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Cultural, Race, and Ethnicity Issues in Health Care

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The world is facing movements of peoples unparalleled in history. Even the heartland of the American continent, which has seen few new population groups since the European immigration of the 19th century, has felt the effects of this restive population shift during the late 1980s and 1990s. Physicians who themselves have had little experience outside their own cultural environment are now dealing with health and social issues of patients who approach their surroundings in profoundly different ways than they might themselves. Yet the differences have always been present.

Cultural groups exist in the United States in many forms, and each has the potential for its members to interpret their world in a different manner. In fact, the subtlety of the differences between peoples with common languages and outward appearances may cause even more misunderstandings and concerns than those with more obvious external dissimilarities.

Western Medicine in the Context of Race, Ethnicity, and Culture

The concepts of race, ethnicity, and culture frequently are addressed interchangeably. Racial distinctions are probably the ones most commonly made in clinical settings—often as part of a rote introductory clause in a patient history—and often have limited clinical utility, occasionally establishing misleading and potentially harmful patient stereotypes. An appreciation of how ethnic and cultural factors influence patient health and the clinical encounter is an important consideration when providing effective disease prevention, health promotion, and treatment interventions.

Race

Racial classifications are generally defined by physical characteristics (e.g., skin color, facial features, hair type) that are shared by a group of people. They form the basis for an assumption of a shared genetic heritage among groups of humans. A presumption of shared genetic traits by a group of people who bear superficial similarity might apply to inbred populations that are geographically isolated, but this distinction becomes less meaningful when one considers the intermingling of human populations over the centuries. When one considers that there is more genetic variation to be found within a given race than between two different races, ascribing genetic traits based on race designations alone adds little to the medical decision-making process.¹

Ethnicity

The word *ethnic* is defined by the *American Heritage Dictionary* as, “of, or relating to, sizable groups of people sharing a common and distinctive racial, national, religious, linguistic, or cultural heritage.” Derivations can also be linked with race. The word *ethnicity* is derived from the Greek terms *ethnos*, referring to the people of a nation or a tribe, and *ethnikos*, equating with “national” or “nationality.”² Ethnicity thus refers to a group affiliation, which is normally expressed in terms of cultural characteristics. Although cultural characteristics are associated with ethnic groups, the members of such groups define and transmit cultural norms.

Culture

Culture can be described as the knowledge, skills, and attitudes learned and passed on from one generation to the next. Cultural iden-

tity is a dynamic, lifelong process that is constantly molded and refined by personal experience. Cultural identity thus incorporates a fluidity that defies conclusive statements about the characteristics of populations that share a common culture. Cultural norms can be modified by level of education, socioeconomic status, and the number of generations an individual is removed from the initial migration of his or her family from one society to another. Indeed, there are often more similarities to be found between two individuals of the same socioeconomic status who are from different cultures than between two individuals of the same culture who differ in socioeconomic status.³ The degree of cultural identity determines the role that family plays for the individual, as well as communication patterns, affective styles, and personal values regarding level of control, individualism, collectivism, spirituality, and religious beliefs. Culture is also modified by age, sex, vocation, disability, and sexual orientation.

Health professionals often participate in a variety of cultures simultaneously: the culture of a family of origin, that of the family of a significant other, the profession entered, or even occasionally a culture dictated by other factors, such as sexual orientation. In turn, the patient presents with a variety of layers of the same cultural cake; recognizing these influences can be a complex, subtle, profound task. As physicians, it is useful to consider the origins of our medical model and how that model determines our approach to patients.

Western Medical Model

The Western medical model was developed in contemporary Western society as a powerful analytic tool to deal with illness. This model developed around the classical Greek myth of Pandora's box in which disease is an intrusion superimposed on humans from the outside. The concept defines the social system within which a defined professional group (i.e., physicians) takes responsibility for the care of persons with compromised function. The model determines the type of questions raised during the history-taking process. Emphasis on physical symptoms often predisposes the interviewer to neglect material of potentially great value (e.g., the social system of the patient). Indeed, cultural factors may create profound differences between patient and physician perceptions of health.

