

Virtual Mentor

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Caring for a Culturally Diverse Patient Population

From the Editor

- Symmetric Discordance** 199
Audiey Kao, MD, PhD

Case and Commentary

- Cultural Differences at the End of Life** 201
Commentary by Diane Rapaport, MD
- Diagnosis: Inadequate Cross-Cultural Communication** 205
Commentary by Anne R. Su

Medical Education

- Grutter v Bollinger** 208
Susanna Smith

In the Literature

- Race, Genomics, and Health Care** 210
Faith Lagay, PhD
- The Case for Racial Concordance between Patients and Physicians** 215
Jeremy Spevick
- Assessing Affirmative Action in Medical Schools** 219
Michelle Lim

State of the Art and Science

- Reducing the Effects of Low Health Literacy** 222
Faith Lagay, PhD

Policy Forum

- Diversity and the Road to the "Land of Best Care"** 225
Lonnie R. Bristow, MD

Medicine & Society

The ABCs of Empowered Communication: A Community-Based Intervention for Patients

228

Derrel Zeno, Coreen Domingo, Anh Tran, Frank Martin, Kimberly O'Malley, Paul Haidet, Richard Street, and Carol Ashton

Upcoming Issues of *Virtual Mentor*

July: Medicine and Industry

August: Pediatrics

September: Physician Well-Being and Burnout

October: Psychiatry

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FROM THE EDITOR

Symmetric Discordance

Audiey Kao, MD, PhD

In 1973 and 1974, Alan Bakke applied to the University of California at Davis School of Medicine but was denied admission. Believing that less qualified minority applicants had been accepted, Mr. Bakke decided to contest the school's admissions policy in court. The US Supreme Court's decision that followed led to the current legal framework, which guides admission policies in institutions of higher learning. In 1978 the Court ruled in *Regents of the University of California v Bakke* that the UC Davis admissions process was unconstitutional because it used a fixed quota to set aside a portion of each entering class for underrepresented minority applicants. While the Court struck down the quota system as a violation of the Equal Protection Clause of the 14th Amendment that guarantees equal treatment under the law, it upheld the use of race or ethnicity as 1 of many factors that institutions of higher learning could consider in selecting qualified candidates.

Recent federal district court rulings have also taken up the issue of race in higher education, prompting the Supreme Court to revisit their landmark 1978 decision. Earlier this year, the Court heard arguments and is soon expected to rule on a case brought by applicants to the University of Michigan law school and its undergraduate college. Once again, these plaintiffs charge that the University of Michigan unfairly denied them admission in favor of less qualified minority applicants. According to most Court observers, the decision will have widespread impact on institutions of higher education including medical schools.

Proponents of considering race and ethnicity as factors in medical school admissions often cite the importance of a diverse physician workforce in light of an increasingly diverse patient population. They argue, for example, that minority physicians are more likely to work in underserved minority communities, and minority patients are more comfortable and satisfied with minority physicians. The concept of patient-physician concordance that underlies this particular argument for more minority physicians is fundamentally impractical and ethically questionable.

While there are other valid reasons to increase minority representation in higher education including medical school, I do not believe that "symmetric concordance" (eg, the matching of Hispanic patients with Hispanic physicians) is justified. On a practical level, individuals in our society are free to live and work where they please, and it would be naïve to think that we can create communities where symmetric concordance between patients and physicians can exist. Even if we could

manufacture these concordant clinical encounters, where would we draw the line on the list of characteristics that must match before we declared that concordance between patient and physician had been met?

From an ethical perspective, it is too convenient for medical educators and physicians to say that one cannot learn to care for a patient that looks different from and speaks a different language than the caregiver. As professionals, we have to develop and cultivate skills and abilities that allow us to competently and compassionately care for whomever may walk into our offices. As physicians, we must understand the importance and value of creating therapeutic symmetry with our patients especially when we are discordant racially, ethnically, religiously, and perhaps socially.

In this issue of *Virtual Mentor*, we focus on the various challenges and thus opportunities that confront physicians when caring for an increasingly diverse patient population. The learning objectives in this month's issue are:

1. Understand the "concordance" theory, (care for culturally diverse populations demands culturally diverse caregivers), and its critique.
2. Recognize benefits to patients and physicians of culturally responsive care.
3. Recognize the contributors to disparities in use of health services.
4. Learn what physicians can do to improve communication with patients from cultures different from their own.
5. Recognize the role of low health literacy in poor patient compliance and poor health outcomes.

My best,

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

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CASE AND COMMENTARY

Cultural Differences at the End of Life

Commentary by Diane Rapaport, MD

Case

When Dr. Lim entered the room, Mrs. Drake's son and daughter-in-law were there. Her daughter-in-law's chair was pulled up to the bedside and she sat there holding Mrs. Drake's hand, rubbing it gently. Dr. Lim greeted them and then examined his patient.

Mrs. Drake had suffered a moderate stroke 3 years ago. At that time she had difficulty swallowing and was unable to move her right side. She could no longer verbalize sentences and could only communicate by pointing. A feeding tube was placed. Recently she developed a pneumonia secondary to aspiration. After suffering a cardiopulmonary arrest she required continued mechanical ventilation for the past 3 weeks. She was minimally responsive, but did open her eyes to command and was able to squeeze with her left hand.

Mrs. Drake's daughter arrived and, as soon as the 3 visitors had greeted one another, they asked to speak with Dr. Lim outside the room. There, Mrs. Drake's son and daughter said that they thought that continued treatment of their mother was causing her to suffer and asked whether or not the ventilator could be removed. They did not want to give up on her and asked his advice.

Dr. Lim could not help but disagree. He himself was the eldest of 6 siblings. His own mother had had a stroke 8 years prior. He and his siblings had taken care of her throughout the years. She was bed-bound and contracted, nonverbal but awake. His siblings followed his directions regarding the care of his mother. He was the doctor and the eldest. He knew the quality of her life was poor but he could not reconcile her loss.

But the Drakes thought differently. Dr. Lim suggested that Mrs. Drake's son and daughter might feel regret or even guilt if they allowed their mother to die. "We each get only one mother," he said to them. The Drake children had discussed this very point at length among themselves. They had agreed that what their mother was currently experiencing was not life and certainly not life as she had enjoyed it. She had been, until 3 years ago, a vibrant woman, active in the town's Cultural Arts Council and in her church and oftentimes winner of the Yard of the Month in recognition of her imaginative and tireless gardening activities. No, that was not "Mom" in the bed, and it had not been since the first of her strokes. Now she was

just a body, lying there with no hope of getting off the ventilator. They felt conflicted. They thought she would be furious at the thought of living like that. However, they did not want her life to end. Of course, their decision was not an easy one. They had been hoping for confirmation or assurance from the professional in charge of their mother's care. Instead, Dr. Lim said, in parting, "Well, there's time. Why don't you think about it. If you stop her feedings, she will starve. If you take her off the ventilator, she will die. What do you want me to do?"

