus on the patient's problem"[13].

Consideration of other caregiver cultural characteristics, such gender, religion, and social class, as well as intercultural aspects of diversity, such as sexual orientation, age, disabilities, and regional differences, are also arguably legitimate "cultures" worthy of consideration, but there has been little if any empirical study of the impact of these considerations on the patient-caregiver relationship. One can infer, however, from the aforementioned extensive investigative study of race, ethnicity, and culture that these other dimensions of multiculturalism significantly affect patient-caregiver rapport and relationship.

While culturally congruent patient-caregiver relationships may be ideal and sought-after in care giving situations, matching the patient and caregiver on all relevant variables is difficult if not impossible in our increasingly multicultural society. There is consensus across most care-giving vocations that, in the face of these multicultural realities, caregivers must become culturally competent in caring for diverse patient populations in spite of the absence of cultural parity between them [14,15]. Across a vast array of professional organizations, standards for cultural diversity education have been formulated as guidelines for professional training and conduct in cross-cultural care giving.

From this work[15, 16] come 7 recommendations for culturally competent caregiver in end-of-life care.

1. *Culturally competent caregivers should not rely upon stereotypes or on any "magic recipe" when approaching patients*[14]. Stereotypes are often misleading. Culturally competent caregivers put aside assumptions and predispositions and make individual assessments of each patient and situation. Stereotypic generalizations are often used as guides in the absence of specific information but should never take the place of a careful inquiry into each patient's situation. Few are exactly alike.

2. *Culturally competent caregivers are aware of and sensitive to their own multicultural heritage and identity, and they value and respect multicultural differences in others*. Cultural sensitivity starts with the self. Caregivers ought to be introspectively aware of their own personal attitudes, beliefs, and values about end of life. Awareness of how cultural systems may have affected their own disposition on many end-of-life matters may enable caregivers to appreciate and be sensitive to differences in their patients' views regarding end-of-life concerns. Similarly, culturally competent caregivers make no assumptions about the meaning of the cross-cultural experience for the patient, while fully understanding the meaning of the cross-cultural experience for themselves[17].

3. *Culturally competent caregivers are aware of their own values and biases regarding end-of-life care and how those may affect their relationships with patients who do not share those values and biases*. While most professionals actively strive to minimize biases, prejudices, and stereotyping, it is helpful to confront one's own biases and be aware of their potential influence on relationships with patients. Culturally sensitive caregivers are vigilant in keeping their assumptions and values regarding end-of-life matters from biasing their perceptions and regard for patients who may approach end-of-life care differently. Consultations, supervision, and intercultural continuing education efforts for professional development can help to minimize biases and maximize cultural competence in end-of-life care.

4. *Culturally competent caregivers are comfortable with multicultural differences in approaches to end-of-life care.* They neither ignore multicultural differences nor pretend or behave as though legitimate cultural differences do not exist. A significant body of research on cross-cultural differences in death and dying has established that such differences are real and challenge caregivers to remain open minded and not impose "shoulds" or judgments on the various approaches to end-of-life care concerns that exist among an increasingly diverse patient population. Culturally competent caregivers realize the importance of cultural knowledge as a means of enhancing their own credibility and skill in the end-of-life care giving relationships[18].

5. *Culturally competent caregivers are willing to facilitate referrals of patients to caregivers who share critical multicultural background variables*. Significant limitations in the patient-caregiver relationship may minimize caregivers' effectiveness. In some end-of-life situations, certain pairings of patients with caregivers work better than others. This realization allows caregivers to acknowledge their limitations and make referrals to others who may be better able to assist the patient's end-of-life care outcomes. While cultural congruence may be the ideal, in many cases the quality of the patient-caregiver relationship can be meaningfully enhanced by the interpersonal style, credibility, and empathy of the caregiver.

6. *Culturally competent caregivers are sensitive to and aware of the institutional barriers that prevent minorities from using institutionalized end-of-life care*. A host of factors (e.g., lack of health insurance, cultural mistrust, and other socioeconomic constraints) limit and serve as barriers to institutionalized end-of-life services for many minority patients and thus may limit the patient's end-of-life care choices. Some adjustments and accommodations can be made to enhance the patient's end-of-life choices. Those factors that cannot be changed must at least be understood so that there is less of a tendency to error in "blaming the victim."