In our medical model, disease is defined as some form of abnormal structure or bodily function that leads to a specific pathology. In this context, disease is a condition most readily identified by the health professional, who attempts to place it in terms of the clas-

sification of disorders that has traditionally developed in Western medicine.

Illness, on the other hand, pertains more to the individual's feelings of a negative state of being or social function; it is the human experience of sickness. Illness then may be said to be the perception of the patient, whereas disease is the perception of the health provider. In many cases these two views of sickness coincide, but frequently there are major discrepancies between them. For example, a physician may detect an elevated blood pressure and communicate the diagnosis of hypertension to a patient, who feels perfectly well and has no symptoms but may feel ill only when beginning the antihypertensive medication. Conversely, a Mexican patient may decide that he or she is suffering from *susto*, or emotional fright. This description of a state of anxiety may fail to be identified by a physician but would be completely accepted and understood by anyone in this person's cultural group. Illness for the patient may have several distinct meanings. It may represent a threat to the individual, in that it may be perceived as possible punishment for a wrongdoing. Many cultures, including groups in the United States, have on occasion viewed various epidemics in this fashion, including human immunodeficiency virus (HIV) infection.

Illness may be also viewed as a loss, as with the loss of independence or the ability to communicate effectively, as would occur following a cerebrovascular accident or with other chronic, debilitating conditions. Conversely, illness may be viewed as a gain, in that there may be advantages to being ill that are more acceptable to society.

Clark⁴ described, in her classic study of a Mexican-American community, a pregnant woman who had been struck by her husband. She sought the aid of a *curandera* to prevent a case of *susto* in her unborn child, as described above. This socially acceptable action allowed her to gain community sympathy against her husband for the physical abuse, which would otherwise have been denied her. The husband was convinced of the error of his ways, and the couple was reunited.⁴

Lastly, the illness may convey no particular significance to the individual patient and may be viewed as a normal part of life. Because biomedicine has been largely interested in the treatment of disease, little attention has been paid to interpreting the meaning of illness. Kleinman et al⁵ noted that "because illness experience is an intimate part of social systems of meanings and rules for behavior, it is strongly influenced by culture." The lack of attention to illness, and therefore to culture, often results in noncompliance or dissatisfaction with health care delivery.

Population Demographic Shifts

Today minority populations—those who often do not subscribe to the Western biomedical model—are the fastest growing segments of the United States population, representing a substantial proportion of the work force for the 21st century.⁶ Southeast Asians and Central Americans made up the largest numbers of immigrants in the late 1970s and 1980s. Census 2000 data revealed dramatic changes from what was initially projected from 1990 results. For the first time, non-Hispanic whites make up less than 70% of the overall population. African Americans and Hispanics each comprise 12% of the population, although Hispanics grew by 61% from numbers in 1990.⁷ Asian Americans grew by more than 45% to make up 3.6% of the current population, while American-Indian representation remains low at 0.7%. Furthermore, the 2000 census allowed a change in options for self-identification. Subsequently, 6.8 million people identified themselves as multiracial.⁸ Physicians of the 21st century will provide care to a population whose characteristics differ markedly from the population in the United States today. Over the next 30 years, the U.S. population will be larger by almost one third, it will be more diverse, and it will be older. The U.S. Census Bureau estimates that by the year 2050 only 52% of the American population will be white, 16% black, 22% Latino/Hispanic, and 10% Asian. These projected demographic trends will influence significantly the patterns of disease and the health care of the population.⁹

Morbidity and Mortality Variations

The health care system is a reflection of current American society. Lack of access to health care due to an inability to pay or lack of insurance, absence of translators when English is not the patient's language, differing health practices, psychosocial and environmental factors, and cultural differences are all major contributors to differences in health status among the various subgroups that comprise the American population.