Commentary

Understanding our own culture, ethnicity, religion, and customs surrounding death and dying can help us as physicians in providing more compassionate guidance and care for a dying patient. Insights into our own attitudes allow us to have our "own stories," our own identities, and help us understand how our personal and family customs support us during difficult and emotional times. Moreover, it is critical to our work as physicians and as caregivers, not only that we think about our own attitudes toward death but also that we learn about our patients' cultures and customs surrounding death.

Looking at our own stories may help us understand our patients' experiences and accept that each person attaches his or her own meaning to death and dying. For instance, for some patients talking frankly about terminal illness is considered inappropriate. Many cultures accept death as a natural part of the life cycle but may not condone open discussions about dying. We might ask ourselves: Does this patient's culture permit autonomy and informed consent? Although this patient is capable of understanding the consequences of health care decisions, is decision-making in this family customarily left to the elder, the oldest male, or the spouse?

We must familiarize ourselves with the customs of our patients in forging a true and trusting partnership with them. Dr. Lim, in our case study, recognizes that this family is not only speaking on behalf of their mother but also making decisions they consider in her best interest by avoiding aggressive therapies that no longer have a likelihood of therapeutic effect.

Dr. Lim, however, may not yet have come to terms with his thoughts and feelings about the possible death of his own parents. Dr. Lim might try to dissect the issue and examine which thoughts apply to this patient and which he might be transferring onto the patient. We should be able to let our own feelings about accepting death for our loved ones be guiding forces to help us talk sensitively about the matter. At the same time, however, it must be acceptable in our medical community to allow our patients' families time to come to a best decision. As physicians we should be comfortable conveying what is the best care we can offer, and we should not be satisfied with simply asking the question "what do you want me to do?"

From a clinical perspective, resuscitation serves a very limited, perhaps negligible, benefit to most patients who suffer from chronic illness. For some patients, the

discussions surrounding a Do Not Resuscitate order or other end-of-life considerations, such as the removal of artificial feeding or mechanical ventilation, provide a sense of relief and allow the patient to have a feeling of control and dignity. They may take comfort in knowing that at the time of death they will not be subjected to battery or other indignities. For others, however, the discussion may lead to a feeling of resignation, or worse, of guilt and loss. For these patients, end-of-life discussions are an added burden as they may feel they are "deciding for death" rather than choosing to maintain dignity.

Families who are "consulted" regarding resuscitation orders for incapacitated loved ones often feel especially pressured by the way physicians frame these difficult decisions. Some clinicians may unknowingly pose the questions in ways that are fraught with burden such as: "Do you want us to feed your mother?" "If your husband stops breathing, should we put a tube in and breathe for him?" "Would you want us to resuscitate your father if his heart stops?" If the family is being consulted about end-of-life decisions, they must be counseled that the issue is not what they want for their loved one, but what their loved one would be willing to endure to prolong life. Perhaps, if families were truly informed of the pain, often without benefit, of most resuscitations and the true discomfort of life on a ventilator they would be more likely to reject these options.

As clinicians we are often bothered by not knowing what we would do in our patients' circumstances and the guilt we feel at unsuccessfully healing a patient. No one wants those they care for to die, neither physicians nor families, yet the true acceptance of an inevitable death is best engineered with a carefully worded, sensitive plan.

The primary clinician should bear the responsibility of collecting the opinions of the consultants and coherently and compassionately explaining why further aggressive treatment may not be a reasonable option in cases where treatment presents, at best, a painful prolongation of life with no clear benefit. The family is best approached with gentle language and genuine acknowledgement of the gravity of the situation. It is unfair and inappropriate to ask, "shall we resuscitate your loved one?" The more appropriate statement would be "in view of the current circumstances, our team recommends that resuscitation, prolonged artificial feeding, or mechanical ventilation should not be offered for the following reasons..."

This approach helps the family feel included in the discussion, appreciate the thought that went into the recommendation, and allay feelings of responsibility for ending the life of a loved one they cherished. Too often, bad decisions regarding prolongation of life with artificial life support are made because the caregiver feels that the decision not to pursue these avenues means they are "giving up." Acceptance of the inevitable end of a terminal illness must not be equated with "giving up." As physicians, we must confront both our own sense of failure when one of our patients is dying--and our own guilt, when we are asked to allow a

family member to die naturally rather than suffer the burdens of technologies that seemingly prolong life without permitting a dignified death.

By heightening awareness of our own cultural influences we become more compassionate caregivers. As physicians we are trained to save lives, to correct metabolic and anatomical derangements, to maintain health, and to give rigorous attention to detail so that we may help "cure" as often as possible. This remains our mission and rightly so, but nothing in our training supplies a structure to comprehend our own attitudes about death. We are left to formulate these insights on our own. If we, as clinicians, continue to think of a patient's imminent death as our own failure, then we are likely to withdraw and place full responsibility for important end-of-life decisions solely on the patient and the patient's family. Without a framework of understanding of what we, our own family, religion, culture, and customs dictate about death and dying, it is most difficult to assist our patients and their families as they struggle with these issues. This deeper understanding should help us forge an impressive bond with our patients and their families. Without it, we may fail our deepest mission, the relief of suffering.

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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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CASE AND COMMENTARY

Diagnosis: Inadequate Cross-Cultural Communication

Commentary by Anne R. Su

Case

Mary (her English name) is a bright, athletic young woman who maintains a high level of physical exercise and training. An exchange student from South Korea, Mary currently lives in Australia with a host family. Several months ago, Mary went to the emergency department with her host mother in a condition of extreme underweight and in a somewhat confused state. The emergency doctor decided to call in the Emergency Psychiatric Service to assess Mary's psychological well-being. Diagnosed as suffering from anorexia nervosa, Mary was kept in the psychiatric ward for 6 weeks where her weight, diet, and emotional state were monitored. During this period, she was extremely compliant with doctors and nursing staff and keen to gain weight. At the time of discharge, an appointment with a specialized counselor was set up to help her through the transition from the hospital back to her host-home environment. During several appointments, the counselor elicited Mary's personal narrative and determined that she was not suffering from an eating disorder at all. Her 6-week hospitalization on the psychiatric ward, the anxiety and fear she experienced, and the concern it caused both her host mother and Korean mother were the unnecessary result of inadequate cross-cultural communication.

Commentary

When Mary arrived in Australia some months ago to live with a host family to better understand English and the Australian lifestyle, her host mother treated her as a part of the family. This included feeding her typical Australian meals such as roast meat, potatoes, cooked vegetables, and fish and chips (the traditional and most popular fast food in Australia). After a while, Mary became constipated. She did what she had always done when feeling ill at home in South Korea—she asked her aunt for advice. Her aunt, who had adopted Mary at an early age, suggested that she take some laxatives. As most Korean children do, Mary followed her parent's advice and started to take the laxative, which she obtained from the supermarket without prescription. At the same time, she continued her intense physical training. As a result, she suffered great weight loss, lack of muscle tone, and general loss of energy. Her host mother became understandably concerned and took her to the emergency department.

