



THE CALIFORNIA ENDOWMENT
A Partner for Healthier Communities

**Resources in Cultural
Competence Education for
Health Care Professionals**

Prepared for The California Endowment
Edited by M. Jean Gilbert, Ph.D.

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Dear Colleague:

The California Endowment is pleased to share our publication *Resources in Cultural Competence Education for Health Care Professionals*. Recognizing the changing national demographics and the unacceptable disparities in access to quality health care across population groups, The California Endowment is committed to building the fields of Multicultural Health and Cultural Competence, in part through the creation of publications such as this.

The Endowment's Cultural Competence Program Area aims to advance this emerging field until culturally responsive and linguistically accessible health care is considered a basic right for consumers and an integral part of quality health systems in California. With the broad dissemination of this publication, The California Endowment adds to its growing number of educational resources and publications designed to develop and to strengthen the ability of health care professionals and organizations to serve diverse and underserved populations.

In April of 2001, The California Endowment provided funding for Jean Gilbert and Julia Puebla-Fortier to solicit input from across the nation to develop consensus standards for cultural competence education of health care professionals. The 18-month process included the work of an expert panel, a working symposium and a listserv comment process involving numerous interested persons, experts and stakeholders. I want to recognize Jean Gilbert, Julia Puebla-Fortier and the expert panel for their work in this endeavor. I also want to commend Jai Lee Wong, Senior Program Officer, and Sakinah Carter, Program Associate, for their leadership, and Joseph Betancourt, M.D., Senior Advisor for The Endowment, and Alice Chen, M.D., Health Policy Scholar in Residence at The Endowment, for their guidance on this project.

These resources are intended to complement our *Principles and Recommended Standards for the Cultural Competence Education of Health Care Professionals* as well as *A Manager's Guide to Cultural Competence Education for Health Care Professionals* publications. We hope this publication will assist health care professionals in their efforts to provide culturally appropriate education with the ultimate goal of contributing to the overall improvement in the quality of health care for all consumers.

As this publication embodies an aggregate of information and opinions gathered from many different sources, it does not necessarily represent the opinions of The California Endowment. We hope you find this resource of benefit, and we thank you, as always, for being an important partner for healthier communities.

Sincerely,



Robert K. Ross, M.D.
President and Chief Executive Officer
The California Endowment

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Julia Puebla-Fortier, M.A., of Resources for Cross-Cultural Health Care, assisted as Co-Chair and Expert Consultant.

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This resource bibliography was compiled as part of the research and environmental scan completed for the project, “Setting Standards for the Cultural Competence Education of Healthcare Professionals,” funded by The California Endowment. This research process made it possible to accumulate, in one document, information on a vast array of data, tools, articles, curricula and other resources relative to the cultural competence education of health care professionals. Given that we have produced a set of *Principles and Standards for the Cultural Competence Education of Health Care Professionals*, it seems appropriate to make available this set of resources to those who might use them in framing a context and rationale for educating health care professionals to be more culturally competent or in developing curricula to achieve that purpose.

Over the past decade, in response to the cultural diversification of U.S. society, the community of health care professionals, especially the accreditation bodies, such as the American Association of Medical Colleges and the Accreditation Council for Graduate Medical Education, and associations connected to the health care professions, such as the American Academy of Nursing and the American Academy of Family Practice, have issued policy statements validating the appropriateness and need for including cultural competence education into basic curricula. Additionally, the Office of Minority Health of the U.S. Department of Health and Human Services (DHHS) published in 2000 the standard for Culturally and Linguistically Appropriate Services (CLAS), and the DHHS Office of Civil Rights made clear health care organizations’ obligation to provide language services for participants in federally funded programs, such as Medicare and Medicaid. These policies and standards, taken together, provide endorsement of cultural competence as an aspect of quality health care and set the stage for expectations about the cultural competence of health care professionals. These documents are listed in the Section I, Policy Statements and Standards.

To provide background and context for this effort, it was necessary to assess the field of cultural competence training for health care professionals as it currently exists, noting both the development of curriculum and models intended for this purpose, both in terms of the basic academic education of physicians, nurses and other health care professionals and cultural competence education occurring in continuing education and training. Section II, Cultural Competence Guidelines, Curricula and Models of Care Designed for Health Care Professionals, provides a veritable history of cultural competence curricula developed over three decades in schools of medicine, residency programs and nursing education. Additionally, some models and frameworks are suggested for conceptualizing the knowledge and skills of cultural competency and their application in health care settings.

Sections III and IV, Guidebooks and Manuals and Cultural Competence Assessments, respectively, provide listings of the various guides to providing culturally competent care that have been created by numerous agencies and groups. The assessments, divided into Organizational Assessments, Personal Assessments and Patient Assessments, offer various methods of evaluating the level of cultural competence in the delivery of services and the knowledge and attitudes of individual care providers. We thought that these types of documents would make clear the kinds of expectations that were being formed in the health care community with respect to knowledge and skills that were required of health care professionals and what kinds of environment allowed them to best exercise those proficiencies.



As with any evolving topic in education, science or policy, there is a body of articles, books and journals that contributes to the discourse surrounding the subject. This discourse reflects the experiences, opinions and comparative views and perspectives of persons working in the field. In this literature, it is possible to trace the progression of ideas and experiences as persons coming from different orientations find out what works and what doesn't, what is needed and what is not, and what factors should contribute to the field as it moves forward. Section V, Articles, Books and Reports, and Section VII, Journals, list contributions to the discourse on cultural competency in health care.

Education and training in the field of cultural competence education for health care professionals has been hampered by a dearth of training tools and resources upon which teachers and trainers could draw. Luckily, in the last few years many sources, such as foundations, government agencies, health care organizations, professional associations and individual trainers have developed important data and tools that can be incorporated into training models and curricula. Sections VI, Videos, and Section VIII, Web Sites, list resources for training tools and information.

As with any bibliography of this type, it is, unfortunately, out of date the day it is printed, and no document of this type can be completely exhaustive. However, this particular document covers the materials that were contributed, reviewed and considered by the Expert Panel and Working Symposium participants who endeavored to create consensus principles and standards for educating health care professionals to be culturally competent. We hope it will be useful to you in your work in the field as well.

1. *Accreditation Council for Graduate Medical Education Outcome Project: General Competencies.* Outcomes@acgme.org

Patient Care is made up of the following: (1) A commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse population; and (2) Sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

2. 2001 American Academy of Family Physicians (AAFP). *Cultural Proficiency Guidelines*. The guidelines were approved by the AAFP Board of Directors in March, 2001. For more information, contact AAFP at 11400 Tomahawk Creek Parkway, Leawood, KS 66211 or call 913-906-6000. Web site: www.aafp.org.

Cultural Proficiency Guidelines

The AAFP believes in working to address the health and educational needs of our many diverse populations. A list of issues to consider in preparing informational or continuing medical education material and programs has been developed to ensure cultural proficiency and to address specific health related issues as they relate to special populations of patients and providers. The list, while perhaps not complete, is meant as a dynamic template to assist those developing Academy material and programming for patients and physicians.

Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Care. Like, R, Steiner, P, & Rubel, A. Family Medicine, Vol. 28 (4).

3. 2001 American College of Emergency Physicians. *Cultural Competence and Emergency Care*. Approved by the ACEP Board of Directors, October. For more information, contact ACEP at 1125 Executive Circle, Irving, TX 75038-2522 or call 800-798-1822.

Abstract:

The American College of Emergency Physicians believes that:

- Quality health care depends on the cultural competence as well as the scientific competence of physicians;
- Cultural competence is an essential element of the training of healthcare professionals and to the provision of safe, quality care in the emergency department environment; and
- Resources should be made available to emergency departments and emergency physicians to assure they are able to respond to the needs of all patients regardless of the respective cultural backgrounds.

4. 1998 The American College of Obstetricians and Gynecologists (ACOG) Committee on Health Care for Underserved Women. *Committee Opinion*, No. 201, March. Copyright Clearance Center Danvers, MA 01923. Call 978-750-8400. For more information, contact ACOG at 409 12th Street, SW, PO Box 96920, Washington, D.C. 20090-6920.

Abstract:

Cultural Competency in Health Care

The racial and ethnic composition of the population of the United States has changed significantly during the past decade. Between 1981 and 1991 there was a 90% increase in the Asian population; a 50% increase in people of Hispanic origin; a 43% increase in Native Americans, Eskimos, and Aleuts; and a 15% increase in the African-American population. The white non-Hispanic population, however, increased by only 4%. As of August 1, 1997, Asians and Pacific Islanders comprised 3.8% of the total U.S. population, Hispanics (of any race) comprised 11%, African Americans comprised 12.7%, and Native Americans, Eskimos and Aleuts comprised 0.9% (1). In some areas of the United States, the combined number of African Americans, Hispanics, and Asians now exceeds that of whites.