Health Status of African Americans

A persistent gap exists in the United States between the health status of African Americans and that of white Americans. Infant mortality for African Americans continues to exceed that of whites and is merely a prelude to other negative health indicators through life: Being black is now considered a health hazard.¹⁰ Even when income

differences are factored in and financial access to prenatal care is ensured, African-American women use prenatal care later and less intensively.^{11,12}

In 1990 the life expectancy at birth for African-American boys and girls was 64.5 and 73.6 years, respectively, whereas that for white boys and girls was 72.7 and 79.4 years, respectively. The infant mortality rate (per 1,000 births) in 1993 was 6.8 for whites compared with 16.5 for African Americans. There was a larger decline in mortality for African-American infants from 1992 to 1993 than for white infants, but the dramatic differences persist.¹³

Health Status of Hispanics

Hispanics are at increased risk for diabetes, hypertension, tuberculosis, HIV infection, alcoholism, cirrhosis, specific cancers, and violent deaths. Poverty and lack of health insurance are the greatest impediments to health care for Hispanics. One third to one fifth of various Hispanic populations (and one fifth of the African-American non-Hispanic population) are uninsured for medical expenses, compared with one tenth of the white non-Hispanic population.

Health Status of Native Americans

Native Americans suffer some of the worst health in the nation and the lowest social status even among minorities and underserved people. Access to health care for Native Americans is more difficult than for the rest of the U.S. population because of their geographic isolation in villages and communities that are large in area and have large reservations, poor transportation, lack of efficient communications systems, and lack of running water and sewage disposal. Travel may require long distances on dirt roads or by air. Native Americans are younger, less educated, less likely to be employed, and poorer than the general population. These factors, combined with high rates of sexually transmitted disease and drug use, favor the spread of HIV. Alcoholism exacts a terrible toll among many Native Americans. Tribal, cultural, educational, economic, and geographic diversity exist among Native Americans and affect their health care.¹⁴

Health Status of Asian-Pacific Americans

Important ethnic differences in risk factors indicate that Asian-Pacific American (APA) groups should be targeted for public health efforts concerned with obesity, hypertension, hypercholesterolemia, and smoking.¹⁴ Conditions endemic in the country of origin and

case rates for tuberculosis among APAs (44.5/100,000) are greater than for other minority groups: African Americans (29.1/100,000), Hispanics (20.6/100,000), and American Indians/Alaska Natives (14.6/100,000).¹⁴

Recognizing Cultural Differences

How we interpret and deal with illness is based on our explanations of illness—explanations that are specific to the social positions we occupy and the belief system we employ. These factors have been shown to modify how we perceive symptoms, what labels we attach to particular illnesses, and how we interpret these labels. How we communicate our health problems, the manner in which we present our symptoms, when and from whom we seek care, how long we remain in care, and our evaluation of that care are affected by cultural beliefs.¹⁵

Most health care providers have a collection of anecdotes about noncompliance by ethnically different patients. As these issues have been studied by medical sociologists and anthropologists, the focus of the problem has come to rest on the provider as much as on the patient. The “fallacy of the empty vessel” is a phrase coined by anthropologists to describe cross-cultural blindness. People tend to ignore parts of cultures (e.g., religion, health care traditions) that differ from their own. The anthropologist Hazel Weidman noted that orthodox health care providers often view Western health institutions as introducing something of significance into ethnic communities where nothing existed before. Thus the existing health traditions in such communities are ignored.

Borkan and Neher¹⁶ developed a framework for use in family practice training programs, modeled after one developed by Bennett.¹⁷ Bennett suggested a model with stages of individual development relative to cultural sensitivity. The Borkan and Neher model built on this model by recognizing the importance of ethnosensitivity to understanding the whole person and by advancing doctor–patient communication. They recognized that the individual trainee’s relationship with other cultures may be more complex than implied by Bennett’s model. The level of sensitivity exhibited by a trainee can vary according to the group encountered (e.g., sensitive and empathetic to Southeast Asians and culturally unaware with respect to Haitians).

Thus Borkan and Neher suggested a model of ethnosensitivity consisting of seven stages, with curricular strategies and goals to address

each stage: (1) fear, (2) denial, (3) superiority, (4) minimization, (5) relativism, (6) empathy, and (7) integration. Fear is the most problematic stage because it may preclude any efforts to provide medical care. Denial can be addressed by attempting to heighten the awareness of trainees to cultural differences. Superiority is the stage where differences are recognized, but trainees tend to rank them according to their own value system. With minimization, cultural differences are viewed as unimportant against the background of basic human similarities. Ethnic and cultural differences are finally acknowledged in the relativism stage and are no longer seen as threatening. With empathy, the trainee can adopt the frame of reference of patients in order to experience events as they would. Integration is the most advanced level of physician awareness and allows the practitioner to become enmeshed in more than one culture.