As in so many other cross-cultural miscommunications, the problem did not arise from bad intentions. Rather, as life continually teaches us, good intentions do not

necessarily bring about good results. In this case, there is no doubt that everyone involved had Mary's best interests at heart and acted accordingly. Physicians and other medical professionals in the emergency department and Emergency Psychiatry Service acted not only competently but also empathically. They followed guidelines and protocol for assessing, diagnosing, and treating her obvious symptoms. Moreover, to guarantee good communication and overcome possible language and cultural misunderstandings, an interpreter was provided as a part of the service, even though Mary's English was acceptable. The hospital took appropriate measures to keep her in a safe environment, stabilizing and nourishing her until she was able to live back in the community. As a part of outpatient service, a counselor was provided. On the social level, Mary's host mother treated Mary like her own daughter. Mary's "mother" (aunt), thousands of miles away, lovingly advised the use of laxatives to alleviate the discomfort her daughter was enduring.

So, what went so wrong? How did the unnecessary 6-week hospitalization with its associated distress (and cost) occur in spite of everyone's good intentions and actions? What the counselor identified after a number of sessions can be called "inadequate cross-cultural communication." Mary never really liked the food offered by her host mother, though it was wholesome and nutritious. But she never said anything unfavorable about it to her host mother or other members of her host family. Quite the opposite, she appeared to be always appreciative and uncomplaining. We all know it is not polite for a guest to say anything unfavorable to his or her host, and this is especially the case according to the cultural norms and customs in South Korea and other East Asian countries. The same applies to discussions of personal health, which are considered private matters in Mary's culture. She would never think it proper to mention her constipation to her host.

This case teaches a number of lessons. For example, it is crucial for medical professionals to be attentive to patients' personal narratives when diagnosing illness and providing care. Mostly, this case makes an important point about cross-cultural communication in medicine. Cross-cultural issues in medicine and health care are not always as dramatic and obvious as life and death situations. On the contrary, most of them are so basic that they can be easily overlooked. In Mary's case, the problem is captured by the Chinese phrase "*shuitou bufu*" (literally, water and soil not suiting), a situation so common that almost every cross-continental traveler has experienced it. That is, one has some difficulties in acclimatizing or being accustomed to the environment including, if not especially, the food. The experience is so common that, apparently, neither Mary's emergency room physician nor the emergency service psychiatrist asked her whether Aussie food agreed with her.

Anne R. Su is a pseudonym adopted by the authors to protect the identity and privacy of the patient.

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MEDICAL EDUCATION

Grutter v Bollinger

Susanna Smith

Now before the Supreme Court are 2 cases that challenge the constitutionality of considering race as a factor in admissions to professional and undergraduate educational institutions. The 2 cases, *Grutter v Bollinger* and *Gratz v Bollinger*, have been brought against the University of Michigan's then-president Lee Bollinger by 2 white students, Barbara Grutter and Jennifer Gratz, who were denied admissions. Ms Grutter and Ms Gratz allege that the university gives unlawful preference based on race when considering students for the University's Law School and College of Literature, Science, and the Arts, respectively.

These cases, which the Court heard in April 2003, will be decided this month and will likely influence admissions policies of undergraduate and graduate institutions and professional schools nationwide. Because of the decision's probable effect on medical school admissions and the future of certain minorities in the physician workforce, it is worthwhile to examine the arguments.

History

Ms Grutter, a white Michigan state resident, applied to the University of Michigan's Law School in December 1996 for admission to the fall 1997 first-year class. Ms Grutter, who was 43-years-old at the time of her application, had graduated from college with a 3.8 grade-point average (GPA) and submitted a LSAT score of 161, placing her in the 86th percentile of LSAT test-takers nationally. Ms Grutter was placed on a wait-list for admission in April 1997 and in June denied admission to the Law School for fall 1997. Ms Grutter brought suit against that University of Michigan and, in March 2001, Federal District Court Judge Bernard Friedman found the law school's race-based admissions policy unconstitutional.

Summary of the Plaintiff's Argument

The plaintiff's (Grutter's) case has 4 main arguments, as follows.

1. The consideration of race in the admissions process is inconsistent with the Equal Protection Clause of the 14th Amendment, which protects against discrimination on the basis of race. Although the Court has in the past allowed for race to be a consideration as a remedial action (i.e., affirmative action), the University of Michigan's stated objective of race-conscious admissions is to create a diverse student body, not to remedy past or present discrimination as was allowed for by the court in *Bakke*.

2. Race-conscious admissions policies must be temporally limited, that is narrow in application and with a foreseeable endpoint. Otherwise, affirmative action policies on the basis of race will contribute to an attitude of racial inferiority and hostility among those it is designed to help. While racial and ethnic diversity in the university setting is valuable, an interest in diversity is simply too indeterminate, open-ended, and unbounded by ascertainable standards.¹ At the University of Michigan there is not only no foreseeable endpoint to the university's policy, but achieving racial diversity has become an end in itself rather than a temporary means to the end of righting past discrimination and achieving greater racial and ethnic equality. If this policy is allowed to continue it would provide permanent justification for race-conscious policies.

3. The University of Michigan has not justified the policy's goal—diversity in the student body—by assessing or measuring the educational benefits. The university did not present evidence to quantify the amount or type of diversity that is needed to derive a greater educational benefit. Such restriction of some individuals' 14th amendment rights to equal treatment requires a reasonable presentation of the state's overriding interest in diversity.

4. The university employs "impermissible stereotyping" in its assumption that students of particular racial or ethnic backgrounds will bring "diversity" to the campus. If the university wishes to include the experiential outlook of particular minorities, it should seek to employ race-neutral admissions policies that examine a student's life experience. The district court, which first heard and decided the Grutter case, found that the Law School had failed to consider race-neutral alternatives when crafting its admissions policy. Even if the Court finds race-conscious admissions policies acceptable in some form, it should find the University of Michigan policy unacceptable because this particular policy falls into the category of a quota (outlawed in 1978 by the Supreme Court in *Bakke*) by designating a percentage range of each first-year class for underrepresented minority students.

The University's Case

The University's main arguments are as follows:

1. It does not violate the Equal Protection Clause because it selects students both by their academic achievements and their likely contribution to the campus diversity. The University of Michigan policy does not use a quota system and is not significantly different from the Harvard plan that the Court approved in the *Bakke* case. The flexibility in the acceptance criteria and the range of percentage of minority enrollment, 11 to 17 percent, is an argument against labeling the admissions process a "quota system." Some minority students who are accepted have lower LSAT scores and GPAs than the majority of other accepted students but these students also graduate, become successful lawyers, and are offered judicial clerkships just like nonminority students.

2. The law school has a role in training leaders and must prepare leaders of all races and ethnicities. Without a system of race-conscious selection, the university could not have meaningful numbers of students from particular minority groups in the law school and such a policy could be equated to resegregation. A multi-racially diverse campus is necessary to create significant interaction between minority and nonminority students, to foster interpersonal growth and an environment of mutual respect, and to promote the responsible practice of law.