Culture and Health Care

During every health care encounter, the culture of the patient, the culture of the provider, and the culture of medicine converge and impact upon the patterns of health care utilization, compliance with recommended medical interventions and health outcomes. Often, however, health care providers may not appreciate the effect of culture on either their own lives, their professional conduct or the lives of their patients (3). When an individual's culture is at odds with that of the prevailing medical establishment, the patient's culture will generally prevail, often straining provider-patient relationships (4). Providers can minimize such situations by increasing their understanding and awareness of the culture(s) they serve. Increased sensitivity, in turn, can facilitate positive interactions with the health care delivery system and optimal health outcomes for the patients served, resulting in increased patient and provider satisfaction.

5. American Nurses Association. *Position Statements: Cultural Diversity in Nursing Practice*. <http://www.nursingworld.org/readroom/position/ethics/etcladv.htm>

Knowledge of cultural diversity is vital at all levels of nursing practice. Ethnocentric approaches to nursing practice are ineffective in meeting health and nursing needs of diverse cultural groups of clients. Knowledge about cultures and their impact on interactions with health care is essential for nurses, whether they are practicing in a clinical setting, education, research or administration. Cultural diversity addresses racial and ethnic differences, however, these concepts or features of the human experience are not synonymous. The changing demographics of the nation as reflected in the 1990 census will increase the cultural diversity of the U.S. population by the year 2000, and what have heretofore been called minority groups will, on the whole constitute a national majority (Census, 1990).

Knowledge and skills related to cultural diversity can strengthen and broaden health care delivery systems. Other cultures can provide examples of a range of alternatives in services, delivery systems, conceptualization of illness and treatment modalities. Cultural groups often utilize traditional health care providers, identified by and respected within the group. Concepts of illness, wellness and treatment modalities evolve from a cultural perspective or worldview. Concepts of illness, health and wellness are part of the total cultural belief system.

6. 1990 American Psychological Association (APA). *Guidelines for Culturally Diverse Populations: APA Guidelines Approved by the APA Council of Representatives* in August. For more information, write to 750 First Street, NE, Washington, DC 20002. Tel. 202-336-5500. www.apa.org/pi/guide.html.

This public interest directorate consists of guidelines, illustrative statements and references. The guidelines represent general principles that are intended to be aspirational in nature and are designed to provide suggestions to psychologists in working with ethnic, linguistic, and culturally diverse populations. There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services. This increased motivation for improving quality of psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs and cultural expectations have been introduced into educational, political, business and health care systems by the physical presence of these groups. The issues of language and culture impact on the provision of appropriate psychological services.

7. 1998 Association of American Medical Colleges. *Teaching and Learning of Cultural Competence in Medical School*. Contemporary Issues in Medical Education, Feb; Vol. 1(5). Division of Medical Education, AAMC, Washington, DC.
8. 2000 CLAS Culturally and Linguistically Appropriate Services in Managed Care Organizations. *Member Services Questionnaire (MCP)*. *Provider Relations Questionnaire (PCP)*. <http://www.omhrc.gov/clas/>.

This project makes recommendations for national standards for culturally and linguistically appropriate services in health care. Based on an analytical review of key laws, regulations, contracts and standards currently in use by federal and state agencies and other national organizations, these standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. Each standard is accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates. Most of the questions in the interviews ask about the operating unit or units that are responsible for delivering health services in variable.

9. 1999 Committee on Pediatric Workforce and the American Medical Association Advisory Committee on Minority Physicians. *Culturally Effective Pediatric Care: Education and Training Issues*. American Academy of Pediatrics, Jan; Vol. 103 (1):167-170.

This policy statement defines culturally effective health care and describes its importance for pediatrics. The statement also defines cultural effectiveness, cultural sensitivity and cultural competence, and describes the importance of these concepts for training in medical school, residency and continuing medical education. The statement is based on the premise that culturally effective care is important and that the knowledge and skills necessary for providing culturally effective health care can be taught and acquired through 1) educational courses and other formats developed with the expressed purpose of addressing cultural competence and/or cultural sensitivity, and 2) educational components on cultural competence and/or cultural sensitivity that are incorporated into medical school, residency and continuing education curricula.

10. 1997. New York State Cultural and Linguistic Competency Standards. New York State Office of Mental Health. For information, contact Design Center, 44 Holland Avenue, Albany, NY 12229. Tel. 518-473-2684.

The methods and strategies employed are discussed and the team members introduced. The scope of the project is presented along with a review of the five domains, or standards for cultural competency in mental health services.

11. Liaison Committee on Medical Education. *Standard on Cultural Diversity*. Full text of LCME Accreditation Standards (from Functions & Structure of a Medical School, Part 2). www.lcme.org

“Faculty & students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness & respond to various symptoms, diseases, & treatments. Medical students should learn to recognize & appropriately address gender & cultural biases in health care delivery, while considering first the health of the patient.”

12. National Association of Social Workers (NASW).
<http://www.naswdc.org/diversity/default.asp#top>

NASW is committed to social justice for all. Discrimination and prejudice directed against any group are damaging to the social, emotional and economic well-being of the affected group and of society as a whole. NASW has a strong affirmative action program that applies to national and chapter leadership and staff. It supports three national committees on equity issues: the National Committee on Women’s Issues, National Committee on Racial and Ethnic Diversity and the National Committee on Gay, Lesbian and Bisexual Issues. The information contained in their web site reflects some of NASW’s material and work on diversity and equity issues.

13. Society for Public Health Education (SOPHE). *Code of Ethics for the Health Education Profession*. <http://www.sphe.org/> (click on “About SOPHE” and then click “Ethics.”)

Abstract:

The Health Education profession is dedicated to excellence in the practice of promoting individual, family, organizational, and community health. Guided by common ideals, Health Educators are responsible for upholding the integrity and ethics of the profession as they face the daily challenges of making decisions. By acknowledging the value of diversity in society and embracing a cross-cultural approach, Health Educators support the worth, dignity, potential, and uniqueness of all people. The Code of Ethics provides a framework of shared values within which Health Education is practiced. The Code of Ethics is grounded in fundamental ethical principles that underlie all health care services: respect for autonomy, promotion of social justice, active promotion of good, and avoidance of harm. The responsibility of each health educator is to aspire to the highest possible standards of conduct and to encourage the ethical behavior of all those with whom they work. Regardless of job title, professional affiliation, work setting, or population served, Health Educators abide by these guidelines when making professional decisions.

14. WICHE Western Interstate Commission for Higher Education. *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups*. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; U.S. Department of Health and Human Services.

“The standards are designed to provide readers with the tools and knowledge to help guide the provision of culturally competent mental health services within today’s managed care environment. This document melds the best thinking of expert panels of consumers, mental health service providers, and academic clinicians from across the four core racial/ethnic populations: Hispanics, American Indians/Alaska Natives, African Americans, and Asian/Pacific Islanders. Developed for states, consumers, mental health service providers, educators and organizations providing managed behavioral health care, the volume provides state-of-the-science cultural competence principles and standards – building blocks to create, implement and maintain culturally competent mental health service networks for our diverse population.” The site provides educators, policymakers and legislators with data and issues-oriented analysis by subject matter.

Cultural Competence Guidelines and Curricula Designed for Health Care Professionals

1. 1995 Alexander, Matthew. *Cinemeducation: An Innovative Approach to Teaching Multi-Cultural Diversity in Medicine*. Annals of Behavioral Science and Medical Education. Vol. 2 (1):23-8. Department of Family Practice, Area Health Education Center, Carolinas Medical Center, Charlotte, North Carolina.
2. 2001 American Medical Student Association (AMSA). *PRIME Cultural and Diversity*, Medical University of South Carolina.
3. 2001 Barakzai, Cricket; Ensign, Katherine. *Family Nurse Practitioner/Physician Assistant Program*. University of California, Davis.
4. 1990 Barker, L. Randol. *Curriculum for Ambulatory Care Training in Medical Residency: Rationale, Attitudes, and Generic Proficiencies*. Journal of General Internal Medicine, Jan/Feb; Vol. 5 (Supplement):S3-S14.

This paper provides a foundation for establishing curricula to train medical residents in ambulatory care. To do so, it first presents reasons that curricula are needed in this area. It then delineates attitudes and proficiencies (knowledge and skills) that such curricula should be designed to instill. Finally, it briefly discusses implications for curriculum development. Extensive tables are provided, including detailed lists of generic proficiencies that residents should attain. Among realms in which these proficiencies lie are organizing the ambulatory care encounter, using interpersonal skills, gathering information through physical examination and other means, obtaining and employing clinically useful knowledge, documenting the encounter, and planning and coordinating care. The paper notes that planning for the discharge of patients from the hospital can contribute to obtaining proficiencies important in ambulatory care.