7. *Culturally competent caregivers appreciate the independent role of individual multicultural dimensions (e.g., race, gender, culture), while appreciating the often combined and interaction of multicultural dimensions (e.g., religion, social class, age, sexual orientation) and their influence on end-of-life issues and care* [14]. Racial, cultural, and ethnic stereotypes are seldom reliable guides alone, but can improve understanding when viewed in combination with considerations of spirituality/religion and social class[19]. Many multicultural dimensions are significant in patient-caregiver end-of-life relationships.

In summary, the importance of the having someone of the same racial and ethnic background is believed to be more important to the ethnic minority patient than to the caregiver. Cultural congruence is believed to enhance the patient-caregiver relationship. While a racial and cultural match between the patient and caregiver is the ideal, other caregiver characteristics are perceived as being as important and worthy of consideration (regardless of the race) in achieving cultural competence in end-of-life care giving. Culturally competent caregivers bring enhanced credibility and particular skill to meeting the end-of-life care needs of an increasingly diverse patient population.

References.

1. Usha G, Ramkissoon S. Race, gender, and class: interlocking oppression in the lives of South Asian women in Canada. *J Women in Social Work*. 1998;13(1):102-114.
2. Baines D. Feminist social work in the inner city: the challenges of race, class and gender. *J Women in Social Work*. 1997;12(3):297-309.

3. Parham T, White J, Ajuma A. *The Psychology of Blacks: An African-centered Perspective*. Upper Saddle River, NJ: Prentice Hall; 1999: 29.
4. Bell C, Bland I, Houston E, Jones G. Enhancement of knowledge and skills for the psychiatric treatment of black populations. In: Chunn J, Dunston P, Ross-Sheriff F, eds. *Mental Health and People of Color*. Washington, DC: Howard University Press; 1983:205-238.
5. Freeman H, Payne R. Racial injustice in health care. *N Engl J Med.* 2000;342(14):1045-1046.
6. Sondik E, Lucas J, Madans J, Smith S. Race/ethnicity and the 2000 census: implications for public health. *Amer J Pub Health*. 2000;90(11):1709-1713.
7. Charnuff R, Pierce R. Differential effects of therapists' race and social class upon patient depth of self-exploration in the initial clinical interview. *J Consult Psychol*. 1967;31(6):632-634.
8. Houston L. *Psychological Principles and the Black Experience*. Lanham, MD: University Press of America; 1990.
9. Bruce J, Beard K, Tedford S, Harmon M, Tedford K. African Americans' and Caucasian Americans' recognition and like-ability responses to African American and Caucasian American races. *J of Gen Psychol*. 1997;124(2):143-155.
10. Barrett R, Heller K. Death and dying in the black experience: an interview with Ronald K. Barrett, PhD. *Innovations in End-of-Life Care*. Available at www.edc.org/lastacts/archives/archivesSept01/intlpersp.asp. Accessed December 3, 2001.
11. Burman S. Cross-cultural therapeutic relationships: entering the world of African Americans. *J Soc Work Prac*. 1999;1999(1):49-59.
12. Balk D. Caring that empowers: meeting the needs of overwhelmed patients. *Death Studies*. 1997;21(2):203-207.
13. Proctor E, Davis L. The challenge of racial difference: skills for clinical practice. *Soc Work*. 1994;39(3):314-323.
14. DeSpelder L, Barrett R. Developing multicultural competency. *The Director*. 1997;61(2):66-68.
15. Sue D, Sue D. *Counseling the Culturally Different: Theory and Practice*. New York: John Wiley & Sons, Inc.; 1990.
16. Atkinson D, Morten G, Sue D. *Counseling American Minorities: A Cross-Cultural Perspective*. Dubuque, IA: William C. Brown Publishers, Inc.; 1989:4.
17. Pierrepointe M. Style and substance: examining the space between patient and therapist in the cross-cultural clinical encounter. *J Soc Work Prac*. 1999;13(1):39-49.
18. Sue D, Zane N. The role of culture and cultural techniques in psychotherapy: a reformation. *Amer Psychol*. 1987;42(1):37-45.
19. Barrett R, Contemporary African American funeral rites and traditions. In: DeSpelder L, Strickland A, eds., *The Path Ahead: Readings in Death and Dying*. Mountain View, CA: Mayfield Publishing Company. 1995;80-92.

