CHAPTER 198

Multiculturalism and Care Delivery

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Every day, in emergency departments throughout the United States, physicians encounter challenging cases that require an appreciation of cultural differences. Lack of understanding of the role of cultural factors can have an adverse effect on physician-patient communication and trust. Health outcomes can also be negatively affected, as demonstrated by a large body of literature on racial and ethnic disparities in types of interventions and outcomes for heart and lung disease. Race, culture, ethnicity, class, gender, economic conditions, spirituality, and sexual orientation define health and illness for patients and affect both access to health care and the quality of services received. Missing these cues may lead to medical errors.[1,2]

The American College of Emergency Physicians (ACEP) Code of Ethics, 1998–99, commits emergency physicians to "protect the rights and best interests of the most vulnerable … [and] secure access to emergency and other basic health care for all."[3] This code also recognizes that "denial of emergency care or delay in providing emergency services on the basis of race, religion, ethnic background, social status, type of illness or injury, or ability to pay is unethical." Lewis Goldfrank, past president of the Society of Academic Emergency Medicine (SAEM) and a member of the Institute of Medicine, and Robert Knopp, Deputy Editor of *Annals of Emergency Medicine*, comment in an editorial about ethnic disparities in emergency department analgesia prescription:

> With the legacy of racism and the growing body of medical evidence indicating differential care in the emergency department and other medical specialties, we believe that the burden of responsibility has now shifted so that the medical profession must now demonstrate that physicians are providing appropriate and timely care for all.… Our integrity as a profession and as a nation hangs in the balance.[4]

The purpose of this chapter is to provide the knowledge base in cultural competence that is essential to meet patient needs, improve health outcomes, reduce racial and ethnic disparities, and achieve professional goals.

RATIONALE FOR CULTURAL COMPETENCE

Changing Demographics: New Challenges for Emergency Physicians

We live in a global community, and both the U.S. population and the types of health problems seen by emergency physicians are constantly changing. In 2000, the U.S. Census Bureau estimated that 12% of the U.S. population was foreign born and 20% spoke a language other than English at home.[5] It is projected that by 2030 the proportion of Hispanics will increase from 13 to 20%, and racial and ethnic minority representation in the United States will exceed 40%.[6]

These figures do not speak to the diversity within these groups. The category Hispanic, for example, is an ethnic grouping counted in the race category of the census, but it fails to capture the significant range of diversity represented by Spanish speakers. Hispanics may share some cultural practices and speak similar versions of the Spanish language but have major differences in vocabulary, history, socioeconomic status, cultural identity, what they call themselves (Hispanic or Latino), levels of acculturation, health beliefs, habits, access to care, and health outcomes.

What do these changes in demographics mean to practicing emergency physicians? The ACEP Code of Ethics challenges us to recognize ethnic and racial differences in health care access and outcomes, to advocate for equity, and to work with other health organizations and providers to contribute to eliminating these disparities.

Racial and Ethnic Disparities in Health Care Access and Outcomes

In the past decade, both financial and nonfinancial barriers to access for racial and ethnic minority populations have been thoroughly documented. These include high rates of uninsurance, lack of prenatal care, hospitalizations for ambulatory-sensitive diagnoses (an indicator of reduced access to primary care), and concentration of minorities in areas of physician shortage.[7] In 2003, the Institute of Medicine (IOM) produced a report commissioned by the U.S. Congress in which more than 100 studies assessing the quality of care for racial and ethnic minorities living in the United States were analyzed.[8] According to the IOM report, minorities received fewer needed services and procedures than whites, after controlling for insurance status, income, and other access factors. These findings applied to a wide range of health conditions, such as cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness. The findings identified cultural and linguistic barriers, fragmentation of the health care system, and differences in sites of care delivery and insurance coverage as explanatory factors. The authors suggest that unconscious bias, prejudice, stereotyping, and physician uncertainty of severity may influence clinical decision-making and allocation of services and procedures. Patient preferences may account for some of the range of distribution of services, but preference alone is insufficient to explain health care disparities. The report concludes that "racial and ethnic disparities in health care exist, and because they are associated with worse outcomes in many cases, they are unacceptable."