5. 1983 Berlin, Elois Ann; Fowkes, William C. *A Teaching Framework for Cross-Cultural Health Care – Application in Family Practice*. Western Journal of Medicine, Dec. 139:934-8. South Bay Area Health Education Center, San Jose, California.
6. 1991 Bobo L, Womeodu RJ, Knox AL. *Principles of Intercultural Medicine in an Internal Medicine Program*. The American Journal of Medical Sciences, Oct; Vol. 302 (4):244-8. University of Tennessee School of Medicine, Memphis, TN.
7. 1991 Borkan, Jeffrey M.; Neher, Jon O. *A Developmental Model of Ethnosensitivity in Family Practice Training*. Family Medicine, Mar-Apr; Vol. 23 (3):212-7. Department of Family and Community Medicine, University of Massachusetts Medical Center. USC – PIH Family Practice Residency Program.

8. 1999 Campinha-Bacote, Josepha. *A Model and Instrument for Addressing Cultural Competence in Health Care*. Journal of Nursing Education, May; Vol. 38 (5):203-7. Primarily for Nursing Education.

Abstract:

The Interlocking Paradigm of Cultural Competence is a model that uses specific theoretical, philosophical, process and assessment factors to develop and implement cultural competence within areas of practice, as well as education and research (Warren, 1999). The five factors include nurse-client interaction, theory, philosophy, process and assessment, which are visually represented in a circular, interrelated overlapping style. Warren (1999) uses the works of Peplau (1952), Leininger (1995), Nichols (1987), Purnell (1998), and Campinha-Bacote (1994) in describing the factors needed to develop and implement cultural competence. This article discusses the “process” factor of cultural competence that health care providers and health care organizations can use as a framework for developing and implementing culturally responsive health care services. This article also proposes an instrument based on this model of cultural competence that will assist in the measurement and evaluation of cultural competence among health care professionals.

9. 1999 Carrillo, J. Emilio; Green, Alexander R.; Betancourt, Joseph R. *Cross-Cultural Primary Care: A Patient-Based Approach*. Annals of Internal Medicine, May; Vol. 130:829-34. New York Presbyterian Hospital-New York Weill Cornell Medical Center, New York, New York.
10. 2000 Clark, Lauren; Zuk, Jeannie; Baramée, Julaluk. *A Literary Approach to Teaching Cultural Competence*. Journal of Transcultural Nursing, July; Vol. 11 (3):199-203.

Abstract:

Cultural competence is a necessity in today’s diverse society and an essential component of clinical practice. As an adjunct to other sources, literature can enrich teaching and sensitize students to cultural issues in health care. “The Spirit Catches You and You Fall Down” is a beautifully written and compelling story well suited for instructional purposes. Although widely recommended, nurses are largely ignored in this story of a Hmong family seeking medical care. The book describes how the health care system failed to provide adequate care to patients from a different cultural background despite providers’ good intentions. Nurse educators can use structured discussion guides to synthesize literary accounts such as “The Spirit Catches You and You Fall Down” with theory and research about cultural competence.

11. 1984 Collins, James L., Mathura, Clyde B., Risher, Debra L. *Training Psychiatric Staff to Treat a Multicultural Patient Population*. Hospital and Community Psychiatry, April; Vol. 35 (4):372-6.

Abstract:

Cultural and linguistic barriers have long been problems in establishing an effective therapeutic alliance between patients and therapists from different cultural, ethnic, and racial backgrounds. The current emphasis on cultural psychiatry has stimulated the inclusion of culturally relevant material in the curricula of American psychiatric residency programs, such as the program at Howard University Hospital in Washington, D.C. After a preliminary study of foreign a preliminary study of foreign patients treated on the psychiatry service, the department of psychiatry established a program of seminars and didactic sessions intended to familiarize staff and trainees with cultural patterns of the largest groups of foreign students attending the university. The department also participated in a transcultural fellowship program for medical students sponsored by the American Psychiatric Association and the National Institute of Mental Health. After describing the programs, the authors briefly discuss such culturally related issues as foreign patients' return to their original language when they develop psychiatric illnesses.

12. 1997 Culhane-Pera, Kathleen A; Reif, Chris; Egli, Eric; Baker, Nancy J; Kassekert, Rosanne. *A Curriculum for Multicultural Education in Family Medicine*. Family Medicine, Nov-Dec; Vol. 29 (10):719-23. Department of Family and Community Medicine, Regions Hospital, St. Paul Ramsey Family Practice Residency, St. Paul.
13. 2000 Culhane-Pera, Kathleen A; Like, Robert C; Lebensohn-Chialvo, Patricia; Loewe, Ronald. *Multicultural Curricula in Family Practice Residencies*. Family Medicine, Mar; Vol. 32 (3):167-73.
14. 1999 Culhane-Pera, Kathleen A. *Intercultural Family and Community Medicine Curriculum*. Department of Family and Community Medicine, HealthPartners – SPRMC.
15. Davis, Betsy J.; Voegtle, Katherine H. Culturally Competent Health Care for Adolescents-A Guide for Primary Care Providers. Published by the Department of Adolescent Health, American Medical Association.
16. 1994 DeSantis, Lydia. *Making Anthropology Clinically Relevant to Nursing Care*. Journal of Advanced Nursing, Vol. 20:707-15.

Abstract:

Transcultural nursing is generally seen as the interface between anthropology and nursing. A prime objective of transcultural nursing has been the translation of concepts from anthropology and nursing into the nursing process to guide a culturally informed clinical practice. To date, there has been a general inability

of transcultural nursing to operationalize the concept of culture to develop culturally competent clinicians; that is, nurses who are capable of knowing, utilizing, and appreciating the effects of culture in the resolution of an individual, group, community, and/or family problem. A model of transcultural nursing is described, for incorporating the concept of culture into patient care. It includes the concepts of cultural brokerage, simultaneous dual ethnocentrism, multiple clinical realities, the patient as cultural informant, and cultural assessment of patient views of clinical reality. The problems of making anthropology and transcultural nursing clinically relevant through the transcultural nursing model are presented and methods are recommended for addressing such problems.

17. 2000 DiCicco-Bloom, Barbara. *Practical Approaches to Developing Cultural Competency*. Home Health Care Management and Practice, Feb. Vol. 12 (2):30-7.
18. 2000 The Division of Medicine in Society: Department of Preventive Medicine, State University of New York at Stony Brook
www.uhmc.sunysb.edu/prevmed/mns/mcs/1/.

The Division of Medicine in Society (DMS) presently occupies an important corner of the Department of Preventive Medicine and consists of a small multi-disciplinary group of medical humanists who run the four-year Medicine in Contemporary Society course taken by all students at the Stony Brook School of Medicine. The Medicine in Contemporary Society (MCS) curriculum begins with fifty class hours, largely small group work, in each of the first two years. The division is nationally recognized as having one of the strongest programs in spite of its relatively small faculty base. Aspects of their course have recently been featured in *Academic Medicine* and *Teaching and Learning in Medicine*.

19. Dowling, Patrick; Cifuentes Henderson, Paula. *Linking Graduate Medical Education to an Underserved Community*. The California Endowment Cultural Competency Residency Program #19911227. UCLA Family Medicine.
20. 1989 Eisenbruch, Maurice. *Medical Education for a Multicultural Society*. The Medical Journal of Australia, Nov; Vol. 151:574-6, 579-80. Department of Child and Family Psychiatry, Royal Children's Hospital, Parkville, VIC.
21. 2000 Flores, Glenn; Gee, Denise; Kastner, Beth. *The Teaching of Cultural Issues in U.S. and Canadian Medical Schools*. Academic Medicine, Vol. 75 (5):451-5. Presented in part at the annual meetings of the Association for American Medical Colleges, Washington, DC and the Pediatric Academic Societies, Washington, DC.
22. 2000 Flores, Glenn. *Culture and the Patient-Physician Relationship: Achieving Cultural Competency in Health Care*. The Journal of Pediatrics, Vol. 136 (1):14-23.

23. 1980 Foulks, Edward. *The Concept of Culture in Psychiatric Residency Education*. The American Journal of Psychiatry, July; Vol. 137 (7):811-6.
24. 1986 Galazka, Sim S; Eckert, Kevin J. *Clinically Applied Anthropology: Concepts for the Family Physician*. The Journal of Family Practice, Vol. 22 (2):159-65. Case Western Reserve University, Department of Family Medicine, Department of Anthropology.
25. 1996 Gill, Paramjit S; Adshead, David. *Teaching Cultural Aspects of Health: A Vital Part of Communication*. Medical Teacher, Vol. 18 (1):61-4. Center for Research in Primary Care and Division of General Practice and Public Health Medicine, University of Leeds, UK.
26. 2001 Godkin, Michael A.; Savageau, Judith A. *The Effect of a Global Multiculturalism Track on Cultural Competence of Preclinical Medical Students*. Family Medicine, Mar; Vol. 33 (3):178-86. Department of Family Medicine and Community Mental Health, University of Massachusetts.
27. 1996 Goldman, Roberta E.; Monroe, Alicia D.; Dube, Catherine E. *Cultural Self-Awareness: A Component of Culturally Responsive Patient Care*. Annals of Behavioral Science and medical Education, Vol. 3 (1):37-46. Brown University School of Medicine.
28. Green, Alexander R.; Betancourt, Joseph R.; Carrillo, J. Emilio. *Cross-Cultural Curriculum Syllabus*. Weill Medical College of Cornell University; New York Presbyterian Hospital Internal Medicine Residency Program.
29. Green, Alexander R.; Betancourt, Joseph R.; Carrillo, J. Emilio. *Integrating Social Factors into Cross-cultural Medical Education*. Academic Medicine, March; Vol. 77 (3):193-7.