Physicians and patients have their own cultural identities. Only by recognizing where one is on the cultural continuum can each encounter be placed in perspective. Knowing oneself and one's views and assumptions, therefore, is the first step in assessing and understanding others.

Individuals often submerge their identification with their past cultural traditions and adopt the traditions of their new country. Harwood¹⁸ enumerated five major factors that may contribute to variation in an individual subscribing to the standards of a group of origin: (1) acculturation, (2) level of income, (3) occupation, (4) area of origin in the mother country, and (5) religion. The level of acculturation may be the most difficult to ascertain by a clinician; eight screening points are delineated for detecting those individuals who tend to be most acculturated into middle-class American standards:

1. Relatively high level of formal education
2. Greater generational removal from immigrant status
3. Low level of involvement within an ethnic or family social network
4. Experience with medical services that incorporates patient education and personal care
5. Previous experience with particular diseases in the immediate family
6. Immigration to this country at an early age
7. Urban, as opposed to rural, origin
8. Limited migration back and forth to the mother country

Harwood pointed out, however, that in times of stress, all individuals may revert to beliefs they do not consistently hold at other times.

Crucial Factors in the Cross-Cultural Clinical Encounter

It should be the goal of any clinical encounter that both the patient and the clinician are able to develop mutual understanding and feel comfortable in the relationship, and that quality health care is delivered in an efficient and timely manner beneficial to the patient. Several factors are necessary for successful physician–patient experience: an awareness of certain core cultural issues, an understanding of the meaning of illness to the patient, an ability for the physician to negotiate across this “cultural divide,” and clarity of communication. Certain elements have been identified as essential for assessing the cultural attributes of a person, community, or group of people and have been termed the domains of culture.

Language

Word usage may not be the same in the cultures of the clinician and the patient, and care should be taken to use simple words that can be easily understood in communication. If a patient does not speak the language of the clinician or vice versa, it is especially important to attempt to alleviate areas of confusion. Up to one third of minority and immigrant households in the United States may be described as linguistically isolated. These are households where no one over the age of 14 speaks English. This poses significant challenges for the physician–patient encounter, especially when translators are not readily available.

A physician, newly arrived at his post on an Indian reservation in the southwestern United States, paid a courtesy call on the chair of the Tribal Council for the group with whom he was assigned. During the course of a half-hour of pleasant conversation, the chair told him that he hoped he would enjoy his stay and find the reservation pleasant. The physician answered by saying that he was sure that he would enjoy his tenure, but that his primary purpose here was to practice medicine and that his enjoyment of his setting was of secondary importance. Within a few hours, word had gotten out on the reservation that the physician had come to the reservation to “practice” (that is, experiment) on the tribe, a misunderstanding that nearly caused his transfer.

Time

Different cultures may hold different concepts of time, which can provide several areas of misunderstanding. For patients from certain cultures, being on time for an appointment may mean within a 15-minute window, within an hour, or within a half-day. The concept of future time may also vary. In some rural-based cultures, advising pa-

tients that they must undertake certain preventive measures to prevent illness at some future time may be difficult to fathom, as their consideration of time may exist only in the present or the next season.

Decision Makers

In some cultures, important decisions, including those involving medical care, may be a communal decision by the extended family or by a designated family leader instead of the spouse or other nuclear family members. In an attempt to expedite an important decision, physicians may alienate these designated decision makers or the patient. Conversely, when the family leader is the patient, other family members may be reticent to accept responsibility for decision making in the event of the incapacity of the family leader involved.

Illness Models

There may be significant differences of opinion between the clinician and the patient, and not just concerning the etiology of certain symptoms. The very recognition of certain conditions as "illness" by the patient and the physician may vary.

An African-American patient presented to a major city hospital emergency room, complaining of nervousness, "shakes," and weight loss over the past several months. He had been unable to sleep and expressed generalized anxiety. Upon more intensive questioning, it was determined by one of the nurses that he felt that one of his former female companions had placed a curse on him, known in the southern coastal region as "the root."