The IOM report also discussed important nonfinancial barriers to access, such as the unequal distribution of physicians in areas where minority populations live. In particular, the number of racial and ethnic minorities living in medically underserved areas is three times the proportion of minorities in the general population. Poor urban communities with high African American and Hispanic representation averaged 24 physicians per 100,000 people compared with 69 physicians per 100,000 in communities with low representation. Although minority physicians are more likely to serve patients with Medicaid or no insurance, enrollment of minorities in health profession schools has been declining for African Americans, Hispanics, American Indians, and Alaskan Natives.[9] In fact, the American Association of Medical Colleges (AAMC) reported that in four states with restrictions against affirmative action, in the year following enactment, there was a 17% decline in applications and a 26% decline in matriculation to medical schools from underrepresented minority groups.[10] A survey conducted in 1997 by the SAEM Task Force on Women and Minorities found that 59% of residency-affiliated sites had no minority faculty member.[11] Dr. Jordan Cohen, president of AAMC, argues that "to achieve diversity in the health profession is not someone else's problem; it is a problem for the profession, for all of us who are concerned about the future of access to health care and the quality of health care that we are going to be able to provide our society."[12]

The National Institutes of Health National Center for Minority Health and Health Disparities, created by Congressional Public Law 106-525 to oversee research in health care disparities, reports that improvements in health have not been universal during the past two decades: "Striking disparities in the burden of illness and death" exist for African Americans, Hispanics, Native Americans, Alaskan Natives, Asians, and Pacific Islanders. Despite a decade of attention focused on racial and ethnic health care disparities, progress in narrowing critical gaps in life expectancy has been slow. Life expectancy for blacks as a whole is 73.2 years versus 78.3 years for the white population—a gap of 5.1 years. For black males versus white males, the gap is even larger (6.2 years). Lower life expectancy for blacks is accompanied by higher rates of cardiovascular disease, cancer, infant mortality, maternal mortality, birth defects, asthma, diabetes, stroke, intentional injury inflicted by others, sexually transmitted disease, and mental illness.[13,14] The reliability of data for Hispanics is limited by inaccurate reporting of race/ethnicity on birth and death certificates, the healthy migrant effect, and the possibility that migrants may return to their country of origin when they become ill or disabled.

Factors Contributing to Disparities in Health Outcomes

In the past decade, reports have been regularly published in major peer-reviewed journals about disparities in the use of diagnostic tests and procedures, access to appropriate treatment modalities, and waiting times to receive care in emergency departments.[15,16]

Test and Treatment Options: Physician-Patient Communication Failure?

Studies document clearly that both Hispanics and African Americans receive fewer analgesics for extremity fractures[17-20] and for musculoskeletal pain[21] than white patients in the emergency department setting, despite no evidence of difference across race and ethnicity in the ability to discriminate painful sensation.[22,23] In secondary analyses of the National Hospital Ambulatory Medical Care Survey data for 1993 to 2005, opioids were less likely to be prescribed to African Americans (23%) and Hispanics (24%) for pain relief than whites (31%),[24,25] and these differences were greatest for patients with the most severe pain.[24] Disparities in emergency department pain treatment continue to persist a decade after identification of racial and ethnic differences in analgesic administration.

Evidence from other specialties corroborates that differences in provision of medically appropriate procedures and therapies are often related to race and ethnicity. In the case of preventive measures, for example, elderly African Americans and Hispanics are less likely to receive influenza and pneumococcal vaccine, and Hispanics are less likely to have a blood pressure check or a cholesterol level within the past 2 years.[26] In the domain of surgery, the operative rate for certain lung cancers was 76.7% for whites and 64% for African Americans, and the 5-year survival was 34.1 and 26.4%, respectively.[27] The authors concluded that if blacks had undergone surgery, the 5-year survival rate would have been similar. An accompanying editorial suggests that the medical establishment take some responsibility for the racial discrimination that results in inadequate emphasis on prevention or insufficiently aggressive care for African Americans.[28]

These issues also apply to disparities between black and white populations with respect to cardiovascular disease. After adjusting for severity and coexisting conditions, African Americans are less likely to undergo either angioplasty or bypass surgery than whites, and differences are more significant for those predicted to benefit most from revascularization.[29] A multicenter emergency department study found racial disparities in access to cardiac catheterization for African Americans and other non-whites with acute myocardial infarction and unstable angina. The researchers also found that African American patients were less likely to receive a timely electrocardiogram or an assay for cardiac markers,[30] and doctors were less likely to prescribe anti-ischemic medications.[31]