Abstract:

The field of cross-cultural medical education has blossomed in an environment of increasing diversity and increasing awareness of the effect of race and ethnicity on health outcomes. However, there is still no standardized approach to teaching doctors in training how best to care for diverse patient populations. As standards are developed, it is crucial to realize that medical educators cannot teach about culture in a vacuum. Caring for patients of diverse cultural backgrounds is inextricably linked to caring for patients of diverse social backgrounds. In this article, the authors discuss the importance of social issues in caring for patients of all cultures, and propose a practical, patient-based approach to social analysis covering four major domains – (1) social stress and support networks, (2) change in environment, (3) life control, and (4) literacy. By emphasizing and expanding the role of the social history in cross-cultural medical education, faculty can better train medical students, residents, and other health care providers to care for socioculturally diverse patient populations.

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Abstract:

This detailed and introspective book chapter describes Dr. Kleinman's experiences in integrating anthropological perspectives and research into a Department of Psychiatry and Behavioral Sciences. Of great value are his carefully delineated analyses of the "fit" between anthropological thinking and clinical practices. He takes pains to make clear the training, background and attitudes needed by anthropologists if they are to positively and practically interact in clinical education and in clinical settings. Candid reflection on his own experiences and case study examples make clear his points.

39. 1996 Krajewski-Jaime; Brown, Karen Strauch; Ziefert, Marjorie; Kaufman, Elizabeth. *Utilizing International Clinical Practice to Build Inter-Cultural Sensitivity in Social Work Students*. Journal of Multicultural Social Work, Vol. 4 (2):15-29. Department of Social Work, Eastern Michigan University.
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44. 2002 Leuning, Cheryl; Swiggum, Paula; Barmore Wiegert, Hazel Marie; McCullough- Zander, Kathleen. *Proposed Standards for Transcultural Nursing*. Journal of Transcultural Nursing, Jan.; Vol. 13 (1):40-6.

Abstract:

For the past 3 years, the Minnesota Chapter of the Transcultural Nursing Society has focused efforts on the development of standards for transcultural nursing practice. The standards, based on Leininger's culture care theory and Campinha-Bacote's model of cultural competence, are intended to foster excellence in transcultural nursing practice, to provide criteria for the evaluation of nursing care, to be a tool for teaching and learning, to increase the public's confidence in the nursing profession, and overall to advance the field of transcultural nursing. The standards are presented as an invitation for individual and collective reflection and commentary.

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Abstract:

Family physicians and other health professionals care for individuals from a wide variety of backgrounds, both in the United States and abroad. The delivery of high-quality primary health care that is meaningful, acceptable, accessible, effective and cost-efficient requires a deeper understanding of the sociocultural background of patients, their families, and the environments in which they live.

It's also critical to become more aware of how one's own cultural values and beliefs influence the provision of clinical care. This guideline of core curriculum was developed by the Society of Teachers of Family Medicine's Task Force on Cross-cultural Experiences, Group on Multicultural Health Care and Education, and Group on Minority Health Care.

46. 1999-2000 Like, Robert. *1999-2000 Annual Report*. Center for Healthy Families and Cultural Diversity Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School.
47. Like, Robert C.; Afran, Joyce G.; Stuart, Marian R.; Gottlieb, Jan E. *Teaching Communication Skills for Working with Diverse Populations*. UMDNJ-Robert Wood Johnson Medical School.
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55. 1993 Marvel, M. Kim; Grow, Mary; Morphey, Peggy. *Integrating Family and Culture into Medicine: A Family Systems Block Rotation*. Family Medicine, July-Aug; Vol. 25 (7):441-2. University of Wisconsin Family Practice.
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57. McDiarmid, Jim. *Merced Family Practice Residency Program: Community Medicine Rotation*. Community Campus Mercy Medical Center Merced-CHW. Contact: mcdiarj@chw.edu.
58. McDiarmid, Jim. *Caring for Diverse Communities: Cultural Competency and Clinical Practices – CPCA Annual Conference*, David Campa.
59. Medical University of South Carolina – Amy V. Blue, Ph.D.
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65. 2001 National MSH Resource Center on Cultural Competency. *The Provider’s Guide to Quality and Culture*. Texas Department of Health.

66. 1982 Ness, Robert C. *Medical Anthropology in a Preclinical Curriculum*. In Chrisman and Maretaki, Eds. CLINICALLY APPLIED ANTHROPOLOGY. Boston: D. Reidel Publishing Company. University of Connecticut Medical School Preclinical Program.

Abstract:

In this book chapter, Ness pays particular attention to the strategies a medical anthropologist must use when integrating cultural concepts into medical courses and activities. He notes that many preclinical medical students have had little experience with the theories and methods of the behavioral sciences and at first have difficulty seeing their relevance to their premed studies. He carefully details how he prepares students to receive this information, how he works cultural issues into the context of medical concepts and purposes, and how he uses different patient-centered and experiential activities in which to embed cultural perspectives. While this article reflects an early attempt to integrate cultural competence into medical education, Ness' savvy and imaginative teaching techniques are applicable to the current medical school curriculum.

67. 2002 Office of Minority Health, U.S. Department of Health and Human Services in association with Rebeca Rios and Jacquelyn Graham of the American Institutes for Research. *Teaching Cultural Competence in Health Care: A Review of Current Concepts, Policies and Practices*. For more information, contact Carlos Rodriguez, Ph.D., Project Director for the American Institutes for Research at 1000 Thomas Jefferson Street NW, Suite 400, Washington, D.C. 20007 or call 202-944-5343. E-mail Carlos Rodriguez at crodriguez@air.org.

Abstract:

With growing concerns about racial and ethnic disparities in health, and the need for health care systems to accommodate increasingly diverse patient populations, "cultural competence" has become more and more a matter of national concern. Training physicians to care for diverse populations is essential. The purpose of this paper is to report findings of an environmental scan that will serve to inform the development of Cultural Competence Curriculum Modules (CCCM) for family physicians. In conducting the environmental scan for the present initiative, they gathered information through literature searches, Internet searches, and phone calls with experts in the field. The purpose of this paper is to synthesize their findings regarding the concepts, policies, and teaching practices with respect to culturally competent health care. They focused on information that pertains particularly to family physicians, which are the subject of this project. The information they gathered fell into three categories that comprise the main sections of this paper: information that provides family physicians with a context and culturally competent care, language access services, and organizational supports – and information related to pedagogical issues of curricula and training.

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69. 1992 Pico, Elaine; Wimbley, mark; Wells, Kenneth B. *First-year Students' Expectations of Interacting with Minority Patients and Colleagues*. Academic Medicine, Vol. 67:411-2. University of California Los Angeles.

Abstract:

In a 1988-89 pilot study, the authors surveyed the first-year medical students at the University of California, Los Angeles, School of Medicine in order to examine the students' expectations regarding future encounters with minority colleagues and patients, and how these expectations related to the students' own race or ethnicity and their perceived levels of experience with various racial-ethnic groups; 89 of 140 students responded (64%). There were significant positive associations between the students' levels of experience working or interacting socially with blacks or Hispanics (regardless of the students' own race or ethnicity) and their perceived likelihood of practicing with black or Hispanic partners, whereas there were significant negative associations between experience with blacks or Hispanics and the perceived likelihood of living in predominantly white communities. Further, the black and Hispanic students expected to have a higher percentage of their patients from black or Hispanic backgrounds than did other students. The authors suggest that these results underscore the importance of evaluating students' experience as well as race or ethnicity when attempting to increase representation of students with a commitment to serve minority populations.

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74. 1999 St. Clair, Anita; McKenty, Leda. *Preparing Culturally Competent Practitioners*. Journal of Nursing Education, May; Vol. 38 (5):228-34. School of Nursing, University of Massachusetts, Amherst, Massachusetts.