Ronald Keith Barrett, PhD is a professor of psychology at Loyola Marymount University in Los Angeles where he teaches, among other courses, one which he created on the psychology of death and dying. He is an internationally recognized specialist on the study of cross-cultural differences in death, dying, and funeral rites, has published widely on African American funeral practices and multicultural perspectives, and has taught a graduate course on cross-cultural counseling. He is also widely known for his expertise on urban youth homicidal violence.

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 444-445.

VIEWPOINT
Concordance Extremis
Audiey Kao, MD, PhD

- According to the 2000 Census, the total US population stood at 281,421,906. Of that total, 69.1 percent are white; 12.3 percent are black/African American; 12.5 percent are Hispanic/Latino; 3.6 percent are Asian; and 0.09 percent are American Indian/Alaskan Native[1].
- According to the American Medical Association, there are 812,713 physicians in the US. Among all US physicians, 75.3 percent are white; 3.6 percent are black/African American; 4.9 percent are Hispanic/Latino; 12.7 percent are Asian; and 0.0006 percent are American Indian/Alaskan Native[2].
- On average, a family practitioner has approximately 1,500 patients in his or her practice[3].
- Some studies suggest that minority patients receive better care from physicians of a similar racial and ethnic background[4, 5]. It is thought that minority patients are more trusting of minority physicians, which promotes improved patient-physician communication. Therefore, some who advocate for greater representative diversity of the physician workforce may support policies that promote concordance in race and ethnicity between patient and physician.
- If patient-physician racial/ethnic concordance were enacted today, it would mean that minority physicians would have patient panels that are several times larger than the current average. Extending patient-physician concordance to such extreme would not only be impractical, it would further reinforce, in a larger sense, that a color-blind society is not attainable.

References
1. U.S. Census Bureau. United States Census 2000. Available at: https://www.census.gov/. Accessed November 28, 2001.
2. American Medical Association. Minority physicians data source. Available at: http://www.ama-assn.org/ama/pub/article/168-187.html. Accessed November 28, 2001.
3. Moore KJ. The salaried FP: the academy's first survey of salaried family physicians. Available at: http://www.aafp.org/fpm/970700fm/salaried.html. Accessed November 28, 2001.
4. Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender, and partnership in the patient-physician relationship. *JAMA*. 1999;282(6):583-589.

5. 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.

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 446-448.

VIEWPOINT

Doctors in Black and White on the Big and Small Screens

Kayhan Parsi, JD, PhD

> Mass media are the most ubiquitous wholesalers of social roles in industrial societies. Mass media, particularly television, form the common mainstream of contemporary culture. They present a steady, repetitive, and compelling system of images and messages. For the first time in human history, most of the stories are told to most of the children not by their parents, their school, or their church but by a group of distant corporations that have something to sell. This unprecedented condition has a profound effect on the way we are socialized into our roles, including age as a social role . . . . The world of aging (and nearly everything else) is constructed to the specifications of marketing strategies[1].

The mass media, including film, television, advertising, and radio, reflect and interpret the world for their audiences. But they also *select* what to cover and interpret, often feeding readers and viewers a narrow portrait of their world. The picture they paint is often neither a full nor representative view of the entire mosaic of humanity. The media, for example, have often served up stereotypical images of minorities, the elderly, those with disabilities, and all people with non-Anglo-American backgrounds. Movies such as *Birth of a Nation*, radio and television shows such as *Amos-n-Andy* and television shows such as *The Secret Life of Desmond Pfeiffer* have been much derided for their racist or stereotypical content.

If images of minorities were rare for much of early mainstream Hollywood, minorities cast as professional physicians and lawyers were rarer still. As Peter Dans explains in *Doctors in the Movies*, "[The fact that Blacks have been virtually invisible as physicians in the movies is not surprising given the racial discrimination in almost every sector of American society until the mid-1960s"[2]. In his chapter on black doctors ("Blacks, the Invisible Doctors"), Dans notes only a handful of films that showcase black physicians: *Lost Boundaries* (1949), *No Way Out* (1950), *Guess Who's Coming to Dinner* (1967), *The Heart is a Lonely Hunter* (1968), *Outbreak* (1995), and *Eve's Bayou* (1997). A mere 6 films in as many decades.