3. A few students of particular minorities, such as African American and Hispanic students, would be accepted without a race-conscious policy. But these few minority students would feel isolated and like token spokespersons for their race. Minority group members must be present in meaningful numbers constituting a "critical mass" to offer the educational benefit of diversity to all the students on campus.

4. Although the University of Michigan itself does not have a history of discrimination, significant discrimination remains in society and must be remedied by higher education institutions; otherwise some professions such as law will be closed to certain minorities. Doing away with race-conscious admissions in higher education might threaten the coherence and stability of our society and the public faith in the institutions of law and law enforcement by preserving "segments of the bar and bench ...for white graduates trained in isolation from the communities they will serve." ²

Analysis

The Court's decision will have wide-reaching effects if it actually makes a statement regarding the constitutionality of considering of race in admissions policies for higher education. It is possible that the Court will find the University of Michigan's policy is unconstitutional because it is a form of a quota. Such a ruling would force the University of Michigan to reconsider its policy but would still leave unanswered the question of whether it is unconstitutional to consider race in university admission policies.

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1. 123 S Ct 1777. Brief for the Petitioner. Accessed May 31, 2003.
2. Grutter v Bollinger. 123 S Ct 1777. Brief for the Respondents; 37. Accessed May 31, 2003.
3. Susanna Smith Is a research assistant in the AMA Ethics Standards Group.

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IN THE LITERATURE

Race, Genomics, and Health Care

Faith Lagay, PhD

The *New England Journal of Medicine's* Sounding Board feature was recently devoted to examining opposing views on the usefulness of race as classification in medical research and treatment.^{1,2} Investigators agree that among the 3 types of factors that influence disease prevalence and response to drugs—genetic, environmental, and cultural—genetic factors play the largest role. But, and here's the specific question the articles debate, are the genetic differences that correlate with disease prevalence and drug response distributed across the human population groups we traditionally call "races" in such a way that knowing a person's race provides useful information about his or her susceptibility to certain diseases or probable response to drug therapy? One group of authors puts the question this way: "To what degree does genetic variability account for medically important differences in disease outcomes among racial and ethnic groups"?³ The exchange of viewpoints on this question is instructive, most strikingly, perhaps, as an example of how researchers in the same field, with access to the same studies and findings, can draw opposing conclusions and support them credibly.

The first Sounding Board article, by Cooper, Kaufman, and Ward, argues that race has not been shown to be helpful in categorizing genetic determinants of disease prevalence and response to drugs and is especially poor in predicting susceptibility of a given, individual member of any race to a specific disease or drug response. The authors of the second article, Burchard, Ziv, Coyle, et al, disagree. They say that the relevance of race and ethnicity is "readily apparent" for mendelian disorders (ie, single gene disorders that behave according to dominant-recessive laws of expression), citing as an example hemochromatosis, "found in all European groups and in especially high frequency . . . in northern Europeans, but . . . virtually absent in nonwhite groups."³ The genetic determinants of non-mendelian, complex disorders are less well understood, but, according to Burchard et al, examples do exist that demonstrate clinically important racial and ethnic differences in the frequency of genes involved in complex disorders.³

The first matter both sets of authors must settle upon is a definition of "race," a definition that is becoming less contentious as time goes on. Most evolutionary biologists now agree that the group of modern day humans (*Homo sapiens*) that began to migrate out of Africa about 100,000 years ago were members of a single, interbreeding group. And, by that time in *Homo sapiens* history, most of the variation present in the human genome of today had already occurred. Because

most genetic variation occurred before the human tribe scattered across the globe, most every genetic variation occurs within every population group that subsequently became known as a race.⁴ Some variation occurred after migration, however, due to the environmental pressures of the climates in which different groups eventually settled. These differences are closely related to climate and environment, which accounts for the fact that the designation "race" is now given, essentially, to 5 groups of humans that adapted to 5 different continental areas and climates: Asia, Africa, Europe (white), Pacific Islands, and the North and South American continents (American Indian and Alaskan native).¹⁻⁴ Hence race can be defined most accurately and succinctly as "a subdivision of the human population that is characterized by specialization to [a] different environment."⁵ To summarize, humankind left Africa having already acquired most of the genetic variation that we see in humans today. Then, climatic pressures (eg, how much or how little sunlight was available) gave advantage to certain genetic mutations (eg, a change in amount of skin pigment), allowing individuals with specific characteristics to thrive in that particular climate and produce offspring that also survived. Eventually, the physical characteristics best adapted to survival on a given continent gained predominance among members of that continental group. According to Burroughs, Maxey, and Levy, those visible physical adaptations that lead us to assign individuals to various races have little relevance to the health effects that are of interest to pharmacogenetics.⁴

This agreed-upon definition of race sets up the research question: Is there a meaningful connection between membership in a continental group known as a race and an individual's susceptibility to given diseases or response to given drugs? And, are these questions worth investigating? Cooper et al say "no" to both questions. "Race," they say, "at the continental level, has not been shown to provide a useful categorization of genetic information about the response to drugs, diagnosis or causes of diseases."⁶ Moreover, they argue, use or misuse of research findings might cause increased bias against members of certain continental population groups (the term Cooper et al prefer to "race"). Past use and common understanding of the term race have connotations that cannot be separated from the narrow way in which the term might properly be applied. Scientists must be mindful of the fact that "science is part of society," and knowledge of the purposes to which their findings might be put must guide their research endeavors. Cooper et al imply, in sum, that the science of genomics should not attempt to trace the distribution of genetic variations in ways that support the "socially defined use of race."⁷ This may be a valid ethical reason for not investigating medically useful connections between genetics and race, but it seems out of place in an argument that claims there are no medically useful connections between the two. It is unlikely that research into these connections would continue for long without the promise of a better (and, hence, more profitable) drug therapy as a goal.

Burchard et al argue strenuously against the view held by Cooper et al. Burchard et al contend that certain "clusters" of genotypes are associated with the major branches of human population known as races and that these race-related genotype

clusters have significance for health and medical treatment.³ In one section of their report, the authors warn of the risks of ignoring race in biomedical research and clinical practice. It is well known, they say, that both disease prevalence and response to drugs differ among racial and ethnic groups. If we do not study genetic differences among these groups, the authors say, we will not be able to identify what contributes to the disparities in prevalence and drug reaction that we know exist. Moreover, they say "if investigators ignored race and ethnic background in research studies and persons were sampled randomly . . . minority populations would never be adequately sampled."⁸ Of course, if Cooper et al are correct, it would not matter that members of minority populations were not adequately sampled.