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78. Streeter, Rob; Campa, David; McDiarmid, Jim. *Second Year Residents on Community Medicine Rotation – Culture Clinic at Golden Valley*. Email: mcdiarj@chw.edu.
- Abstract:*
Films to be viewed each week by second-year residents prior to their clinical session. The films are separated into three-week intervals and topics range from culture and religion, Hmong patients and “Spirit Doctors” to slavery, African-American health issues, and cultural diversity of four cultures.
79. 1998 Tervalon, Melanie; Murray-Garcia, Jann. *Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education*. Journal of Health Care for the Poor and Underserved, Vol. 9 (2):117-25.
80. Thom, David H. *Culturally Competent Care: Measurement, Clinical Outcomes, and Intervention*. Stanford University School of Medicine. Division of Family and Community Medicine, Stanford University School of Medicine. For more information, contact David Thom at Stanford University, Office of Research Affairs, 3333 California Street, Suite 315, Box 0962, San Francisco, CA 94118. E-mail: dthom@itsa.ucsf.edu.
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1. American Medical Student Association Home Page – Diversity in Medicine. <http://www.amsa.org/div/>

Abstract:

The American Medical Student Association (AMSA) is the oldest and largest independent association of physicians-in-training in the United States. The association focuses its energies on the problems of the medically underserved, inequities in our health-care system and related issues in medical education. There is a PowerPoint presentation that outlines current health disparities with a closer look at the causes and student-driven solutions. An exercise called Diversity Shuffle and modules, Cross-cultural Issues in Primary Care and Cultural Competency in Medicine Project in a Box, are provided to educate, provoke interest and encourage discussion about differences and similarities within our communities. This site also has an online survey which addresses the required cultural diversity curricula at schools.

2. 1983 Berlin, Eloise Ann; Fowkes, William C. Jr. *A Teaching Framework for Cross-cultural Health Care*. Western Journal of Medicine, Vol. 139 (6):934-938.

Abstract:

Significant demographic changes in patient populations have contributed to an increasing awareness of the impact of cultural diversity on the provision of health care. For this reason, methods are being developed to improve the cultural sensitivity of persons responsible for giving health care to patients whose health beliefs may be at variance with biomedical models. Building on methods of elicitation suggested in the literature, [the authors] have developed a set of guidelines within a framework called the LEARN model. Health care providers, who have been exposed to this educational framework and have incorporated this model into the normal structure of the therapeutic encounter, have been able to improve communication, heighten awareness of cultural issues in medical care, and obtain better patient acceptance of treatment plans. The emphasis of this teaching model is not on the dissemination of particular cultural information, though this too is helpful. The primary focus is rather on a suggested process for improved communication, which we see as the fundamental need in cross-cultural patient-physician interactions.

3. 1999 Betancourt, Joseph R.; Carrillo, J. Emilio; Green, Alexander R. *Hypertension in Multicultural and Minority Populations: Linking Communication to Compliance*. Current Hypertension Reports, Vol. 1:482-8.

Abstract:

Cardiovascular disease disproportionately affects minority populations, in part because of multiple socio-cultural factors that directly affect compliance with anti-hypertensive medication regimens. Compliance is a complex health behavior determined by a variety of socioeconomic, individual, familial and cultural factors. In general, provider-patient communication has been

shown to be linked to patient satisfaction, compliance, and health outcomes. In multicultural and minority populations, the issue of communication may play an even larger role because of linguistic and contextual barriers that preclude effective provider-patient communication. These factors may further limit compliance. The ESFT Model for Communication and Compliance is an individual, patient-based communication tool that allows for screening for barriers to compliance and illustrates strategies for interventions that might improve outcomes for all hypertensive patients.

4. 1991 Bobo, Loretta; Womeodu, Robin J.; Knox, Alfred L. Jr. *Society of General Internal Medicine Symposium: Principles of Intercultural Medicine in an Internal Medicine Program*. American Journal of Medical Science, Vol. 302 (4):244-248.

Abstract:

Internal Medicine and medicine-pediatric residents completed a questionnaire that measure variables including sociodemographics, family dynamics, cross-cultural exposure, and exposure to intercultural medicine principles. Questions were answered regarding perceptions of their patients and level of comfort discussing specific cultural variables. Gender, training status and geographic background did not influence responses, but the responses of European-Americans (71%) vs. ethnic minorities and foreign medical graduates (29%) were significantly different. European-Americans were more likely to be men, less likely to have an urban background, and their self-described socioeconomic status was upper-middle to upper class. European-Americans vs. all others differed in their perceptions of patients' financial support, and reasons for doctor-patient miscommunications. The European-Americans had significantly less exposure to friends and classmates, and instructors of ethnic origins different than their own prior to residency training. [Their] data supports the inclusion of intercultural medicine principles in the general medicine curriculum.

5. 2000 Brach, Cindy; Fraser, Irene. *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*. Medical Care Research and Review, Vol. 57 (1):181-217.

Abstract:

This article develops a conceptual model of cultural competency's potential to reduce racial and ethnic health disparities, using the cultural competency and disparities literature to lay the foundation for the model and inform assessments of its validity. The authors identify nine major cultural competency techniques: interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, immersion into another culture, and administrative and organizational accommodations. The conceptual model shows how these techniques could theoretically improve the ability of health systems and their clinicians to deliver appropriate services to diverse populations, thereby improving outcomes and reducing disparities. The authors conclude that while there is substantial research evidence to

suggest that cultural competency should in fact work, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly.

6. 1991 Burkett, Gary L. *Culture, Illness, and the Biopsychosocial Model*. Family Medicine, May/June; Vol. 23 (4):287-91.

Abstract:

Family medicine has appropriated the biopsychosocial model as a conceptualization of the systemic interrelationships among the biological, the psychological and the social in health and illness. For all its strengths, it is questionable whether this model adequately depicts the centrality of culture to the human experience of illness. Culture (as meaning system) is not an optional factor that only sometimes influences health and illness; it is prerequisite for all meaningful human experience, including that of being ill. A more adequate model of the relationship between culture and illness would demonstrate the preeminence of culture in the experience of illness among all people, not just members of “exotic” cultures; would view healers as well as patients as dwellers in culture; would incorporate the role of culture as meaning system in linking body, mind, and world; and would promote the significance of the cultural context as a resource for research and therapy.

7. 1998 Campinha-Bacote, Josepha. The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care (3rd Edition). To place an order, contact: Transcultural C.A.R.E. Associates, 11108 Huntwicke Place, Cincinnati, OH 45241. Tel. /Fax 513-469-1664.

Abstract:

The proposed conceptual model can provide health care providers with an effective framework for delivering culturally competent care. The model's constructs of cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire have the potential to yield culturally responsive interventions that are available, accessible, affordable, acceptable, and appropriate. The goal of engaging in the process of cultural competence is to create a “cultural habit.”

8. 1996 Campinha-Bacote, Josepha. *The Challenge of Cultural Diversity for Nurse Educators*. The Journal of Continuing Education in Nursing, Mar/Apr; Vol. 27 (2):59-64.

Abstract:

Nurses are awaking to the critical need to become more knowledgeable and culturally competent to work with individuals from diverse cultures (Leininger, 1994). However, teaching cultural awareness in nursing education can present a major professional challenge for nurse educators. This article discusses cultural competence and presents a conceptual model of culturally competent health care. Based on this model, the article also discusses the implementation of a four-session cultural diversity program in a rural hospital setting.

9. 1997 Carballeira, N. *The LIVE and LEARN Model for Cultural Competent Family Services*. Continuum, Jan./Feb., pp. 7-12.
10. 1999 Carrillo, J. Emilio; Green, Alexander R.; Betancourt, Joseph R. *Cross-cultural Primary Care: A Patient-Based Approach*. Annals of Internal Medicine, Vol. 130 (10):829-834.

Abstract:

In today's multicultural society, assuring quality health care for all persons requires that physicians understand how each patient's sociocultural background affects his or her health beliefs and behaviors. Cross-cultural curricula have been developed to address these issues but are not widely used in medical education. Many curricula take a categorical and potentially stereotypic approach to cultural competence that wed patients of certain cultures to a set of specific, unifying characteristics. In addition, curricula frequently overlook the importance of social factors on the cross-cultural encounter. This paper discusses a patient-based cross-cultural curriculum for residents and medical students that teaches a framework for analysis of the individual patient's social context and cultural health beliefs and behaviors. The curriculum consists of five thematic units taught in four 2-hour sessions. The goal is to help physicians avoid cultural generalizations while improving their ability to understand, communicate with and care for patients from diverse backgrounds.

11. 1996 Clinton, Jacqueline F. *Cultural Diversity and Health Care in America: Knowledge Fundamental to Cultural Competence in Baccalaureate Nursing Students*. Journal of Cultural Diversity, Vol.3 (1):4-8.

Abstract:

In order for undergraduate nursing students to integrate cultural diversity concepts into clinical practice, they require prerequisite theoretical knowledge of the relationships between cultural phenomena and health. This article is an overview of a beginning level theory course designed to enhance students' cultural awareness and sensitivity to United States ethnic groups. These attributes are viewed as two of the antecedents of culturally competent nursing practice.

12. 1997 Culhane-Pera, Kathleen A.; Reif, Chris; Egli, Eric; Baker, Nancy J.; Kassekert, Rosanne. *A Curriculum for Multicultural Education in Family Medicine*. Educational Research and Methods, Vol. 29 (10):719-723.