In the aftermath of the civil rights era and with the enormous influx of foreign physicians into American medicine, one would expect the media to strive to capture the new diversity in the profession. But this has not happened. Hollywood continues to neglect minority physicians in many contemporary films and television shows. Although NBC's *ER* has been lauded for its intelligence and verisimilitude, the casting of the show still does not reflect the fact that 25% of physicians in the US are international medical graduates, mostly of Asian and Middle Eastern descent.

One tertiary character on the show, played by Ming-Na, is Asian despite the fact that 1 of 6 physicians practicing in America is of Asian descent.

Author Forrest Wood has criticized successful television producer Stephen Bochco for his now-defunct show *City of Angels*. The show purportedly tried to highlight medicine through the eyes of African American physicians. Yet Wood correctly pointed out in a recent review that this show failed in its attempt to present a realistic portrait of an inner-city public hospital, one mostly staffed by physicians of Asian and Middle Eastern descent. The promising but overly earnest *Gideon's Crossing* had a token Asian physician, played by Ravi Kapoor. Even the new NBC sitcom *Scrubs*, billing itself as a farcical take-off on residency training, doesn't risk losing mainstream audiences who prefer their docs to look like them rather than like international residents from East and South Asia.

Portrayal of physicians with disabilities has also been spotty. Although the *ER* character Dr. Kerry Weaver walks with an arm crutch, the actress who portrays her, Laura Innes, does not have a disability. In fact, an actress who does have a disability, Christopher Templeton, was denied an audition for the part. According to Gloria Castaneda, who works with the Media Access Office, a disability liaison group to the entertainment industry, *ER* received a great deal of criticism from the disability community. "That was a mistake '*ER*' took a lot of flak for," said Castaneda. "It upset a lot of people in the disability community. *ER* has been very careful since then as to whom they hire with disabilities." *ER* has since taken pains to provide greater opportunities to actors with disabilities[3].

One would think that the portrayal of women physicians would have fared better than that of other minorities. Yet, outside the female physicians who populate the ensemble cast of *ER*, one would be hard pressed to name a famous female physician from either the small or large screen. As Dans points out in his chapter on women physicians, "Where Are All the Women Doctors?" "Asked to name a male movie doctor, you might rattle off Dr. Kildare, Dr. Christian, or a television version like *Marcus Welby*. Chances are, though, unless you're a film buff, you probably couldn't name a woman doctor." Dans goes on to state that although there were women doctors in films from the 1930s, they were not played by self-possessed actresses such as Katherine Hepburn, Bette Davis, or Joan Crawford. Rather, actresses such as Kay Francis were cast in these roles as "long-suffering, unappreciated, and conflicted heroines. . . "[4]. Besides the popular *Dr. Quinn, Medicine Woman* that ran from 1993 to 1998 and starred Jane Seymour, few contemporary films or television shows have had a female physician lead. Exceptions include *The Prince of Tides*, with Barbra Streisand as a psychiatrist, *Beyond Rangoon*, with Patricia Arquette as a physician, and *City of Angels*, with Meg Ryan improbably cast as a heart surgeon. Dans notes that "[t]he good news for budding filmmakers is that the great American woman doctor film has yet to be made"[5].

Despite the great interest among the various media in the medical profession, films and television programs too often fail to depict accurately the great diversity among health care professionals and the patients they treat. At its best, the media can perform a valuable service in raising the level of thinking and discussion about social issues and ethical dilemmas that divide Americans. In the past, it has done so sensitively and dramatically in films such as *Philadelphia* (AIDS) and *Dead Man Walking* (capital punishment), for example, as well as comedically in television shows such as *All in the Family* (racism) and *Maude* (abortion). Filmmakers and television producers are losing a golden opportunity to educate viewers by dramatizing communication problems between patients and physicians of different races, creeds, and descent and by exploring differences in cultural values concerning 2 events that eventually touch all of us—sickness and death. As a result of the media's inattention to the true diversity in American medicine, viewers come away with a skewed and outdated picture that helps neither patients nor physicians.