In recent years, racial and ethnic disparities in emergency department treatment decisions have also been identified for admission following a diagnosis of pancreatitis,[32] for care related to mild traumatic brain injury[33,34] and headache,[35] for rate of appendicitis rupture,[36] and for underdiagnosis of psychiatric disease.[37]

Discrimination and Health Outcomes

Deleterious health consequences that result from racial discrimination have been well documented.[38-42] In a study of the nation by state, in states where more respondents to the General Social Survey indicated that blacks lacked innate ability, there was a closely associated increase in age-adjusted black mortality that was considerably stronger than the correlation for mortality and socioeconomic status.[43] Mechanisms used to cope with the stress of racism have been shown to backfire by adding to health risks, as in the case of smoking, substance abuse, and overeating.[44,45] Racism-induced stress has been shown to be negatively associated with disease entities such as diabetes, hypertension, depression, and preterm birth.[46-50] Similar experiences have been described for homosexuals vis-à-vis homophobia.[51]

Race-Based Medical Decision-Making

Racism, sexism, and homophobia can interfere with the establishment of trust and the delivery of effective medical care if providers create or establish barriers based on their own internal biases, prejudices, and negative reactions to racial or cultural characteristics, such as skin color or clothing styles. Patients read these reactions clearly during an encounter with a provider. A barrier is created, and the opportunity for a good medical outcome may be lost. Provider biases against people with certain stigmatized diseases, such as HIV and substance abuse, can also create barriers to effective health care. When primary care physicians viewed scripted video interviews with hypothetical patients with chest pain who had similar symptoms, risk factors, vital signs, and thallium stress test and electrocardiographic findings, they were less likely to refer African American women for cardiac catheterization than men and whites, even though the scripts varied only by race and gender.[52] Disparities profiling can result in both under- and overdiagnosis and thus contribute to medical error.[53,54]

Failure of Trust

Patients from minority communities have reason to be skeptical about the validity of medical research and the appropriateness of medical recommendations. Participants in the Tuskegee study, for example, were not notified when effective treatment for syphilis became available because researchers wished to investigate the natural course of the disease.[55] Middle-class African American patients often rate their physician interactions as less participatory than when the doctor is of the same race as the patient.[56,57] Yet this option for physician-patient congruence is rarely available to minority patients because only 4% of physicians are black, whereas 12% of the population is black.[8]

In the Agency for Health Quality Research National Healthcare Disparities Report, blacks and Hispanics were found to be more critical of the patient-provider relationship than were whites. A higher percentage of adult blacks and Hispanics rated their health care at less than 6 on a scale of 1 to 10 in the past year and believed that they would have received better care if they were of a different race or ethnicity. The report provided evidence confirming perceptions of a lower quality of medical care. For example, when black and Hispanic adults older than 65 years were hospitalized for pneumonia, they were less likely than comparable whites to have blood culture samples drawn and antibiotics administered in accordance with current recommendations. Hispanics with myocardial infarction were less likely to receive aspirin or a beta-blocker on admission and discharge. In comparison to white dialysis patients, fewer blacks and Hispanics in need of a kidney were registered on waiting lists for transplant or had received a transplant within 3 years.[58]

Language and Effective Medical Care

According to the 2000 U.S. census, 47 million Americans (18%) speak a language other than English at home, 21.3 million speak English less than very well, and 10.7 million speak English not at all or not well.[59] Patients with limited English proficiency are more likely to defer needed services, leave against medical advice, miss appointments, fail to adhere to treatment regimens, lack a regular provider, and report poorer health status.

