Multicultural America: A Multimedia Encyclopedia

Medicine and Ethnic Diversity

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As the 2010 census shows, the United States is becoming increasingly diverse. The shifting demographics have a strong impact on the practice of medicine in various ways, particularly because patients belonging to a minority ethnic group such as African American, Hispanic American, American Indian, Alaska Native, Asian American, Native Hawai'ian, and Pacific Islander tend to have worse health outcomes than their Caucasian peers. According to the Office of Minority Health, patients from these groups are at a higher risk of illness and death from heart disease, stroke, diabetes, HIV/AIDS, asthma, hepatitis B, obesity, and certain cancers. Additionally, the Institute of Medicine found that minorities are less likely to receive certain types of treatment such as dialysis and transplants, and particular cardiac procedures like bypass surgery.

Ethnic and racial minorities are more likely to receive more drastic procedures, such as amputations, as a result of diabetes. In order to best provide quality health care for a diverse patient population and overcome increasingly pronounced health disparities, medicine must take ethnicity and related factors such as religion, language, and health care beliefs, as well as social determinants of health, into consideration in medical practice, research, and education.

History of Mistreatment

Ethnic and racial minorities have not always been treated well within the medical field, which has resulted in mistrust of the medical system within some ethnic communities. Before the civil rights movement demanded equal treatment, ethnic and racial groups were often separated from Caucasian patients in hospitals, clinics, and other health care services. Often, these segregated areas for patients of minority racial and ethnic backgrounds were less equipped than medical institutions that catered to the Caucasian population. Ethnic and racial minority patients were at risk for being refused treatment, discriminated against, and not given adequate care, and were often blamed for their condition.

Therefore, taking into account ethnic diversity in the practice of medicine is vital to the diverse population in the United States. One cannot have the discussion of ethnic diversity and the practice of medicine without approaching the essential presence of cultural competency for those who practice or are involved in the process of medical care. Cultural competency is not just the simple knowledge of facts about each culture, it is also an acquired set of positive beliefs, attitudes, and values that allows for positive and effective interactions with individuals and groups of people who are culturally different from one's own group. Cultural competency is a multifaceted set of knowledge and actionable skills that is essential for application in every interaction, including relationships from the casual setting to the professional setting. Specifically, cultural competency in the practice of medicine is a topic of discussion that is now, more than ever, an essential and currently ongoing discussion as a result of the cultural, racial, and ethnic diversity of individuals in our communities and workplaces.

For every stakeholder in medicine, from the patient to the doctors and staff who provide care, culture touches every aspect of health care: patient treatment plans, medication, medical procedures, and the working relationship of the doctors and staff who deliver these services to benefit the patient. In effect, there are numerous cultures working together, including the patient, in an effort to provide the best health care and treatment. Therefore, such an enormous amount of cultural variety calls for knowledge and actionable skills that address the intersection of many different cultures working together and understand cross-cultural dynamics in medicine.

The practice of medicine involves a number of culturally sensitive components. Specifically, treatment plans that involve doctor-prescribed medications and health behaviors must be communicated and articulated in ways that result in patient ability, understanding, and willingness to follow the prescribed medications and health behaviors. Therefore, effectively weaving ethnic diversity into the practice of medicine must involve treatment, treatment plans, and communication that are amenable to patients of all cultural backgrounds.

A few factors that can play into effective medical treatment of ethnically diverse patients include environmental

racism; access to and affordability of treatment; access to and ability to live in healthy environments; access to and ability to practice a healthy diet; the culture of the individual and the family; family roles in decision making; views of leaders and authority figures; religious practices; and culturally specific behavioral factors such as dietary restrictions, use of home remedies, cultural communication styles, and mistrust or misconceptions about the health care system. In addition, the approach to medications might vary by culture, ethnicity, and race. An individual's or group's decision on when to seek care, levels of pain tolerance, and genetic differences in medication metabolism and response might also be factors to consider in terms of medical treatment and culturally related medicines. Therefore, application of diversity to the practice of medicine while following ethical protocols in treatment is key.