The work of Burroughs, Maxey, and Levy, also cited above, supports the arguments of Burchard et al. Writing in a special supplement in the *Journal of the National Medical Association* in 2002, these authors conclude that significant genetic differences exist "among racial and ethnic groups in the metabolism, clinical effectiveness, and side-effect profiles of many clinical drugs."⁹ After providing many examples of race- and ethnicity-related differences in response to cardiovascular drugs and nervous system agents, the authors conclude that therapeutic substitution in drug formularies puts members of certain racial and ethnic groups at risk and that significant numbers of patients who are members of these groups should be included in drug metabolism studies and clinical trials.¹⁰

The 3 articles discussed here agree on a couple of points, one being the use of the term "race" to refer to the human population groups that settled in 5 major continental land masses, each remaining isolated from the other 4 groups long enough to develop distinguishing predominant physical characteristics. They also agree that gaining information about the distribution across racial and ethnic groups of gene-related disease prevalence and drug response is an intermediate step. While this information may prompt a physician to ask certain diagnostic questions or begin therapy at a given dosage, the information is not predictive of how an individual patient will react and cannot be applied across the board to all patients who declare themselves members of a given race or ethnicity. When we can routinely and inexpensively obtain each individual's genotype as we now obtain his or her blood type, the biological designation "race" will be of little interest in medicine. Then physicians can concentrate on the cultural and lifestyle differences among patients that interact with genetic contributors to health outcomes.

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IN THE LITERATURE

The Case for Racial Concordance between Patients and Physicians

Jeremy Spevick

Proponents of affirmative action in medical school admissions often argue that enrollment should reflect the diversity of society. Often not stated explicitly, an underlying assumption of this argument is that, given a choice, people prefer to go to physicians of their own race. With an ever-increasing number of minority patients, this argument suggests that more minority physicians are needed so minority patients can choose to see a physician of their own race.

Professional organizations in medicine, such as the Association of American Medical Colleges and the American Medical Association have articulated the benefits of racial diversity in the physician workforce.¹ The theory forwards 3 possible benefits to public health of an ethnically and culturally diverse physician workforce. First, literature has shown that minority doctors are more likely to treat minority patients,² who often live in underserved areas. Augmenting the number of minority physicians may result in more health care resources going to those most in need. Racial concordance, which is made possible by having a diverse physician population, may promote greater physician understanding of the social, cultural, and economic factors that influence their patients. This understanding fosters trust and communication, 2 elements essential to an effective patient-physician relationship.¹ Racial diversity may also help direct medical research into more diverse areas. Problems perceived by researchers influence the direction that research follows, and, as a result, ethnic diversity may help advance research in areas where it is currently lacking.

As the Supreme Court considers the Michigan Law School case, the policy of achieving diversity in professional school admission, which allows for concordance between attorney and client (in the Michigan case) or patient and physician (in the case of medical schools), is under more debate than ever. Is it true that patients who have a choice of health care providers will seek out one of their own ethnic background? Are patients with a racially concordant physician more satisfied with their medical care than others? These and other similar questions have been the subject of many studies over the past 3 years. The results seem to support the assumptions of the racial concordance theory, a result that may have several policy implications.

In the September 2002 issue of the *Journal of Health and Social Behavior*, Thomas Laveist and Amani Nuru-Jeter tell of their work to determine whether racial

concordance is associated with a greater satisfaction in care.³ They used data from the 1994 Commonwealth Fund Minority Health Survey of 2720 people who had a regular source of health care. The ethnic breakdown within this group was 910 white patients, 745 African American patients, 676 Hispanic patients, and 389 Asian American patients.

Respondents to this phone survey were asked to classify their own race, the race of their physician, and whether or not they had a choice in selecting their physician. Patients then rated, on a scale of 1, poor, to 4, excellent, the degree to which their physician had: provided quality health care, treated them with dignity, made sure they understood what they were told, and listened to their health problems.

Among several interesting conclusions, Laveist and Nuru-Jeter found that people who could choose their doctors were significantly more likely to be race concordant with that doctor than those who could not choose. This finding applied to all ethnic groups. With the exception of Asian Americans, all other groups were most likely to have a white physician. The other major finding of this study was that respondents of each racial group reported the highest level of satisfaction with their physician when they were racially concordant.^{3, 4}

A number of other studies have examined different aspects of the concordance theory. In 1999, Cooper-Patrick et al examined the extent to which patients were involved in their medical care.⁵ More than 1800 respondents were asked to rate their physician's participatory decision-making (PDM) style on a scale of 1-100. Although gender concordance between doctors and patients was not significantly related to PDM score, the researchers found that patients in race concordant relationships rated their visits as significantly more participatory than patients in race discordant relationships. This study adjusted for patient age, gender, education, marital status, health status, and the length of the patient-physician relationship.

In November of 2000, Mark Doescher et al examined whether ethnicity was associated with patients' trust in their physicians.⁶ Respondents rated trust by assessing whether their doctors put patients' needs above their own and referred them when necessary and to what extent their doctors were influenced by insurance rules. Although the study did not identify the race of the patient's physician, conclusions were that, after adjustment for socioeconomic factors, minority group members (Latinos and African Americans in this study) reported less positive perceptions of their doctors than did white respondents. Considering that Latino and African American physicians make up only 3.5 percent and 2.6 percent of the physician population.⁷

One common objection to the concordance theory is that patients may see doctors of their own race not because they feel these doctors can better relate to them, but because minority doctors tend to be more conveniently located in minority communities. Although it is still debated, Saha et al found in 2000 that African

Americans and Hispanics chose racially concordant physicians because of personal preferences, not solely due to geographic accessibility.⁸

The literature seems to indicate that patients from minority populations tend to prefer physicians of their own race. More research is needed to examine the reasons for this preference. Different answers to this question would suggest different policy options. Laveist and Nuru-Jeter propose 3 hypotheses to explain the preference for racially concordant patient-physician relationships. The first is that patients feel more comfortable with doctors of the same race. In this scenario, there is an intrinsic feeling of connectedness amongst members of the same racial group, which can lead to more trust. The policy implication of this hypothesis would be to continue efforts, such as affirmative action, to increase ethnic diversity in the medical field. A second hypothesis is that the preference for racial concordance stems from negative attitudes people have about members of other ethnic groups, "the internalization of broader societal racism."⁹ Under this hypothesis, solutions lie with continued social reforms that promote racial tolerance. The final hypothesis is that current attitudes about racial concordance are based on past experiences. For example, a patient may have had a particularly good visit with a physician of his or her own race in the past and generalizes from this experience that the concordance was responsible for the satisfactory visit. This experience influences the patient's future preferences. Assessing the impact of this hypothesis involves looking at how nonminority doctors are educated to improve their cultural awareness and responsiveness.

While it is becoming accepted that patients are generally more satisfied with their medical care when they have a racially concordant patient-physician relationship, the reasons for this are not understood. Exploring each of the proposed hypotheses will be very important in helping set educational and social policy and settling the debate over affirmative action admissions policies in medical schools.