Transcribed audiotapes of medical encounters in a pediatric emergency department setting were studied to ascertain differences in communication error rates for patients who were aided by professional hospital interpreters compared with those who had an ad hoc interpreter (e.g., family, friend, or nonprofessional hospital worker) and those who had no interpreter available. They found that communication errors occurred equally among the ad hoc and the no interpreter groups. These errors included left out words (52%), incorrect words (16%), substituted words (13%), interjected personal views (10%), and added words (8%). The errors of ad hoc interpreters were more likely to result in clinically significant medical errors, such as omitting drug allergies and giving inaccurate instructions on dosing and route of administration.[60] The use of untrained nonprofessional employees as interpreters resulted in serious translation errors, including omissions, additions, and substitutions for what the patient is trying to say, and the use of relatives, particularly children, may violate privacy and disrupt family norms of authority.[61-64]

A cross-sectional survey at a public hospital emergency department suggested that there is a patient-perceived need for interpreter services, and the highest patient satisfaction ratings are obtained when patients can communicate directly with their physicians.[65] Satisfaction ratings for patients using ad hoc interpreters are lower, and rates are lowest when an interpreter should have been used but was unavailable. In one retrospective study of Spanish-, Haitian Creole-, and Portuguese Creole-speaking patients presenting to the emergency department with chest pain, headache, and abdominal pain, the investigators found that the use of trained interpreters was associated with increased intensity of emergency department services, reduced emergency department return rate, increased clinic utilization, and lower charges during the next 30 days, without any simultaneous increase in length of stay or cost of visit.[66]

A statewide emergency department patient satisfaction survey in Massachusetts indicated that non-English speakers were less satisfied with their emergency department care, were less willing to return for care, and reported more problems with emergency care.[67] The authors state that interpreter service is likely to improve the satisfaction of this group.

Evolution of New Standards for Health Care

In response to the identification of unacceptable differences in both health care provision and health care outcomes, state Medicaid regulations and Health Plan Employer Data and Information Set criteria now reflect the need to establish quality performance measures to ensure access to appropriate services for culturally diverse populations.[68] A new standard of care has been established that requires institutions and practitioners to provide for medical needs in the patient's primary language and in a manner compatible with patients' health beliefs and practices. Health care institutions and providers are asked to collect data stratified by race, ethnicity, and language and to institute quality improvement efforts when cross-cultural differences in outcomes of care, process indicators, or patient satisfaction are detected. They are asked to develop culturally competent systems of care based on an assessment of the organization's mission, goals, policies, practices and services, staff training needs, and the current diversity of the staff.

After the assessment process, health care organizations must identify opportunities to improve the cultural competence of the organization and its delivery of health care services to a diverse population. At the top of the list is the improvement of interpreter services. Hospitals are asked to establish minimum performance standards for interpreters that include training in culturally specific medical language and code of ethics. These requirements have been codified as a set of standards for culturally and linguistically appropriate services (CLAS Standards) by the Office of Minority Health and the Agency for Health Care Research and Quality and published in the Federal Register (December 15, 2000).[69] In spring 2000, the Massachusetts legislature took a positive step in the direction of compliance with these standards by passing a law requiring all emergency departments to provide interpreter service and authorizing the state to provide Medicaid reimbursement for interpreter services.

Culturally Competent Approach to Language Barriers

In 1996, the SAEM Task Force on Physician-Patient Communication identified lack of a common language as the most common barrier to communication in the emergency department. Professional medical interpreters were recommended for the following reasons: (1) confidentiality, (2) medical knowledge and a common vocabulary with the provider, and (3) fluency.[70] Two emergency department case reports illustrate this point.[71]

A 50-year-old Mexican American man who spoke only Spanish was seen in the emergency department because of “chest pain.” Because no translator was available, an electrocardiogram and chest radiograph were ordered. The electrocardiogram was normal; the chest radiograph showed a widened mediastinum suggestive of a dissecting aortic aneurysm. An aortogram was subsequently performed, which demonstrated a normal aorta. At some point, a Spanish-speaking physician was able to elicit a 1-year history of difficulty swallowing and regurgitation of food. A barium swallow was performed, which revealed achalasia.

A 22-year-old Vietnamese man arrived in the emergency department unresponsive and comatose with small, reactive pupils. Naloxone hydrochloride and 50% dextrose in water were administered without response. The medical history was obtained from a family member who spoke some English. It consisted of brief answers to specific questions and was not helpful diagnostically. A lumbar puncture and examination of the cerebrospinal fluid ruled out meningitis. A clerk later recalled that a child with the same last name was admitted the previous day for headache, nausea, and vomiting caused by carbon monoxide poisoning. In retrospect, it was clear that the history obtained from a family member who was under stress and giving vague answers to pointed questions was inadequate. The authors conclude that “a trained bicultural translator can effectively elicit the history as conceptualized by the patient or family and translate it both linguistically and in the format of Western medicine.”