Historically, ethical protocols were not consistently followed when ethnically diverse patients underwent medical treatment, including the lack of prior consent for medical research. One of the most well-known instances was the Tuskegee Study of Untreated Syphilis in the Negro Male. From 1932 to 1972, the U.S. Public Health Service conducted a longitudinal study on syphilis in poor, rural African American sharecroppers, who were given the impression that they were being provided with free health care when in fact they had not given informed consent and were denied treatment, even though penicillin had become the standard treatment for syphilis as early as the late 1940s. As a result of the undisclosed information concerning diagnosis and possible treatment for the disease, many participants died of syphilis or spread it. When the story about the unethical study broke, public outcry led to the establishment of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and federal laws and regulations that further protect participants in medical research. Additional efforts related to the development, revision, and enforcement of ethical standards in biomedical research continue today.

Another well-known example of the mistreatment of minorities in medical research is the case of Henrietta Lacks, who had cervix cells removed, without her explicit permission or knowledge, while undergoing treatment for cervical cancer. Her cells were then multiplied in the lab, sold, and used extensively in research, with no financial recompense to Henrietta Lacks (who passed away from the disease) or her family. As a result of Henrietta Lacks's case, the ethical issue of informed consent became standard protocol within the medical system. These two infamous cases, as well as countless other instances of discriminatory medical practices based on stereotypes, prejudice, and ignorance, widened the power gap between the medical community of mostly Caucasian male doctors and the ethnically and racially diverse patient populations that they served.

Ethnic and racial minorities were also barred from entering medical school, with the first African American doctor graduating from an American medical school in 1847. However, it was not until much later that medical schools were desegregated. Continued discrimination, lower access to quality education and mentoring, and socioeconomic factors still create barriers that prevent ethnic and racial minorities from applying to and entering medical school.

Contemporary Medicine

As U.S. demographics have diversified and the struggle for equal rights has reshaped American society, the practice and teaching of medicine have changed. Since the 1960s and 1970s, medical schools across the nation have focused efforts on programs designed to increase and diversify the physician workforce so that doctors will better reflect and serve the diverse demographic populations that make up American society. Efforts include continued work on pipeline and baccalaureate programs that help prepare underserved, underprivileged, and ethnic and racial minority students to become competitive applicants for medical school through academic counseling, standardized test and interview preparation, and rigorous biomedical courses.

However, certain ethnic populations are still underrepresented in medicine, and more work needs to be done earlier to encourage young students to dream about and prepare for a career in medicine and to help them graduate from college. The Supreme Court will rule on whether or not race can be considered as one of many

factors in the admissions process, and the Association of American Medical Colleges (AAMC) has filed an amicus brief in support of race as an important component to consider in the holistic admissions process, as a way to help diversify the student body to the benefit of all students and future patients. Expanding the definition of diversity to also include students from rural backgrounds, those who are financially disadvantaged, first-generation college graduates, members of single-parent households, and nontraditional students will also help ensure that the physician workforce better mirrors society at large.

Related to diversifying the physician workforce is a focus on primary care and serving the underserved. Despite having one of the highest rates of spending on health care per individual, the United States lags behind other nations on health outcomes. Part of the reason for this is that there are many populations in the United States that have restricted access to care, lower education and awareness of positive health behaviors, and a lack of health insurance and access to nutritious food and preventative care.

More attention also needs to be placed on raising the awareness and skills of physicians for understanding and addressing social determinants of health. Knowledge of the external factors that impact the health of patients is an important factor in designing relevant health care plans. Further understanding of how medical treatment and prescriptions may differ for patients of various ethnicities also needs to increase through targeted recruitment efforts for medical research and trials, as well as research topics that consider the social determinants of health in prevention and treatment procedures.

Funding for this type of research also needs to be provided and encouraged on all levels. Grants with a public health focus can contribute to a knowledge base and medical innovations that can help the most at-risk populations while benefiting the health care system as a whole by decreasing health care costs and improving patient health outcomes. Established in 1986, the Office of Minority Health focuses on the development of programs and policies targeting racial and ethnic minority populations, with the goal of improving health and eradicating health disparities. Continued work needs to be done on how inequities in medicine perpetuate health disparities, and how to better address social determinants of health and health outcomes through changes in the medical system, a shift from a focus on treatment to prevention, and an increase in access to quality care.

Great strides have also been made in raising the general level of awareness and acceptance of the importance of culturally competent health care that engages diverse patients. An additional focus on patient- and family-centered care that takes into consideration each unique individual's situation, environment, health beliefs, and practices, has recently become ingrained into the medical school curriculum and general policies of hospitals throughout the country.