References

1. Gerbner G, Learning productive aging as a social role: the lessons of television. In:Bass SA, Caro FG, and Chen YP, eds., *Achieving a Productive Aging Society*. Westport, CO: Auburn House; 1993:207.
2. Dans P. *Doctors in the Movies: Boil The Water and Just Say Aah*. Bloomington, IL: Medi-Ed Press; 2000:149.
3. Feran T. "Disabled gained and lost ground on TV." *San Diego Tribune*. Dec. 16, 2000;E-9.
4. Dans, 123.
5. Dans, 147.

Kayhan Parsi, JD, PhD is a fellow in the AMA Ethics Standards Group.

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 449-451.

PERSONAL NARRATIVE

Through the Physician's Eyes: A Case for Programs that Promote Diversity

Sheila Roundtree, MD

I remember, vividly, my first day of medical school in a small southern town. As I entered the classroom, a large amphitheater capable of seating 400, I knew that my life would be forever transformed. The dean's office categorized me as a nontraditional student because I had completed undergraduate work nearly a decade earlier. Interestingly, like a growing number of nurses, I had realized that I could direct patient care at least as well as I could execute physicians' orders.

As I selected a seat in the room that would literally become my second home, I recalled the demographic breakdown of our class; 85 percent were of European descent, and 65 percent were male. Indeed, as I perused the congregation of my fellow classmates on that summer morning, the numbers played out accurately. While the tasks that lay ahead were daunting, I remained confident. Unlike any of the other students, I was born and raised in the same inner city neighborhood where the school is located, and by all accounts the odds were against my ever escaping this impoverished community. Honestly, I was confident because I had been groomed for success.

Although my parents had received little more than grade school educations, my formal education commenced in *Project Headstart*, a federally funded program designed to prepare economically disadvantaged children for first grade. And although no one in my neighborhood spoke standard English, I benefited from after school and weekend tutorials offered by *Upward Bound*. *Upward Bound*, also federally sponsored, is a program whose mission is to prepare adolescents from low income families for college. I participated in this program throughout my high school career, and the experience was invaluable. In addition to academic lessons, our mentors organized outings to local theatrical productions and summer trips to such varied places as Washington, DC and New York City. Prior To joining *Upward Bound*, I had not traveled beyond a 20-mile radius of my hometown.

Even though I have successfully completed medical school and residency, I am ever mindful of all the assistance I received along the way. I have no doubt that I am exactly where I should be, in the clinical setting taking care of patients. My work with the American Medical Association as a member of the Minority Affairs Consortium (MAC) Governing Council has allowed me to add the role of physician-advocate to my clinical practice. The goals of MAC are to promote diversity in the profession, eliminate racial and ethnic and disparities in health care,

assist physicians in delivering culturally effective health care, and increase the participation of minority physicians in organized medicine. We are currently launching a Doctors' Day campaign in which minority physicians around the country will literally go back to school and introduce children to the field, and we are seeking funds to help defray the cost of medical school for students.

The scope of medicine is as vast and rich and colorful as the men and women who practice it. Many believe that a more diverse provider group may be better able to deliver effective care to today's patients. While this hypothesis can be argued, most would agree that as medicine becomes more diverse, it becomes broader and richer in its scope and perspectives.

During recent ward rounds we examined and discussed a 63-year-old Native American woman who frequently bounces back with exacerbation of her congestive heart failure. All indications suggest that Mrs. M takes her medications as prescribed, and the home nurse relates that she usually follows an appropriate diet. The problem, it seems, is the food she consumes at family meals, ceremonial activities, and other community gatherings. Then there is the 58-year-old Latino man with diabetes who understands very little English and struggles with the information imparted by our entirely monolingual team. Moreover, I am often reminded of the tragic case of the 19-year-old African American who had systemic lupus erythematosus with multi-system involvement. When her medical resident told her, "You cannot become pregnant," the patient thought he meant exactly what he had said—that she could not become pregnant, that she was infertile. Several months later, the young woman was surprised to learn that she had, in fact, conceived. The fetus spontaneously aborted in the first trimester, and the patient nearly succumbed to accelerated hypertension and renal failure.