The previous example also illustrates that bilingualism is necessary but not sufficient. There are nuances and sociocultural assumptions in both languages as well as nonverbal cues that must be communicated along with words for effective diagnosis, treatment, and disposition. The medical interview is the heart of the medical encounter between physician and patient, yet in an interpreted interaction, neither patient nor physician is in a position to judge the accuracy or completeness of a lay interpreter’s translation. Clearly, omissions, additions, opinions, guesses, and distortions can lead to serious mistakes and unnecessary diagnostic procedures.

Standards and certification for medical interpreters are needed to ensure consistency and quality. The Massachusetts Medical Interpreter Association recommends that standards cover interpretation, the cultural interface, and ethical behavior. Because the meaning inherent in the message is rooted in culturally specific beliefs, values, assumptions, customs, and norms, and language is itself an expression of culture, it may be necessary for a medical interpreter to go beyond a literal interpretation to explain unstated assumptions and to find new ways of communicating untranslatable words or concepts. In addition to maintaining confidentiality, the medical interpreter has an ethical burden to uphold the trust of both parties and assure them that the considerable power associated with the interpreter’s role will not be abused and that information will be faithfully conveyed without interjecting the subjective opinions and thoughts of the interpreter. Even with such qualified interpreters, the emergency physician still needs to monitor the flow of the interview and, from time to time, clarify meaning and ensure understanding. This can be done by having the interpreter repeat what he or she thought the patient meant and asking the patient to repeat what the interpreter said. It is important to observe the interaction for phrase length as an indication of material not translated or added by the translator.

Using Cultural Competence to Cross the Barrier of Different Beliefs, Values, and Life Experiences

Both physicians and patients have a culture that they bring into the examining room. Differences between their cultures have an impact on the physician-patient encounter. Awareness of one’s own values and those of others can enhance both satisfaction and health outcomes. The SAEM task force report cautioned, however, that it is dangerous to hold strong preexisting assumptions about any cultural group because variations within cultures often exceed variations between them. A patient who is thoroughly acculturated into American society may be offended by a health care provider’s attribution of traditional beliefs. Even in the context of a busy emergency department encounter, it is necessary and feasible to get to know the individual patient sufficiently to make a rough assessment about level of acculturation, or at least to ask rather than to assume.

In some cultures, the diagnosis of specific diseases can be particularly problematic. For example, in African American and Puerto Rican communities, cancer is often perceived as a fatal disease. Patients may therefore avoid initial evaluation or choose no treatment when diagnosed, even when the cancer is identified at an early stage and the prognosis is good. A health care provider who understands these health beliefs and concerns can work collaboratively with patients to provide health information in a format that the patient can accept.

Alternative healing systems have strong cultural roots. In 1997, the U.S. population made an estimated 629 million visits to providers of alternative health care—approximately 243 million more visits than to conventional health care providers and an increase of 47% since 1990. An estimated 44% used at least one complementary alternative therapy in 1997.[72]

Folk medicine is too diverse for providers to know all possible practices, but emergency physicians need to know some of the more common therapies and ask their patients about them. For example, more than a few emergency physicians have called social workers to investigate children with apparent bruises caused by coining, which involves vigorous rubbing of the skin with coins and warm oil (tiger balm) to release the “bad wind” (reduce fever). These parents, who have attempted to help their children by using health care practices that are widely accepted in their communities of origin, feel accused, and the trust between the physician and the family may be irrevocably lost. Similarly, herbal remedies can be effective or at least harmless, but occasionally they can be toxic, as in the case of clay ingestion by pregnant women, the use of marijuana tea to treat asthma, and powders containing high concentrations of lead oxide to treat *empacho*, a condition in which it is believed that a substance (usually food or saliva) gets “stuck” to the walls of the stomach or intestines, causing an obstruction. Specific uses of folk medicine need to be elicited respectfully in a careful history and evaluated. Recommendations can then be presented nonjudgmentally, and alternative folk remedies that are benign can be prescribed along with needed allopathic medications.