Questions for Discussion

1. Which of the 3 hypotheses on why patients prefer a racially concordant physician do you find most convincing?
2. Which do you believe contributes more to the prevalence of racially concordant patient-physician relationships: patient preference or geographic accessibility of minority physicians? Why?
3. Can "cultural competence" be taught in medical school, or will there always be social and cultural subtleties that only members of the same ethnicity share?

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IN THE LITERATURE

Assessing Affirmative Action in Medical Schools

Michelle Lim

In December 2002, the United States Supreme Court accepted 2 cases, *Gratz v Bollinger* and *Grutter v Bollinger*, that take up the use of race and ethnicity as factors for consideration in admission to the University of Michigan's undergraduate program and law school, respectively. The Court is expected to make a momentous decision this month regarding the constitutionality of using racial preferences in admissions policies, a decision that could affect admissions policies in all forms of higher education including medical schools.

Dr. Jordan J. Cohen, current president of the Association of American Medical Colleges, defends the continuation of affirmative action admission policies in a recent *JAMA* article. *The Consequences of Premature Abandonment of Affirmative Action in Medical School Admissions*.¹ He argues that affirmative action in medical schools remains necessary at this time to educate an ethnically and racially diverse physician workforce. He offers 4 reasons why diversity is important and states that medical schools have an obligation to select and educate a future physician workforce that can respond to a diverse patient population and to society's evolving health care needs.

With a growing minority population in the United States, medical schools must select and train an ethnically diverse physician workforce to better understand how individuals from different cultural backgrounds interpret and experience illness and disease. Medical students need more than textbook and classroom learning to grasp how cultural factors influence patient care. Cohen states that diversity among students and faculty is indispensable in offering quality medical education where students interact with mentors, peers, and patients of diverse racial, ethnic, and cultural backgrounds and varying worldviews. He firmly believes that prohibiting admissions committees from using affirmative action admissions policies is likely to set up medical schools--and future physicians--for failure in fulfilling their contract with society.

Cohen stresses that a racially and ethnically diverse physician workforce is critical to improving access to care and widening the scope of medical research with minority populations. In his article, Cohen cites several sources, which document that underrepresented minority (URM) physicians are more likely to devote their careers to working with underserved and uninsured populations. He also suggests that because investigators tend to research problems they have observed or

experienced within their cultural sphere, universities must ensure diversity in their MD and PhD programs to advance and broaden research in medicine and public health.

Another reason for supporting affirmative action, in Cohen's opinion, is that it makes good business sense to create diversity among managers of health care organizations. He suggests that a diverse group of physician leaders and managers may better anticipate the needs of and deal effectively with individuals from a wide variety of backgrounds and, thus, ensure the success of the organization that they direct.

Cohen believes the best way to achieve the above-mentioned goals is through affirmative action admissions policies. Without these policies, the proportion of URM applicants (African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans) will drop, as happened during the late 1990s when a series of court and legislative activities (ie, California's Proposition 209, *Hopwood v Texas*, Initiative 200 in Washington state) outlawed schools from giving any consideration to the racial and ethnic backgrounds of their applicants.

URM applicants often have lower GPAs and MCAT scores than their white and Asian American counterparts and have less chance of being admitted on academic credentials alone. Cohen points out, however, that "to be more qualified than someone else for admission to medical school is not simply a matter of having higher grades or MCAT scores."² Admissions committees also scrutinize applicants for less quantifiable qualities such as evidence of leadership, overcoming adversity, capacity for hard work, commitment and willingness to serve others, particularly the underserved, and ability to communicate effectively. Cohen stresses that, over the years, admissions committees have become adept at selecting highly qualified minority applicants who have less than stellar GPAs and MCAT scores. He further adds that there are several assessments during medical school that minimize the possibility of awarding a medical degree to an unqualified individual.

In his support of affirmative action, Cohen acknowledges critics of affirmative action who argue that the acceptance of minority students with lower academic credentials is a form of racism and contend that only by maintaining equal standards for all will minority students, over time, excel on their own. While Cohen admits the possible validity of this theory, he believes that it calls for an unrealistic "rapid reversal of deeply rooted societal and cultural norms" to close the diversity gap in medicine.³ He suggests that removing race-conscious admissions policies requires remedying unequal educational opportunities, eliminating cultural disparities, significantly reducing economic barriers, and removing more subtle forms of discrimination. He further asserts that other alternatives such as "percentage plans," in which every high school's top graduates are guaranteed college admissions, and other surrogate markers such as living in a low-income zip code, coming from a disadvantaged family background, having overcome adversity,

or expressing a willingness to serve the underserved simply do not guarantee the intended outcome of achieving racial and ethnic diversity.

Although Cohen admits that, ideally, race would not be a consideration in medical school admission, he supports race-conscious admissions policies as the best answer to the need for diversity among students in medical education at present.

Questions for Discussion

1. Do you agree with Cohen's 4 reasons for ensuring diversity in medical schools?
2. Do you think that affirmative action admissions policies are the only means of achieving such diversity?
3. Cohen suggests that the abolishment of affirmative action would be premature. At what point (if any) would it be appropriate to consider outlawing affirmative action? How would we assess when that point has or will be reached?
4. Do you agree that affirmative action actually reinforces racism by suggesting that URM students need a more lenient set of qualifications?

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STATE OF THE ART AND SCIENCE

Reducing the Effects of Low Health Literacy

Faith Lagay, PhD

According to the National Adult Literacy Survey, nearly half the US population is either functionally illiterate or marginally literate. Members of these groups are limited in their ability to read and understand text and are unable to write, for example, a brief letter explaining an error in a bill.¹

Such widespread limited literacy has special significance for physicians and other health care professionals. Low literacy and, specifically, low *health* literacy—the term that refers to a patient's ability to understand common health care communications, such as prescription instructions, test results and insurance forms—affects adherence to treatment that, in turn, may affect treatment outcomes. Studies show, for example, that among surveyed patients, 28 percent did not know when their next appointment was, 42 percent did not understand the instruction "take medication on an empty stomach," and 86 percent could not understand the rights and responsibilities section of a Medicaid application.²⁻⁴ Low health literacy can also discourage patients from attempting to seek health services. In fact, literacy is the single best predictor of health status, correlating more closely with health status than age, income, employment status, education, or race and ethnicity.⁵⁻⁸

For several years, reducing the health effects of low health literacy has been a priority of the American Medical Association Foundation and the American Medical Association. Their recently produced health literacy kit, entitled *Help Your Patients Understand*, places responsibility for patients' understanding squarely on the shoulders of health professionals. The kit contains a comprehensive manual for clinicians; a video documentary about low health literacy; a CD-ROM with digital files of the manual, video, and presentation hand-outs; a physician questionnaire that can be used to obtain Category 1 CME credits; patient literature and buttons for office staff; and additional resources for education and involvement.

From the AMA Foundation and AMA health literacy kit's comprehensive manual, *Health Literacy: A Manual for Clinicians*, here are (1) a checklist for patient-friendly office procedures and (2) 6 steps to improved interpersonal communication with patients.