Abstract:

Background and Objectives: To deliver effective medical care to patients from all cultural backgrounds, family physicians need to be culturally sensitive and culturally competent. Our department implemented and evaluated a 3-year curriculum to increase residents' knowledge, skills and attitudes in multicultural medicine. Our three curricular goals were to increase self-awareness

about cultural influences on physicians, increase awareness about cultural influences on patients and improve multicultural communication in clinical settings. Curricular objectives were arranged into five levels of cultural competence. Content was presented in didactic sessions, clinical settings and community medicine projects. Methods and Results: Residents did self-assessments at the beginning of the second year and at the end of the third year of the curriculum about their achievement and their level of cultural competence. Faculty's evaluations of residents' levels of cultural competence correlated significantly with the residents' final self-evaluations. Residents and faculty rated the overall curriculum as 4.26 on a 5-point scale (with 5 as the highest rating). Conclusions: Family practice residents' cultural knowledge, cross-cultural communication skills, and level of cultural competence increased significantly after participating in a multicultural curriculum.

13. 2000 Donini-Lenhoff, Fred G.; Hedrick, Hannah L. *Increasing Awareness and Implementation of Cultural Competence Principles in Health Professions Education*. Journal of Allied Health, Vol. 29 (4):241-245.

Abstract:

Even as the importance of improved communication between health professionals and patients grows, the factors making it more difficult continue unabated-everything from expanding medical technology and increased sub-specialization to America's ever-increasing cultural diversity. This article looks at some of the ways health care professionals, administrators, accreditors, and educators across the continuum of medical and health-related professions are seeking to increase the cultural competence skills of current and future practitioners. Many of these efforts, however, are still too recent and limited to produce measurable results. Data on the implementation of educational standards and curricula need to be collected, analyzed, and disseminated to begin to identify the degree to which standards and educational materials are being developed and implemented and what, if any, impact they are having on the delivery of culturally effective care.

14. 2000 Flores, Glen. *Culture and the Patient-Physician Relationship: Achieving Cultural Competency in Health Care*. Journal of Pediatrics, Vol. 136 (1):14-23.

Abstract:

It is hardly news to physicians on the front lines of patient care that the cultural diversity of our patients is broadening daily. Those of us who want to provide sensitive, competent care to families from cultures other than our own are in urgent need of practical advice. In many health care settings today, this need is addressed by "diversity consultants" who put their "clients" through mind-numbing exercises. It is unusual to come out of such exercises with a practical strategy to use in the office or clinic. In this context, readers will find the article by Flores a much-needed breath of fresh air. Although the author bases his recommendations that any health care provider can immediately incorporate into his or her practice. The specific recommendations are targeted at those caring for Latinos, but the model of cultural competency he presents is widely applicable.

15. George Washington University – Module 2: Cultural Competence. <http://learn.gwumc.edu/iscope/Cultcomp.htm>.

This web page details a specific outline for the George Washington University School of Medicine students. It provides learning objectives, definitions, case histories and examples of potential differences in values, references and links. It presents general information about cultures, minority populations, and recently immigrated minorities, compares and contrasts non-verbal communication, such as distance, eye contact, and body language, to verbal communication and offers self-reflection and team exercises.

16. 1987 Gonzalez-Lee, Teresa; Simon, Harold J. Simon. *Teaching Spanish and Cross-cultural Sensitivity to Medical Students*. Western Journal of Medicine, Vol. 146 (4):502-504.

Abstract:

The authors note that the Department of Community and Family Medicine at the University of California, San Diego (UCSD) and the UCSD Medical Center recognized that communication process is a vital factor in patient care. Also, they recognized the need to overcome language and other cultural barriers to enable health care professionals to understand the concepts of health and illness in other cultures and to teach the tenets of science-based medicine to patients from diverse cultural backgrounds. As a result, health care providers and the teaching faculty designed two specialized Spanish and cross-cultural programs—one for the second-year medical students of the UCSD School of Medicine and the other for family medicine residents at UCSD-Medical Center in San Diego. The demographics and location of San Diego contributed to the rationale for the establishment of these programs. The authors describe the novel approaches and frameworks of the two different programs and their success with the programs thus far. The two programs share the objectives of developing a high-level of cross-cultural understanding and sensitivity among students by means of a language acquisition process and through carefully supervised contacts with Latino patients in clinical settings.

17. 2002 Green, Alexander R.; Betancourt, Joseph R.; Carrillo, J. Emilio. *Integrating Social Factors into Cross-Cultural Medical Education*. Academic Medicine, Vol. 77 (3):193-197.

Abstract:

The field of cross-cultural medical education has blossomed in an environment of increasing diversity and increasing awareness of the effect of race and ethnicity on health outcomes. However, there is still no standardized approach to teaching doctors in training how best to care for diverse patient populations. As standards are developed, it is crucial to realize that medical educators cannot teach about culture in a vacuum. Caring for patients of diverse cultural backgrounds is inextricably linked to caring for patients of diverse social backgrounds. In this article, the authors discuss the importance of social issues

in caring for patients of all cultures and propose a practical, patient-based approach to social analysis covering four major domains — (1) social stress and support networks, (2) change in environment, (3) life control, and (4) literacy. By emphasizing and expanding the role of social history in cross-cultural medical education, faculty can better train medical students, residents and other health care providers to care for socioculturally diverse patient populations.

18. Hablamos Juntos Resource Center: Models, Approaches, and Tools.
<http://www.hablamosjuntos.org/resourcecenter/default.asp>

The purpose of the resource center is to provide users with general resources to language access, information about the rationale for a program like Hablamos Juntos, information about what is being done in the field of language barriers, and information about what they are learning from their grantees and colleagues. The Models, Approaches, and Tools document, prepared by the National Council on Interpreting in Health Care, reviews four types of models that are being used to improve language access: Bilingual Provider Models, the Bilingual Patient Model, Ad Hoc Interpreter Models and Dedicated Interpreter Models. Within each of these types, the advantages and disadvantages of different models are discussed.

19. 1998 Janes, Sharyn; Hobson, Kay. *An Innovative Approach to Affirming Cultural Diversity Among Baccalaureate Nursing Students and Faculty*. Journal of Cultural Diversity, Vol. 5 (4):132-137.

Abstract:

“Cultural Diversity” has become the buzzword of the nineties. The United States has become the most culturally diverse nation in the world. Since there is no arena where cultural diversity is more critical than health care, it is imperative that nursing students and faculty become comfortable with the issues surrounding the delivery of culturally competent care. The University of Southern Mississippi has developed an innovative program with a dual purpose: (a) to provide an environment of mutual understanding and respect for people of different cultures; and (b) to provide a comfortable environment where minority students can be valued and nurtured.

20. 1999 Kai, Joe; Spencer, John; Wilkes, Michael; Gill, Paramjit. *Learning to Value Ethnic Diversity - What, Why and How?* Medical Education, Vol. 33 (8):616-623.

Abstract:

Learning to value ethnic diversity is the appreciation of how variations in culture and background may affect health care. It involves acknowledging and responding to an individual’s culture in its broadest sense. This requires learning the skills to negotiate effective communication, a heightened awareness of one’s own attitudes, and sensitivity, to issues of stereotyping, prejudice and racism. This paper aims to contribute to debate about some of the key issues that learning to value ethnic diversity creates. Although some medical training

is beginning to prepare doctors to work in an ethnically diverse society, there is a long way to go. Promoting 'value ethnic diversity' in curricula raises challenges and the need to manage change, but there are increasing opportunities within the changing context of medical education. Appropriate training can inform attitudes and yield refinement of learners' core skills that are generic and transferable to most health encounters. Care must be taken to avoid a narrow focus upon cultural differences alone. Learning should also promote examination of learners' own attitudes and their appreciation of structural influences upon health and health care, such as racism and socio-economic disadvantage. Appropriate training and support for teachers are required and learning must be explicitly linked to assessment and professional accreditation. Greater debate about theoretical approaches, and much further experience of developing, implementing and evaluating effective training in this area are needed. Medical educators may need to overcome discomfort in developing such approaches and learn from experience.

21. 1978 Kleinman, Arthur; Eisenberg, Leon; Good, Byron. *Culture, Illness, and Care - Clinical Lessons from Anthropologic and Cross-Cultural Research*. Annals of Internal Medicine, Vol. 88 (2):251-8.

Abstract:

Major health care problems, such as patient dissatisfaction, inequity of access to care and spiraling costs, no longer seem amenable to traditional biomedical solutions. Concepts derived from anthropologic and cross-cultural research may provide an alternative framework for identifying issues that require resolution. A limited set of such concepts is described and illustrated, including a fundamental distinction between disease and illness, and the notion of the cultural construction of clinical reality. These social science concepts can be developed into clinical strategies with direct application in practice and teaching. One such strategy is outlined as an example of a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application. The implementation of this approach in medical teaching and practice requires more support, both curricular and financial.