The practitioner and the patient will inevitably bring different beliefs and values to the medical encounter; the key to cultural competence is respectful negotiation of these differences without imposing the power of physician expertise, thus protecting patient autonomy. If patients are satisfied, they will carry out follow-up recommendations and return to the emergency department in the future when they need emergency care.

In a review of Hispanic cultural practices, Flores suggests a five-step approach for the pediatric emergency department that is applicable to all emergency medicine: The physician should (1) explain that he or she is aware that a given folk illness exists; (2) ask whether the parent or patient has ever heard of it; (3) ask whether the patient has the folk illness now; (4) ask what treatment the patient is receiving for the condition; and (5) suggest alternatives to harmful folk remedies, accommodating wherever possible (nonjudgmentally) to folk illness beliefs and practices, and integrating the use of harmless folk remedies into the treatment plan when the patient so desires.[73]

Interpreting the Culture of Medicine to Patients from Diverse Backgrounds

There are inherent conflicts between the culture of medical care, particularly emergency department culture, and the cultures of many patients. Physicians are expert in diagnosing and treating *diseases*, which represent abnormal structures or functions of the human body (the pathophysiology of disease states). On the other hand, patients experience *illness*, a subjective, feeling state that is interpreted through the lens of culture and has a personal and social meaning. The patient is an expert in his or her own illness and its effects on daily living, whereas a physician is expert in the effects of diseases on organ systems. Both ways of looking at the world have validity, but they are radically different.[74] Unfortunately, the culture of medicine tends to recognize only its own interpretation and perspective. A culturally competent approach recognizes both and works to integrate the best of both worlds.

A patient may have very high blood pressure, HIV, or early cervical cancer and not experience symptoms. If patients do not feel sick and experience no alteration in functioning, they may not accept a physician's diagnosis. There may be conflict between the patient's perception of causality and the physician's, as in the case of the differences between the medical diagnosis of hypertension and the commonly accepted view of hypertension as "high blood" in the African American community.[75]

On the other hand, a patient may feel sick—be ill, weak, and dizzy, with extreme fatigue or abdominal pain—yet the physician is unable to diagnose a disease despite a thorough history, physical examination, testing, and appropriate consultation. For example, *susto*, an illness recognized by Mexican Americans, causes listlessness, insomnia, depression, and anorexia and is believed to be caused by exposure to a frightening experience. Treatment requires the patient to speak openly about the events that led to the susto, followed by bedrest and a ritual that includes prayers, incantations, and *barridas* (sweeping of the body with an egg, a candle, or herbal teas).[76]

To be most effective, physicians need to investigate how patients view the causality of their illnesses and how they experience them in order to negotiate a therapeutic intervention. Exploration might take the form of comments and questions such as, "Help me to see through your eyes how you understand this problem. Have you or someone you know experienced it before?" The role of the physician is to accept the patient's experience as uniquely his or hers or, when possible, reframe it in terms of medical knowledge. Then both physician and patient will be satisfied with the outcome of the encounter.

Role Expectations in Western Medicine: Opportunity for Misunderstanding

The culture of medicine, especially in emergency medicine, has its own set of patient expectations, rules and regulations, language, and dress distinctions that reflect a hierarchy of authority, a characterization of patients as good or bad, and different sets of behaviors toward patients depending on the category to which they have been assigned. The "good emergency patient" is acutely ill but waits patiently until called without complaining, requesting pain medications, getting angry, or being loud or disruptive. The "good patient" understands the triage system and provides a clear, concise, pertinent history with enough information for accurate diagnosis. The "good patient" does not take up physician time with minor complaints, feelings, or tangentially related information. The "good patient" accepts invasive examinations and procedures without protest, agrees to admission or to a discharge plan, does not require long explanations of rationale for treatment, and has a support system in place for a safe discharge. A "good patient" who does not speak English brings someone to interpret, someone who can bridge the cultural divide and help with transportation upon discharge. A "good patient" does not moan, scream for a nurse or doctor, or act violently. A "good patient" does not have family members who are emotionally upset, stir up trouble, or challenge providers. A "good patient" uses seat belts, maintains personal hygiene and normal weight, takes prescribed medications, avoids drugs and cigarettes, and exercises. "Good patients" share a trust, understanding, and belief in scientific, modern, technological medicine and its value. Because they comprehend the physician's explanation of causality—for instance, bacterial infection as a cause of pneumonia—they agree to a discharge plan and adhere to a treatment regimen. They understand medical jargon and require very little explanation and ask a minimum of questions. "Good patients" help maintain the flow through the emergency department, whereas their opposites obstruct the flow. "Good patients" get better; the "bad patient" keeps coming back, has chronic recurrent conditions, and has confusing or difficult to resolve problems.