I recall the summer clerkship as a member of a busy ward team in a major medical center in Minnesota. An African American patient from the southeastern United States mentioned that she had consumed large quantities of "pot liqueur" during the previous week as she was suffering with gastrointestinal symptoms. The senior resident initiated delirium tremor orders; he did not realize that "pot liqueur" is simply the liquid remnant of cooked vegetables and is completely nonalcoholic.

Is the care that Native American doctors give Native Americans superior to that offered by Caucasian or Latino physicians? Should I assume that African American patients are inherently more comfortable with me than with physicians from other racial and ethnic backgrounds? These are complex and compelling questions. Can we teach students in Minnesota medical schools what pot liqueur is? Of course. Can we give every patient who is sick and vulnerable the courage to press an unfamiliar-looking, assertive, perhaps intimidating physician by asking, "Why can't I get pregnant? Is this same patient more likely to feel comfortable enough to ask a physician who looks and talks like her? These are tougher questions. Clearly, cultural nuances and commonalities are not to be dismissed as factors that might make a difference in a patient's outcome.

An increasing number of citizens and advocacy groups question the necessity, and even the appropriateness, of affirmative action initiatives and programs designed to assist poor children. I believe our profession and our patients benefit from the experiences and strengths of those from a variety of backgrounds, and I sincerely doubt that I would be where I am today without the aforementioned programs. Physicians are challenged to consider the serious implications of blanket elimination of such programs. Can we afford the consequences?

Sheila Roundtree, MD is a staff physician at a VA facility in South Carolina. She is married to Michael Slaughter and is the mother of one child, Elizabeth. Dr. Roundtree is a member of the AMA's Minority Affairs Consortium Governing Committee and is interested in caring for the poor and other underserved populations.

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 452-454.

PERSONAL NARRATIVE

Through the Student's Eyes: Questions about Religion as a Category of Diversity in Medicine

Sam Huber

Considering religious affiliation as a category of difference enhances the expanding discussion of diversity in medical care. However, describing religious diversity as a relevant difference is potentially costly to physician and patient rights. Difficult restrictions may be placed on both physicians and patients to protect expression of religious differences, and the ability of physicians to function as patient advocates may be compromised.

If one goal of increasing diversity in the health care system is to decrease the feeling that a physician doesn't or can't understand the patient, then it is important to look at one of the major ways in which we construct understanding. Religion is such a means, serving to help us figure out what we want to do. In structuring understanding, religious beliefs can act as an important feature of decision making and communication. Distinguishing between right and wrong also applies to how we understand states of health and disease. Furthermore, patients report that they want their physician to ask about religious beliefs in certain situations[1]. In this light, religious differences are differences that matter.

Moral Discrimination?

If religion is a relevant difference, it is important to ask if it is a morally relevant difference. That is, does it deserve a protected and privileged place in medicine, and is it then appropriate to allow people to discriminate on the basis of religion? Under most circumstances, patients are already free to choose a physician and to accept or refuse treatment. Would it be appropriate for a patient to refuse treatment by a particular physician on the basis of that physician's religion? Should a patient's request for a physician of a certain religious affiliation be honored?

Similar questions are in play for physicians. While the AMA's *Code of Medical Ethics* provides that, under most circumstances, physicians are free to choose whom they will serve as patients, physicians are also instructed to be non-discriminatory in many regards[2]. It would seem, then, that it would be unethical for a physician to refuse to treat a patient on the basis of that patient's religious beliefs, but it would be permissible for a physician to set up a practice which is intended to treat only patients of a specific faith.

Special Autonomy?

If respect for religious beliefs occupies a protected position under the auspices of diversity, then do religious reasons warrant increased clout in decision making and treatment negotiation? Do they constitute a special form of autonomy that trumps other reasons? In the balance of patient autonomy, physician autonomy, and physician beneficence, refusal of treatment is already well protected and could not be strengthened by religious beliefs. On the subject of patient requests for otherwise inappropriate treatment on religious grounds, Orr and Genesen argue (without clearly defining "inappropriate") that such requests should usually be honored[3]. The authors contend that religious decisions are more than personal preferences, in that they reflect rational extensions of extrinsic values. When religious reasons are given for seeking inappropriate treatment, Orr and Genesen recommend that physicians engage patients using tenets and principles from the patient's own religion. They further suggest the use of a religious interpreter if necessary in order to "balance the reasons behind the requests" with arguments from the patient's own beliefs. Additionally, the authors invite the difficult situation of physicians telling patients that they (the patients) are wrong about their religious beliefs. This is an inappropriate use of reduction according to religious theory, as well as being at odds with the authors' own premises[4]. Orr and Genesen, using Wreen[5], state that the holder of the belief is more important than its truth state, but then they ask physicians or their interpreters to discover the truth or falsity of the claim. More importantly, this inappropriate use of reduction ends up in a type of "true for me" relativism that dissolves any hope of meaningful conversation in decision making.