These changes in medical practice, which allow patients to have a voice in their treatment, enhances the delivery and effectiveness of health care through the creation of relevant health care plans that are tailored to the individual. Additionally, curriculum in medical schools and professional development training for physicians needs to include elements related to diversity and inclusion, health disparities, social determinants of health, and how these factors influence medical care, treatment, and patient outcomes.

Topics focusing on the development of cultural competence skills, such as communication, addressing language barriers by working with an interpreter, knowing and addressing religious barriers, and ethnic health beliefs and practices, are just a few of the skills that physicians need in order to accurately treat a diverse patient population. Additionally, ethnically diverse faculty members are at higher risk for being unsatisfied in their positions, for experiencing a longer period before and between promotions, and for leaving medical education more quickly than their Caucasian peers. More work needs to be done to improve the medical education and working environments to create a more inclusive and welcoming environment for diverse faculty. Improving the retention rates of diverse faculty in academic medical centers and teaching hospitals will help provide students from underrepresented ethnic backgrounds with mentors and role models who may have had similar experiences and barriers that they overcame.

Technological advances in medical care may help improve the health of all patients and allow for focused attention to be placed on addressing health disparities. The move toward electronic medical records allows for better communication and access to medical information between health care professionals and the people they serve. The practice of medicine continues to expand its recent focus on interprofessional and interdisciplinary teams, which increase the chances of relevant care and adequate followup and improves the information flow between health care professionals in various settings that serve the same patients.

Transcript

- This trailer is on a journey in South Carolina offering free HIV screenings as part of an effort to stem the spread of a deadly killer. About one quarter of infected Americans don't know they have the disease and this team is worried about one particular demographic.
- Back in the day, they used to say that this is a white, gay disease. Guess who the face of HIV is now? Me and you.
- HIV/AIDS is the number one cause of death among African American women between the ages of 25 and 34. It is killing them at more than 20 times the rate of white women, but still many are too scared to speak out about protection.
- We've got to be responsible for our actions and make our brothers know it's not an option. Make them use a condom.
- Why don't they tell the guy, 'Well, we're gonna use condoms'? Why? They don't do it because they fear rejection. Men have the power. I've seen a lot of that down here. Men: they have the power.
- Advocates are trying to give women the knowledge and confidence they need to prevent the spread of the disease.
- Your results are right here. They are negative.
- They say women need to be able to assert themselves with their sexual partners and some predict that if the majority of black women don't take steps to guard against getting infected, the results will be devastating.
- There will be a time capsule in the future that will be open and it will say that in the 21st century there was an epidemic and that epidemic was called HIV/AIDS and there were a people, and they were called African Americans. The only way you will be able to see what we look like will be in some museum.
- The Obama administration recently asked for $6.5 billion to fight HIV/AIDS overseas, while less than $1 billion is being spent on prevention domestically. It's an amount that critics argue is not enough to stem the growing epidemic at home.

Interprofessional and interdisciplinary teams also help address certain challenges in treating ethnically diverse patients, such as potential language barriers and religious beliefs. Culturally and Linguistically Appropriate Services developed standards for working with patients who have diverse cultures and languages in order to provide equal opportunity for representation and access to health care services in a manner that will ensure that the best and most appropriate care will be provided to the patient. Related is health literacy, or the ability to obtain and understand health care information. Even when a patient's mother tongue is English, he or she may still have a low health literacy that affects medical care by preventing him or her from taking medication properly, understanding where best to seek care for particular ailments (such as a primary care facility versus the emergency room), communicating with the physician, or understanding health care costs and reimbursements.

Addressing the linguistic barriers of language and health literacy, alongside the possession of awareness and understanding of the social determinants of health, disparities, and historical reasons for mistrust within ethnic and racial minority communities are important factors in the provision of quality, culturally competent medical

care for all patients. With culturally competent care, medicine can eradicate health disparities.

- patients
- racial minorities
- health disparities
- medical schools
- cultural competency
- health care
- medicine

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See Also:

- Culturally Responsive Pedagogy/Culturally Relevant Teaching
- Disability and Ethnic Diversity
- Ethnopharmacology
- Health Beliefs and Practices
- Health Disparities and Ethnic Diversity
- Public Health and Ethnic Diversity

Further Readings

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