Thus, it is not surprising and no fault of their own that people from different cultures may find it impossible not to violate one of the many rules and regulations of the emergency department. Every medical encounter is potentially a cross-cultural experience, and negotiating the divide is a challenge for both patients and providers. Cultural competence involves a reframing of many of these unstated rules because they prevent us from looking beneath the surface and addressing real problems. When a patient comes in with vague complaints, there may be a social stressor that has tipped the balance of mental health. There may be circumstances that the patient does not feel comfortable sharing with the provider because of cultural, racial, or language barriers, or there may have been an overload of negative stimuli related to racial and ethnic discrimination—a crisis for the person and the body this person inhabits.[77,78] People from minority cultures experience stressful events daily that the white provider, secure in his or her socioeconomic status and membership in the dominant majority, can only imagine: being passed by the 15th taxi in a row because "it's not safe to pick up blacks"; being followed in a department store because you and your friend were speaking Spanish; having to "dress up" to go to the store to avoid a possible humiliating moment; or standing in line to register at a hotel, dressed in professional clothing, and being asked by a white person in line, "Hey, can you take my baggage to my room?" In each of these cases, assumptions were made about the person on the basis of a stereotype related to physical appearance or presumed country of origin. There is mounting evidence that these types of negative encounters engender clinical depression and anxiety and contribute to hypertension and other medical sequelae. If a patient self-defines as having an emergency by showing up at the emergency department, the problems that cause that person to come deserve our respect.

A study of racial and ethnic patterns of emergency department use found that four times as many African Americans and Hispanics as whites report the emergency department as a source of care.[79] Patients who "overuse or abuse" the emergency department are seen as "bad patients," but the reasons given in this study for patients' use of the emergency department are entirely rational: (1) Individuals seen in the emergency department need not request an appointment to receive care; (2) emergency departments provide sophisticated medical technology; (3) emergency departments operate 24 hours a day; (4) emergency department services are often covered by health insurance and other options are not; (5) emergency departments have a tradition of free care; (6) many communities lack culturally competent private practitioners; and (7) emergency departments are often close to inner-city neighborhoods, whereas many primary care providers have abandoned the city center environs for the suburbs. These reasons may explain, at least in part, why U.S. emergency departments had an estimated 115.3 million visits in 2005.

To practice good medicine in this health care and social environment, emergency physicians must critically question and reframe the moralistic good patient/bad patient paradigm. We, like our patients, are at the whim of forces beyond our control, and both patients and practitioners will experience higher levels of satisfaction if these issues are addressed directly. Patients must take responsibility for their own behaviors whenever possible, but physicians can and should work with health care institutions to adopt policies that improve access to culturally competent health care. These actions can help create a safe environment for both practitioners and patients.

RECOMMENDATIONS

Diversity among the emergency department patient population poses a challenge to emergency physicians. Recognition of cultural differences, knowledge about diverse cultures, awareness of the health impact of cultural beliefs and practices, and sensitivity to patients' needs can reduce access barriers and improve clinical outcomes and hospital-community relationships, while reducing the number of repeat visits and the cost of health care. Diversity education also creates a rich environment for conceptualizing and researching health problems.[80,81]

There are many opportunities for emergency departments and their institutions to improve their care of multicultural communities. These include plans to address problems related to (1) a lack of protocols for patient care; (2) a lack of resources for translation and cross-cultural interpretation; (3) an incorrect perception that attention to cultural competence adversely affects flow and efficiency; (4) a lack of cross-cultural teaching guidelines and standards in medical education; (5) inadequate recruitment and retention of minority residents, faculty, and practitioners; and (6) a lack of pathways for communication and collaborative work with communities.