Scientists or Shamans?

Who is to win the day when patients request treatment that is not medically indicated in the professional judgment of the physician? Although consensus could be reached on the issue of a treatment that could bring unnecessary risk or harm to the patient, the issue appears murkier if the procedure requested is seen by the physician as neither dangerous nor beneficial. A physician providing a treatment known to be ineffective could be seen as a shaman rather than a scientist. This is even more troubling if the treatment is not associated with appreciable harm. Apart from the idea of medicine as its own type of healing ritual, the identity of a physician may be at stake. To provide a treatment with the expectation that nothing will happen is outside of the limits of scientific medicine. On the other hand, the hope of some sort of placebo-like effect could argue for therapeutic privilege to be invoked in this situation.

What to do?

The above confusion suggests that religious beliefs hold a problematic place in the medical world. That need not be the case. If we ease the imperatives of religious protection and acquiescence to patient-requested treatment, perhaps religion can slide into a more beneficial, less adversarial, and properly integral position in decision making and communication.

Difference matters, and religion is a difference that matters as a general rule. However, in the realm of patient-physician communication, what is important is that physicians recognize that religion is a difference that *might* matter to this particular patient. To do this, physicians must gain comfort with the idea of religion playing a role in decision making. Religious beliefs should be a communication issue, not part of a card game. In a medical setting, the process can be as important as the outcome, so sensitivity is more tenable and beneficial than competency or adversity. Just as it is important for patients to work out their understanding of belief, health, and disease, it is useful for physicians to seek understanding of their own feelings about religion, their beliefs, and their personal relationship to treatment issues. In this model of constructing understanding, the emphasis is on asking the questions, not winning the day or finding the truth.

References

1. Ehman JW, Ott B, Short TH. Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? *Arch Inter Med*. 1999;159(15):1803-1806.
2. Principle VI; Opinion 8.02: Ethical obligations of medical directors; Opinion 9.12: Physician-patient relationship: respect for law and human rights, Opinion 9.131: HIV-infected patients and physicians; Opinion 10.05: Potential patients. In AMA. *Code of Medical Ethics. Chicago*, IL American Medical Association; 2000.
3. Orr RD, Genesen LB. Requests for "inappropriate" treatment based on religious beliefs. *J Med Ethics*. 1997;23(3):142-147.
4. Proudfoot W. *Religious Experience*. Berkeley: University of California Press; 1985.
5. Wreen MJ. Autonomy, religious values, and refusal of lifesaving medical treatment. *J Med Ethics*. 1991;17(3):124-130.

Samuel Huber is a research assistant in the AMA Ethics Standards Group.

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Virtual Mentor
American Medical Association Journal of Ethics
December 2001, Volume 3, Number 12: 455-457.

PERSONAL NARRATIVE

Through the Student's Eyes: Cultural Diversity and the Individual Patient

Erika Fullwood

Diversity. A major buzz word here at the turn of the century. My parents grew up actively fighting racism; I still hear stories of the revolution that was the 60s and 70s. I sometimes wonder if my generation has that same fervor, the same desire to effect change in the world. One certainly cannot say that the battle against racism is over, but my time is one where fostering and accepting diversity has become the prominent social force. I like to think of it as a positive attack on the same problem, taking the offensive and being proactive.

As the nation comes to focus on diversity more and more, people are beginning to have a stronger appreciation for the things that make them unique. They are more resistant to being lumped into groups, and organizational structures have set a dynamic pace in trying to adapt to this increasingly heterogeneous melting pot. Look at education, marketing, and entertainment; evidence for changes in these sectors is readily apparent. Medical education and the practice of medicine have in no way been exempt; if anything, these may be some of the *most* affected arenas.