It was difficult in this case for the clinician to accept both the patient's explanation of the etiology of the symptoms and the very existence of the illness described.

Treatment and Effectiveness of Intercession

On occasion, the patient and clinician agree that significant illness is present, but the reasons for the illness and the appropriate treatment may differ significantly.

A woman who had recently moved to Los Angeles from central Mexico presented an 11-month-old child to a physician's office with signs of diarrhea and mild dehydration. The mother, through an interpreter, told the clinician that the child had *mollera caida*, literally "fallen fontanelle." Her method of treatment was to place salt on the fontanelle, turn the child upside down to fill out the sunken spots, and give the child *manzanilla* (chamomile) tea. The clinician, on the other hand, was concerned about the diarrheal etiology and wished to initiate oral rehydration.

Traditional Role of Healer

For better or worse, much of the outcome deriving from the encounter between the clinician and patient depends on the expectations and experiences of the patient in his or her cultural group. If the healer is expected to be omnipotent and make the diagnosis by observation only, questioning by the clinician may be taken as a sign of ignorance or incompetence. The healer may also have been an integral part of the community of the individual and be well respected and liked, or the converse may have been true. These attitudes may be transferred over to the clinician, who is unaware of the expectations bestowed by the patient.

Managing Cross-Cultural Differences

Cultural sensitivity training is implemented regularly in only a small number of medical schools. A 1991 study revealed that only 13% of schools offered cultural sensitivity courses to their students, with all but one being optional.¹⁹ A national survey of family practice residencies in 1985 revealed that only 26% provided learning experiences in culturally sensitive health care.²⁰ However, a 1998 Association of American Medical Colleges' survey revealed that almost 70% of the 94 schools that responded taught courses in cultural competence. Fifteen percent plan to introduce it into the curriculum in the near future. Approximately one third (36%) of residencies offer some kind of formal teaching in this area.^{21,22} The Liaison Committee on Medical Education also launched a new Diversity Standard in May 1999. It notes that students must understand and be able to deal with various belief systems, cultural biases, and other culturally determined factors that influence the manner in which different people experience illness and respond to advice and treatment. Furthermore, the Society of Teachers of Family Medicine (STFM) Task Force on Cross-Cultural Experiences published recommended curriculum guidelines to assist in training family physicians to provide culturally sensitive and competent health care.²³ The goal in such training is competence in recognizing bias, prejudice, and discrimination, using cultural resources, and overcoming cultural barriers to enhance primary care.

Cultural differences can easily lead to differences in the models by which a clinician or a patient might explain a presenting condition and the most effective course of management. Figure 1.1 suggests the ultimate goal in cross-cultural medicine: effective integration of patient and clinician knowledge to produce a shared model

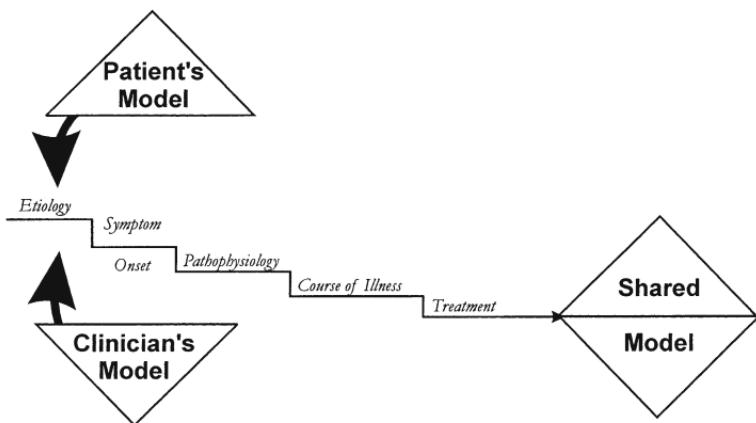


Fig. 1.1. Integration of patient and clinician knowledge to produce a shared model of care.

of care. When a clinician recognizes that a possibility exists for significant differences in the explanatory models of illness and the approach for management, it is necessary to supplement the traditional history to ascertain these issues and develop a plan for coming to some understanding with the patient.

LEARN Model

Berlin and Fowkes²⁴ developed an instrument useful to clinicians for negotiating the differences that may exist between patient and provider. The LEARN acronym is based on the following five steps (Fig. 1.2).