Concrete recommendations, based on the CLAS standards, have been proposed for pediatric emergency settings and can be applied universally: (1) Institutions should employ trained medical interpreters and a diverse workforce; (2) pharmacies should label prescriptions and provide medical instructions in the patient's primary language; (3) administrators should post multilingual signs and ensure that handouts and forms are translated; (4) quality improvement programs should collect and analyze data and provide information to monitor

BOX 198-1 BASIC SKILLS IN AN INTERCULTURAL CURRICULUM

Communicate an interest in and respect for the patient's culture.

Tactfully and respectfully ask for general cultural information (e.g., herbal remedies, acupuncture, coining, moxibustion, or other cures attempted).

Elicit the patient's understanding of and beliefs about illness or health problems.

Request information regarding folk medicine beliefs—for instance, "mal ojo" (the evil eye or evil spirit) among Mexican Americans, voodoo among Haitians, yin and yang among Chinese patients, "rootwork" among African Americans, and "spiritism" (the ability of spirits to make people sick or cure them) among Puerto Ricans.

Interpret verbal and nonverbal behaviors in a culturally relevant manner.

Negotiate a culturally appropriate health care plan with the patient and his or her family as partners.

Demonstrate an ability to work as a team with a medical interpreter in the bilingual medical encounter.

From Goldstein E, et al: Intercultural medicine. In Jensen N, Van Kirk J (eds): A Curriculum for Internal Medicine Residency. Philadelphia, American College of Physicians, 1995.

BOX 198-2 POLICIES FOR INSTITUTIONAL IMPROVEMENT

Educate emergency department personnel about the circumstances of patients' lives and the interesting cultures that have evolved to deal with these circumstances using a variety of formats:

1. A series of hospital inservices to provide information about each specific patient group that uses the institution
2. Small focus groups with patients to improve our understanding of our patients' needs and begin the process of freeing providers from racial and ethnic stereotypes that create barriers to good medical care
3. Training utilizing videotapes and role-playing exercises to enhance movement along the cultural competence continuum

Meet with community organizations to build trust and create partnerships for preventive education.

Hire employees who reflect the culture, ethnicity, and socioeconomic background of emergency department patients to improve the quality of services.

Provide interpreter services, visual aids, and other educational materials in a variety of languages, and provide multilingual health education classes.

Participate as an institution in community health fairs.

outcomes based on race/ethnicity; and (5) a diverse group of patients should be enrolled in research studies to improve outcomes.[82]

Recommendations from the IOM report for a series of additional legal, regulatory, and policy measures were highlighted in an *Academic Emergency Medicine* editorial and include the following: (1) patients in public managed care organizations should have the same patient bill of rights as patients in private health maintenance organizations, (2) the number of health care providers who are members of racial and ethnic minority groups should be increased, (3) resources must be adequate to enforce penalties for civil rights violations, (4) incentives to promote disparities should be stringently limited, (5) health care professionals should have opportunities for cross-cultural education, (6) patient participation in decision-making should be enhanced through education, (7) community health care workers/advocates should assist patients to negotiate the health care system successfully, (8) the diversity of faculty and residents must be improved, (9) a cross-cultural curriculum should be developed for residency training and continuing education, and (10) physicians must educate themselves and the general public about the need to eliminate racial and ethnic disparities in health care.[83]

■ SUMMARY

Changing demographics manifest themselves in a diverse emergency department patient population, and emergency department practitioners must learn to be culturally competent and promote systemic change to provide quality care. Essential cultural competence tools for providers include recognition of cultural differences, respect for individual opinions and perspectives about health and illness, and, most important, the ability and willingness to negotiate differences to offer the best opportunity for good health care outcomes. Culturally appropriate health care systems must be incorporated into emergency departments, which serve as the gateway to our health care institutions.

Basic skills proposed in an intercultural curriculum developed by Goldstein and associates for internal medicine residents can apply equally to emergency physicians (Box 198-1).[84] Policies that will promote cultural competence, increase patient satisfaction, and improve health outcomes include those listed in Box 198-2.

The references for this chapter can be found online by accessing the accompanying Expert Consult website.