If medicine were simply the diagnosis of disease and prescription of pills or surgery, the repercussions of these social changes would be mild. Yet we know that so much of medicine is interpersonal relationships and delving into the very private world of our patients. We ask patients to share their daily existence; we ask them to alter their lives, be it diet, exercise, or new ways to reduce stress. Towards the end of life, we ask patients to examine their beliefs, ponder their meaning of life and death, and consider exactly what brings value to their existence. Medicine boils down to two fundamental but crucial topics: communication and decision making; culture plays an overwhelming role in both domains. As the population we care for changes, we must adapt and find ways to connect to those individual issues that will affect the manner in which we provide care for each of our patients.

I often reflect on my development as I complete my medical student training. I strive to be a superb physician, not only one who has expertise within his field, but one who has gained the respect and trust of his patients. Ideally, medical students and physicians would bond immediately with every one of their patients upon entering the room for the first time. There are some patients with whom you feel a kinship, even friendship, and some with whom a bond will never form, except for a mutual and distant respect. This becomes increasingly clear throughout my third year. I happen to be from the city in which I attend medical school, a fact that

sometimes wins me a warmer welcoming from patients. Furthermore, several times a day, I come across a warm smile or an appreciative nod and hello from patients who are not even mine. More often than not, these are African Americans. That connection frequently comes into play when I see African American patients, especially when I am with residents or colleagues of another race. The discussion I have with black patients often has more candor and honesty.

I recall one particular case from my Pediatrics rotation. An 8-year-old African American boy had been in an accident at home and lacerated his right thigh. I entered the patient's room in the ED with my intern. Before introductions could even be made, the patient's mother immediately demanded to know if we were "real doctors" or just in training; she wanted no students "working on her son." I clarified our roles, specifically that I was a student and would simply observe, if that was acceptable (I entered the room with the goal of taking the history and physical, but it was clear that an adjustment was necessary). As the intern began to take the history, out of the corner of my eye, I saw the patient's mother begin to relax and look me over. She smiled and asked where I was from. I explained that I went to high school nearby and have family in the area; the smile widened. She began to ask the usual questions about college and medical school. Soon, I was able to obtain a detailed history from her, while the intern interviewed the child. By the time it came to treatment, the patient's mother wanted to give me, the student she was initially so strongly resistant to, the opportunity to sew her son's complicated laceration. Despite many friendly overtures and attempts to engage in conversation, the intern was never able to gain the same comfort, openness and trust from the patient's mother. Finally, the mother mentioned to me "how nice it is to see an African American face helping provide care for my son."

Do I believe that I, as an African American, will be better equipped to provide care to African Americans in the future? No. It is perfectly natural to be drawn to and comfortable with familiarity. Yet, as students and physicians who care for a broad population, it is our duty to move past those initial barriers to develop a strong patient-physician relationship, regardless of who the patient is. It is not easy, and it takes time.

If culture is a group's set of beliefs and practices, and fostering diversity is embracing the qualities that make each of us unique within those cultural groups, then being equipped to deal with an increasingly diverse environment is just one step beyond cultural competence. We must go forward from understanding the concept of culture to a more sophisticated attempt at comprehending how culture, along with age, sex, education, and a host of other factors come together to create and impact one person, our patient. How do you create culturally competent physicians? Should students arrive in medical school with this skill already? Was it their parents' responsibility? Should this be a concern of medical schools at all? Is it enough to have a "diverse" student body? Should this be a formal part of medical training? Clearly, these answers are in development, and these issues are being evaluated at medical schools across the country. Just as the goal of medical school

is not to teach all of medicine in 4 years, but to provide a firm background and tools with which future physicians can continue to gain knowledge, no medical school should endeavor to create a culturally omnipotent physician either. The school's role is to teach students to respect their patients' individualism, to listen, to ask genuine questions, and to strive to provide equal care to all patients. A good start would be to encourage students to be truly interested in their *individual* patients and to remember that it is a privilege to be a physician.

"Carefully listening while providing comfort and companionship, sometimes referred to as the "sacrament of presence," is often the best medicine we have to offer, and it's exactly what our patients need"[1].

References

1. Larimore WL. Diary from a week in practice. *Am Fam Physician*. 2001;64(3):597-599.

Erika Fullwood is a third-year medical student University of Rochester School of Medicine.

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