Checklist for Patient-friendly Office Procedures⁹

1. Exhibit a general attitude of helpfulness.
2. When scheduling appointments,

- a. Have a person, not a machine, answer the phone.
 - b. Collect only necessary information.
 - c. Give directions to the office.
 - d. Help patients prepare for the visit: Ask them to bring all their medications and a list of questions.
3. Use clear and easy-to-follow signage.
 4. Ask staff to welcome patients with a general attitude of helpfulness.
 5. During office check-in procedures,
 - a. Provide assistance with completing forms.
 - b. Collect only essential information. Provide forms in patients' languages.
 - c. Provide forms in an easy-to-read format [eg, large print, uncrowded on the page].
 6. When referring patients for tests, procedures, or consultations,
 - a. Review the instructions.
 - b. Provide directions to the site of referral.
 - c. Provide assistance with insurance issues.
 7. When providing patients with information,
 - a. Routinely review important instructions.
 - b. Provide handouts in an easy-to-read format.
 - c. Use nonwritten modalities, eg, diagrams and pictures.

Six Steps to Improving Interpersonal Communication with Patients¹⁰

1. Slow down. Communication can be improved by speaking slowly and by spending just a small amount of additional time with each patient. This will help foster a patient-centered approach to clinician-patient interaction.
2. Use plain, nonmedical language. Explain things to patients as you would explain them to a family member.
3. Show or draw pictures. Visual images can improve the patient's recall of ideas.
4. Limit the amount of information provided, and repeat it. Information is best remembered when it is given in small pieces that are pertinent to the tasks at hand. Repetition further enhances recall.
5. Use the teach-back or show-me technique. Confirm that patients understand by asking them to repeat back your instructions.
6. Create a shame-free environment. Make patients feel comfortable asking questions. Enlist the aid of others (patient's family, friends) to promote understanding.

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POLICY FORUM

Diversity and the Road to the "Land of Best Care"

Lonnie R. Bristow, MD

How to achieve the goal of *best care* for every American? Consider these facts: in the year 2000 African Americans comprised 12.9 percent of the US population but only 2.5 percent of our nation's physicians, and only 7.7 percent of the pool of applicants to medical school. Some groups fared even worse. While Mexican Americans, for example, made up 7.3 percent of the US population, they comprised only 1.9 percent of the medical school applicant pool. The US Census Bureau projects that by 2050, more than 40 percent of the US population will be people of color. At present, the burdens of illness and their attendant costs fall disproportionately on those populations that have minority status in the United States and that are likewise underrepresented throughout the health professions. This is more than pure coincidence.

How does increasing the diversity of US health professionals figure into the equation of *best care* for *all* Americans? This question spans the entire spectrum of all health professionals, not just physicians. The short answer—diversity amongst the caregivers is not only the right thing to do; it's also very much the smart thing to do. America is fighting to maintain its leadership position in a global economy. To compete effectively, we will need optimal health for our workforce. Those burdens of illness, injury, and disability, with their attendant costs, must be reduced to the barest minimum possible for all Americans, if we are to achieve and maintain maximum productivity for our nation.

In its 2001 report, *Crossing the Quality Chasm*, the Committee on Quality of Health Care at the National Academy of Sciences' Institute of Medicine declared that our nation should adopt 6 aims for health care for all Americans. I think of them as being the readily measurable parameters of quality; in effect, they are the dimensions of true quality. The care Americans receive should be safe, effective, patient-centered, timely, efficient, and equitable. The centerpiece is the patient-centered dimension. Too often health care focuses on the needs of the hospital, the caregivers themselves, the intermediary payers, or some corporate entity or part of the government. Patient-centered means the care should be designed and produced to meet the needs and wishes of the patient, not only those needs dictated by science but also those emanating from the unique cultural perspective of that person. Every American should have access to culturally competent care if that care is to be truly patient-centered.

Achieving the long sought goal of *best care* for every American, unarguably, makes good moral sense. Having a healthy national workforce also sharpens our competitive edge, but what role does diversity play? It can be said that diversity is an essential element but not sufficient by itself, to achieve cultural responsiveness in any medical interaction. Significant increases of diversity in the medical and health care professions would demonstrate that there's more than just talk in our claim to respect the richness and contribution of all cultures. It's difficult to make the case that we value all cultures if, *de facto*, the dominant "majority" monolithically excludes others from the full range of opportunity America has to offer.

Perhaps more important than what the dominant culture offers all others is what those cultures contribute to our mutual goal: *best care* for every American. For diversity to make its maximal contribution, however, it must embrace the opportunity for exploration, and exploitation in a creative way, of some of the cultural differences that a diverse group of individuals brings to the table. There is often more than one way to attack a problem. I strongly believe that people of different ethnic and cultural backgrounds often bring different problem-solving skills and techniques to a given problem. Having several creative ideas can often prove better than a monolithic approach. The whole really is greater than the sum of its parts--but only if it is allowed to function interdependently as a true whole, rather than simply a collection of parts.

Diversity and Creative Thinking

The business sector seems to reflect the benefits of a diverse workforce. A 1998 survey of over 1000 managers and executives of American companies by the American Management Association (whose member companies make up about 25 percent of the American workforce), showed that where the senior management of a corporation had great "heterogeneity" (referring to a mix of genders, ethnic backgrounds, and ages), there was a consistent correlation with superior corporate performance, as compared to corporations in the same industry group which had traditional "homogeneity." Such companies are evidently more productive and more creative, which translates into better bottom lines for their stockholders. Logic cries out that the same circumstances should apply well in health care. Different problem-solving skills should lead to more creative thinking about clinical and research problems, patient satisfaction, and cost containment. *Everybody* benefits from this type of problem solving, not simply minority groups.

Diversity, then, is an essential component for culturally responsive care, which, in turn, is vital to achieving *best care* for all Americans. Achieving greater diversity in all health profession education *is* truly the smart thing to do.

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MEDICINE AND SOCIETY

The ABCs of Empowered Communication: A Community-Based Intervention for Patients

Derrel Zeno, Coreen Domingo, Anh Tran, Frank Martin, Kimberly O'Malley, Paul Haidet, Richard Street, and Carol Ashton

Health disparities continue to exist despite improvements in health care delivery and access. Even when access to care, diagnosis, and severity of disease are the same, members of different racial and ethnic groups tend to use preventive and diagnostic services at different rates. This suggests that the emerging disparities are occurring within the context of the medical interaction between physician and patient. Given that patient-physician communication is a significant part of the medical interaction and has been shown to affect health outcomes, patient satisfaction, and adherence to treatment recommendations, evidence suggests that noted disparities might largely be a result of communication difficulties within the medical interaction.¹

Based on these findings, researchers from the Houston Center for Quality of Care and Utilization Studies designed a communication intervention to improve the patient-physician interaction. The results of these efforts yielded a patient-centered community education intervention, the *How to Talk to Your Doctor* (HTTTYD) program. Grounded in effective communication theory, this educational forum empowers patients to become their own best advocates in the medical interaction by teaching them the skills necessary to successfully negotiate optimal medical care through proactive participation with their physicians and other caregivers.