1. Listen. Ask the patient such questions as “What do you think is causing this problem?” “Why do you think it started in this way?” “What do you think this illness is doing to you?” “What do you fear the most about this illness?” “How severe is it?” “What do you think is going to happen to you?” “What kind of treatment do you think you should receive?” These questions give the clinician the framework to understand the patient’s model of etiology of illness and the opportunity to demonstrate empathy and understanding.
2. Explain. With this step the clinician explains his or her interpretation of the medical condition. It may be nothing more than a supposition, but it is important that the clinician present an understanding based on Western medical tradition.

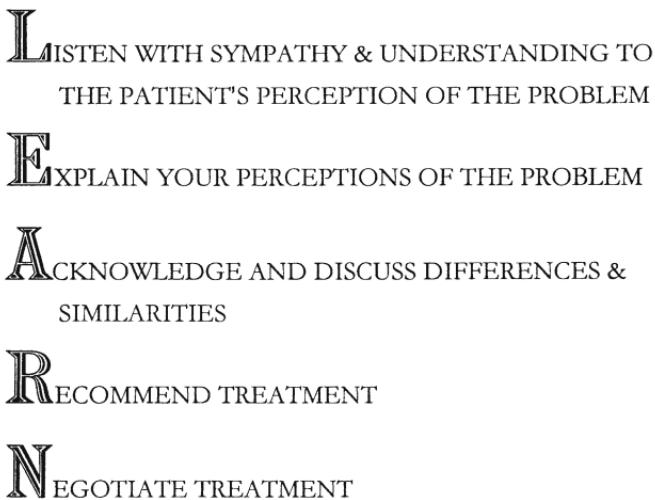


Fig. 1.2. Managing cross-cultural differences: the LEARN model. (Source: Berlin and Fowkes,²⁴ with permission.)

3. Acknowledge. It is important to acknowledge the patient's explanatory model and begin to develop areas where agreement can be met and conflicts between explanatory models can be resolved.
4. Recommend. In this stage, the clinician can recommend a plan for action that incorporates the patient's explanatory models of illness and those of the clinician.
5. Negotiate. Berlin and Fowkes consider this step the most important. It includes incorporating the patient's and clinician's understanding and plans. The final step may well be an amalgamation of the two belief systems that can be mutually tolerated.

In the case of the child with the *mollera caida*, the physician listened carefully to the mother's explanation of the cause of the sunken fontanelle. She then explained to the mother that in her view the cause of the sunken fontanelle was the diarrhea, but acknowledged the concern of the mother for restoring the fullness of the fontanelle. Because the mother was using boiled *manzanilla* tea, she negotiated with the mother to add sufficient nutrients to the tea to compose an oral rehydration solution and encouraged this part of the traditional treatment to continue.

Working with Translators

Special care is needed with interviews involving translators to ensure the accuracy and completeness of the information and the cooperation of the patient. Clinicians must view the translator as part of a

team whose members collaborate to arrive at a competent plan for the patient:

1. Look at the patient when speaking. Always address the patient, not the interpreter, and speak in the first person directly to the patient, asking the interpreter to interpret in a direct fashion.
2. Use comforting body language, recognizing that it is instantaneously interpreted by the patient.
3. Whenever possible, explain to the interpreter in advance what you are trying to say and accomplish during the interview.
4. Assume that there will be misunderstandings, particularly when you are using nonprofessional interpreters.
5. Remain aware and test your patient's understanding. Some patients may understand your language even if they choose to use an interpreter; or, conversely, patients who speak fairly well in the language of the clinician may not have the same level of comprehension.
6. Keep the sentence structure simple, avoiding complex phrases.
7. If there are a significant number of patients in your practice who speak a particular language, it alleviates some misunderstanding if the clinician learns as much of the language as possible. This effort increases the trust of the patient and allows the clinician to more readily pick up errors by the interpreter.²⁵
8. Be especially wary of the accuracy of interpretation from family members, particularly concerning the sexual or gynecologic history of female patients. In certain cultures it is taboo to discuss these topics with the patient, even when interpreting for the clinician. Also, in many cultures children are particularly problematic when acting as translators.

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