22. 1983 Kristal, Laura; Rennock, Patrick W.; Foote, Sandra McLaren; Trygstad, Carl W. *Cross-Cultural Family Medicine Residency Training*. The Journal of Family Practice, Vol. 17 (4):683-687.

Abstract:

Over the past four years the University of California, San Diego (UCSD), Family Medicine Residency Program has developed a cross-cultural training program. The goal of the program is to prepare residents to function as effective health care providers in medically underserved areas with ethnically diverse patient populations. The required training activities include: (1) a Spanish language course; (2) a clinical rotation in a community health clinic serving a Hispanic, medically under-served population; (3) a preceptorship in home-based health education and counseling for Spanish-speaking families; and (4) a set of

cross-cultural sensitivity training activities that are part of the Residency Behavioral Science Program. The UCSD Cross-Cultural Family Medicine Training Program is described here as a prototype for consideration by other family medicine residency programs.

23. 1996 Like, Robert C.; Steiner, R. Prasaad; Rubel, Arthur J. *Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care. Family Medicine*, Vol. 28 (4):291-297.

Abstract:

To aid in dissemination of curriculum guidelines created by Society of Teachers of Family Medicine (STFM) groups and task forces. Family Medicine will begin publishing such guidelines when deemed to be important to the Society's members. The information that follows are recommendations for helping residency programs train family physicians to provide culturally sensitive and competent health care. These guidelines were developed by the STFM task force and groups listed below and have been endorsed by the Society's Board of Directors and the American Academy of Family Physicians. Family Medicine encourages other STFM groups and task forces to submit similar documents that can serve as curricular models for residency training and medical education. Groups or task forces that submit information to the journal should follow the Instructions for Authors published each year in the January issue of Family Medicine and available on the Internet on STFM's home page (<http://stfm.org>).

24. 1999 Louden, Rhian Frances; Anderson, Pauline Monica; Gill, Paramjit Singh; Greenfield, Sheila Margaret. *Educating Medical Students for Work in Culturally Diverse Societies. JAMA*, Vol. 282 (9):875-880.

Abstract:

Recent attention has focused on whether government health service institutions, particularly in the United Kingdom, reflect cultural sensitivity and competence and whether medical students receive proper guidance in this area. [The researchers' objective with this study was to] systematically identify educational programs for medical students on cultural diversity, in particular, racial and ethnic diversity. Studies included in the analysis were articles published in English before August 1998 that described specific programs for medical students on racial and ethnic diversity. Of 1,456 studies identified by the literature search, 17 met the criteria. The following data were extracted: publication year, program setting, student year, whether a program was required or optional, the teaching staff and involvement of minority racial and ethnic communities, program length, content and teaching methods, student assessment and nature of program evaluation. Of the 17 selected programs, 13 were conducted in North America. Eleven programs were exclusively for students in years one or two. Fewer than half the programs were part of core teaching. Only one required program reported that the students were assessed on the session in cultural diversity. [This] study suggests that there is limited information available on an increasingly important subject in medical education. Further research is needed to identify effective components of educational programs on cultural diversity and valid methods of student assessment and program evaluation.

25. 1999 National Center for Cultural Competence, Georgetown University Child Development Center; 3307 M Street, NW Suite 401, Washington, DC 20007-3935. Tel. 800-788-2066. cultural@georgetown.edu.

Abstract:

The policy brief provides a rationale for cultural competence in regards to demographics, eliminating disparities, and improving the quality of services and health outcomes. It also discusses meeting legislative and accreditation mandates, gaining a competitive edge in the market place, and decreasing liability and malpractice claims. A Checklist to Facilitate the Development of Culturally and Linguistically Competent Primary Health Care Policies and Structures is provided. Cultural competence at the organizational and individual level is a developmental process. It gives steps in a continuum from cultural destructiveness to cultural proficiency.

26. 1994 Nora, Lois Margaret; Daugherty, Steven R.; Mattis-Peterson, Amy; Stevenson Linda; Goodman, Larry J. *Improving Cross-cultural Skills of Medical Students Through Medical School-Community Partnerships*. Western Journal of Medicine, Vol. 161 (2):144-147.

Abstract:

Postulating that a program integrating language skills with other aspects of cultural knowledge could assist in developing medical students' ability to work in cross-cultural situations and that partnership with targeted communities was key to developing an effective program, a medical school and two organizations with strong community ties joined forces to develop a Spanish Language and Hispanic Cultural Competence Project. Medical student participants in the program improved their language skills and knowledge of cultural issues, and a partnership with community organizations provided context and resources to supplement more traditional modes of medical education.

27. 2000 Nunez, AE. *Transforming Cultural Competence into Cross-Cultural Efficacy in Women's Health Education*. Academic Medicine, Vol. 75 (11):1071-80. Correspondence can be sent to Dr. Nunez at nuneza@drexel.edu.

Abstract:

To prepare students to be effective practitioners in an increasingly diverse United States, medical educators must design cross-cultural curricula, including curricula in women's health. One goal of such education is cultural competence, defined as a set of skills that allow individuals to increase their understanding of cultural differences and similarities within, among, and between groups. In the context of addressing health care needs, including those of women, the author states that it is valid to define cultural groups as those whose members receive different and usually inadequate health care compared with that received by members of the majority culture. The author proposes, however, that cross-cultural efficacy is preferable to cultural competency as a goal of cross-cultural education because it implies that the caregiver is effective in interactions that involve individuals of different cultures and that neither the

caregiver's nor the patient's culture offers the preferred view. She then explains why cross-cultural education needs to expand the objectives of women's health education to go beyond the traditional ones, and emphasizes that learners should be trained in the real-world situations they will face when aiding a variety of women patients. There are several challenges involved in both cross-cultural education and women's health education (e.g., resistance to learning; fear of dealing openly with issues of discrimination; lack of teaching tools, knowledge and time). There is also a need to assess the student's acquisition of cross-cultural efficacy at each milestone in medical education and women's health education. Components of such assessment (e.g., use of various evaluation strategies) and educational objectives and methods are outlined. The author closes with an overview of what must happen to effectively integrate cross-cultural efficacy teaching into the curriculum to produce physicians who can care effectively for all their patients, including their female patients.

28. Perspectives of Differences: *A Diversity and Cross-Cultural Medicine Teaching Module for the Internet*. <http://dgim.ucsf.edu/pods/html/main.html>

"Perspectives of Differences" is a curriculum that teaches the principles of diversity and cross-cultural medicine. The need for instruction on issues of diversity and cross-cultural training across all health professional programs is nationally recognized. "Perspectives of Differences" is designed for trainees at all levels of health professional training. The program includes four Perspectives of Differences (PODs) for the individual trainee to learn the knowledge, skills and attitudes needed to become culturally competent providers."

29. 1998 Robins, Lynne S.; Fantone, Joseph C.; Hermann, Julica; Alexander, Gwen L.; Zweifler, Andrew J. *Improving Cultural Awareness and Sensitivity Training in Medical School*. Academic Medicine, Vol. 73 (10 Suppl.):S31-S34.

Abstract:

Authors describe a series of sessions for first year medical students at the University of Michigan. Sessions included videotapes, small groups discussions, and other diversity exercises. Introspection, self-awareness and some knowledge about the connection between culture and patient care were the program goals. This set of activities was specifically designed to mitigate medical students' resistance previously documented by program planners following the presentation of other multicultural material. In an intriguing evaluation strategy, Likert ratings of sessions were stratified by whether participants were minority men, minority women, majority men or majority women. Consistently, across 8 points of evaluation, the lowest rating was given by majority men. Focus groups data documented that majority men "felt under attack" in this year of the program. In subsequent years, incorporating participants' suggestions for more clinically-oriented examples and additions of facilitators with clinical experience, ratings increased significantly. Majority men were apparently much more engaged in the program than in the previous year. This is an important and to-date rare example of the implementation and evaluation of specific instructional techniques in multicultural medical education.

30. 1997 Scott, Carol Jack. *Enhancing Patient Outcomes Through an Understanding of Intercultural Medicine: Guidelines for the Practitioner*. Maryland Medical Journal, Vol. 46 (4):175-80. Emergency Department, University of Maryland Medical Center.

Abstract:

As cultural and ethnic diversity increase within American society, physicians face new challenges in recognizing patients' culturally defined expectations about medical care and the cultural/ethnic dictates that influence physician-patient interactions. Patients present to practitioners with many mores related to concepts of disease and illness, intergenerational communication, decision-making authority and gender roles. In addition, many cultural groups follow folk medicine traditions, and an increasing number of Americans seek treatment by practitioners of alternative therapies before seeking traditional western medical attention. To facilitate patient assessments, enhance compliance with health care instructions, and thus achieve the best possible medical outcomes and levels of satisfaction, practitioners must acknowledge and respect the cultural differences patients bring to medical care environments.