The program is structured around 3 central premises: (1) patients who are active communicators achieve better health outcomes; (2) it is less resource-intensive to effectuate change in a patient's communication style than in a physician's; and (3) ethnically diverse populations often have a more pronounced need for effective communication interventions. Purposefully developing the program as a community-education intervention rather than a clinical-education intervention facilitates a broader reach. For this reason, it is able to encompass diverse patient populations who routinely need medical care, including disease-specific support groups (breast cancer survivors), the elderly, and various community health center patients.

The program is a 2-hour community education forum, intended for small audiences, ranging from 20 to 40 participants. To ensure that both sides of the patient-physician interaction are presented, 2 trainers, typically a physician and a non-

physician, staff each forum. The forum is organized along 4 main learning objectives or discussion topics: (1) recognition of barriers to good patient-physician communication; (2) recognition of examples of effective patient-physician communication styles; (3) application of strategies presented in the forum for improving communication in the medical interaction; and (4) recall of good patient-physician communication strategies.² To promote participants' understanding and active participation in the forum, each participant is given a 20-page, fully illustrated HTTYD guidebook (available in English and Spanish) organized along the 4 main learning objectives outlined above.

After completion of the consent process and a pre-intervention survey, the co-trainers lead the participants through the 4 main learning objectives. As a means of facilitating an understanding of barriers to good communication, participants are asked to share out loud some of the difficulties that they have encountered in communicating with their physician(s). These responses are recorded on a flip-chart and bring about a lively discussion as participants quickly realize that they are not alone in their difficulties and that their concerns are the same or similar to those experienced by the participants at-large. A recognition of communication barriers facilitates a simultaneous recognition of effective communication styles and naturally segues into the second learning objective, that of understanding different communication styles and identifying good communication strategies in the medical interaction. In this section, trainers lead a discussion on patient and physician roles in the medical interaction and help the participants to translate this information into an understanding of the potential impact of these roles on their respective communication styles. Mediated by an understanding of the context of these communication styles, participants are guided through the third learning objective; that of strategizing and applying communication techniques learned during the forum. Specifically, the 3 *ABC* tips suggested are: (a) *Ask* questions in order to receive information, (b) *Be* prepared for the appointment, and (c) *Communicate* and express health concerns. The fourth and final learning objective presented is that of practicing tips for good patient-physician communication. This objective is accomplished by the trainers role-playing a patient-physician interaction, which the participants are then asked to evaluate in light of the previous 3 learning objectives. The script is then reenacted using the suggestions of the participants. After a brief review of the main points of the HTTYD program, the trainers entertain participant questions. The forum concludes with a post-survey.

Using a pre-post survey format to determine the effectiveness of the HTTYD program, researchers collected data from 7 different sites in the greater Houston metropolitan area over a 9-month period (June 2001 – February 2002). The pre-survey comprises demographic questions including age, education, gender, income, race/ethnicity, and current employment status. The pre-survey also includes questions from The Patient Confidence in Communication Scale³ (Table 1). The post-survey includes questions relating to the quality of the forum, materials used, and participants' sense of self-efficacy following the forum.

Descriptive statistics were compiled on the demographics of 110 participants who consented for inclusion in our study. Of the 110 participants 75 percent were women. The age range was 20 to 91 years, with an average age of 51 (± 18.3). The majority of the participants were African American (52 percent), followed by White (24 percent), Hispanic (20 percent), Asian Indian (<1 percent), and Vietnamese (<1 percent). Sixty-one percent of the participants reported some college education, 55 percent reported full-time employment, and 35 percent reported their general health as "very good" or "excellent."⁴

An exploratory factor analysis was conducted on the Patient Confidence in Communication Scale (PCCS) items. The analysis provided evidence that 1 factor formed the basis for the 7 items. The item variance, accounted for by this single factor, at pre- and post-intervention, was 53 percent and 52 percent, respectively. Also, communalities ranged from .59 to .83 at pre- and post-intervention, respectively. The internal consistency of the items at pre- and post-intervention was .84 and .83, respectively.⁴

Results of the repeated measures ANOVA for the effect of time revealed statistical significance ($p = .001$) in participants' mean confidence levels from pre- to post-intervention. Testing for the effect of group also revealed statistical significance ($p = .001$) in mean pre- and post-intervention PCCS scores of the participants. However, testing for the group by time interaction was not statistically significant ($p = .09$). More specifically, the mean pre-post intervention improvement was not statistically different for participants at the 7 sites.⁴

Table 1
Patient Confidence in Communication Scale (PCCS)

No.	Item
1.	I can easily list problems or barriers that get in the way of good patient-doctor communication.
2.	I can easily list the reasons why I need to communicate effectively with my doctor.
3.	I can easily give examples of what my role, as a patient, should be when I talk to my doctor.
4.	I can easily list goals I want to achieve when talking to my doctor.
5.	I can easily give examples of what a good doctor's role should be when he/she interacts with me.
6.	I know ways to improve my communication with my doctor.
7.	I use good communication skills when talking to my doctor.

Note: Response categories for all items were (1) Strongly Disagree, (2) Disagree, (3) Slightly Disagree, (4) Slightly Agree, (5) Agree, and (6) Strongly Agree.

Overall, the findings indicate that although the participants at the centers reported different levels of confidence in communication at both pre- and post-intervention and the level of confidence increased from before to after the intervention, in the final analysis, the change in communication confidence levels was similar for all 7 sites despite the diverse nature of the audience. Also of interest was that self-reported improvement in confidence level was the same regardless of the co-trainer pairs. Thus, effectiveness of the forum was not only site-independent but facilitator-independent, as well.

One of the major strengths of the HTTYD community education forum is its applicability to diverse audiences – from disease-specific cohorts to healthy individuals to senior citizens; all groups have been found to benefit equally. Its adaptability to a "train the trainer" format significantly broadens dissemination capabilities, extending it to varied audiences. In addition, the limited 2-hour format has been found to be greatly conducive to participant attendance.

One of the major limitations of the program is that findings were based on self-reported data. Likewise, an inability to follow up with participants precludes a determination of whether skills taught in the program are actually being incorporated into participants' repertoire of skills in their navigation through the medical interaction. Importantly, inability to follow up also precludes a determination of whether participants' adherence to the learning objectives actually leads to better health outcomes.

As of this writing, the continuing education forums remain well received by the community and, largely by request, the Houston Center for Quality of Care and Utilization Studies continues to conduct 8-10 forums per year at the local level. Based on recent inquiries, strategies for expansion of current dissemination activities at the national level are in the process of being evaluated. In addition, the feasibility of 3- to 6-month follow-up strategies is also being considered for inclusion in the program.

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2. Tran AN, Haidet P, Street R, O'Malley KJ, Martin F, Ashton C. Empowering communication: A community-based intervention for patients. *Patient Education and Counseling* 2002. In Press.
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