31. 1996 Shapiro, Johanna; Lenahan, Patricia. *Family Medicine in a Culturally Diverse World: A Solution-oriented Approach to Common Cross-cultural Problems in Medical Encounters*. Family Medicine, Vol. 28 (4):249-255.

Abstract:

Using cultural sensitivity in the training of family practice residents generally results in positive consequences for patient care. However, certain potential problems associated with cross-cultural educational efforts deserve examination, including patient stereotyping, assumptive bias, and the confounding of ethnicity with class and socioeconomic status. Even awareness of these pitfalls may not guarantee physician avoidance of other barriers to effective patient care, such as communication difficulties, diagnostic inaccuracies, and unintentional patient exploitation. Despite these complications, future family physicians must continue to participate in educational activities that increase sensitivity toward and understanding of patients of different ethnicities. This article discusses certain features characteristic of the ways in which cultural variables operate in the doctor-patient encounter and identifies specific ways in which residents can successfully elicit and use cultural knowledge to enhance patient care.

32. 1998 Tervalon, Melanie; Murray-Garcia, Jann. *Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education*. Journal of Health Care for the Poor and Underserved, Vol. 9 (2):117-125.

Abstract:

Researchers and program developers in medical education presently face the challenge of implementing and evaluating curricula that teach medical students and house staff how to effectively and respectfully deliver health care to the increasingly diverse populations of the United States. Inherent in this challenge

is clearly defining educational and training outcomes consistent with this imperative. The traditional notion of competence in clinical training as a detached mastery of a theoretically finite body of knowledge may not be appropriate for this area of physician education. Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.

33. 1998 Welch, Melissa. *Required Curricula in Diversity and Cross-cultural Medicine: The Time is Now*. Journal of the American Medical Women's Association, Vol. 53 (Suppl.):121-123.

Abstract:

Culture affects the health of patients in many ways. The increasing diversity of the US population and of medical students, residents, and faculty underscores the need for training in diversity and cross-cultural medicine. Curricula addressing culturally diverse populations are well defined in nursing and psychiatry, but have only recently been introduced in medical school and residency programs. This discussion reviews the justification for introducing specific, required curricula in diversity and cross-cultural medicine for all residency programs. Principles underlying diversity curricula, effective teaching approaches, and challenges to consider when implementing such curricula are discussed. Teaching and evaluation strategies from the published literature are highlighted. Based on the literature review, examples of ways to integrate diversity and cross-cultural curricula into academic-based residency programs are described.

34. 1998 Zweifler, John; Gonzalez, Anna Marie. Teaching Residents to Care for Culturally Diverse Populations. Academic Medicine, Vol. 73 (10):1056-1061.

Abstract:

To care for diverse populations, authors propose that three areas outside the traditional medical curriculum must be presented to students: cultural competency, public health, and community oriented primary care. "The goal is to have physicians go beyond addressing the needs of individual patients to partnering with community and on the community level to improve the health of many individuals." These are overlapping disciplines, according to the authors, each with its own set of challenges in teaching residents about them. For instance, authors see an effective public health intervention effort as limited by financial constraints, saying, "Imagine if primary care residents could refer to a community health worker as easily as they could order an x-ray or refer to a cardiologist!" Authors are very frank about the expectation for residents' competencies, insisting:..."an overall sensitivity to the influence of the patient's culture and the willingness to try to understand the patient's perspective, no matter how different, and no matter how little the physician knows of the patient's culture, is both realistic and necessary for good care."

Guidebooks and Manuals

1. Administration on Aging. *Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families*. <http://www.aoa.dhhs.gov/minorityaccess/guidebook2001/default.htm>.

Abstract:

This guidebook is designed for use by providers of services to racially and ethnically diverse older populations. There is growing interest in learning how effective, culturally appropriate services can be provided by professionals who have mastered culturally sensitive attitudes, skills, and behaviors. It is only an introduction and not intended to substitute for more rigorous and on-going study. For readers who have taken more formal courses to acquire cultural competence, this guidebook might serve as a review. The guidebook is divided into six chapters and five appendices. Each of the first three chapters takes a particular perspective or point of view critical to understanding cultural competence. For example, in Chapter Two they explore the meaning of cultural competence. Part A provides a definition of culture and discusses the intervening factors that determine the impact of culture. Part B provides a definition of cultural competence, Part C outlines the barriers to accessing services experienced by minority elders, and Part D gives an overview of research accomplished in this area.

2. 2001 American Medical Association. *Cultural Competence Compendium*. <http://www.ama-assn.org/ama/pub/category/4848.html>.

Abstract:

The contents of the Cultural Competence Compendium include cultural competence articles in American medical news and related cultural competence links. The foreword is written by Nancy W. Dickey, M.D., President of the American Medical Association. The compendium contains links to physician professional organizations, resources emphasizing communication skills, and curriculum and training materials. Needs and resources for specific populations can be found, specifically for underserved and underrepresented racial, ethnic, and socioeconomic groups. Here, you can also find information on complementary and spiritual practices and their impact on effective care, relevant materials from nursing and other health professions, patient support materials, including self-help group resources, and representative cultural competence publications. The *Project to Enhance the Cultural Competence of Physicians* can be found in Section 10, Part 3.

3. Center for Cross-Cultural Health. *Six Steps Toward Cultural Competence: How to Meet the Health Care Needs of Immigrants and Refugees*. For information, contact: CCCH at 1313 SE 5th Street, Suite 100B, Minneapolis, MN 55414. Tel. 612-379-3573. CCCH@crosshealth.com.

Abstract:

The report is for anyone interested in the relationship between health and culture in Minnesota. It provides information on how health care can be more accessible to immigrants and refugees who go to Minnesota.

4. 2001 CSAT'S Knowledge Application Program; CDM/JBS Joint Venture. *Treatment Improvement Protocol: Improving Cultural Competence in Substance Abuse Treatment – A Meta-Analysis of the Literature.*

Abstract:

This guidebook provides definitions and discusses the importance of culture and cultural competence in substance abuse treatment, cultural competency principles for substance abuse clinicians, and the process of change and recovery. The author offers techniques in multicultural counseling, substance abuse counseling with specific populations, and discusses outreach and linkages, as well as organizational cultural competence. There is also a special segment on culturally competent screening, assessment, and treatment planning.

5. Davis, Betsy J. & Voegtle, Katherine H. *Culturally Competent Health Care for Adolescents. A Guide for Primary Care Providers.* Department of Adolescent Health, American Medical Association, 515 N. State St., Chicago, IL 60610.

Abstract:

This handbook discusses the affect of culture on adolescents, their development and their health care. It offers suggestions on how primary care physicians can assess cultural beliefs and practices that affect adolescent health care and recommends techniques for working effectively with adolescents and their families. A section is devoted to specific information on major U.S. racial/ethnic groups. Resource organizations are cited and an appendix gives guidelines for using interpreters in a medical encounter.

6. Department of Health and Human Services. *Cultural Competence: A Journey.* For further information on BPHC's cultural competency programs, contact: Health Resources and Services Administration, Bureau of Primary Health Care, Office of Minority and Women's Health, 4350 East West Highway, Bethesda, MD 20814.

Abstract:

The publication summarizes the evolving experiences of community programs affiliated with the Health Resources and Services Administration's Bureau of Primary Health Care providing services to culturally diverse populations. This is geared towards professionals devoted to the promotion of health and the prevention, early intervention, and treatment of acute and chronic diseases.

7. 2001 Department of Health and Human Services (DHHS). *Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families.* <http://www.aoa.dhhs.gov/minorityaccess/guidbook2001>

8. Heartland Alliance for Human Needs and Human Rights. *“Building Linguistic and Cultural Competency: A Tool Kit for Managed Care Organizations and Provider Networks that Serve the Foreign-Born.”* A Publication of the Mid-America Institute on Poverty. Contact: Heartland Alliance for Human Needs and Human Rights, 208 South LaSalle, Suite 1818, Chicago, IL 60604.

Abstract:

The purpose of the manual is to introduce the managed care industry, and its administrators and practitioners, to issues related to the implementation of health care services in LEP communities. It combines into one volume, an overview of the primary theoretical and research literature on the health beliefs, conditions, and health seeking behaviors of the foreign-born. It explores the unique needs of linguistically and culturally diverse populations while offering concrete ideas about how to meet those needs. It provides specific models and tools designed to achieve linguistic and cultural competency in the administration of systems and in the delivery of health care services.

9. La Maestra Family Health Center, Inc., San Diego, CA; FC/FGM Task Force Project. Female Circumcision/Female Genital Mutilation: An Introductory Manual for Health Care Providers.

Abstract:

The manual is primarily geared toward health care professionals whose clients include women and girls from communities, especially African communities that traditionally practice FC/FGM. The purpose of the manual is to provide health care providers with an outline of information pertaining to the practice of FC/FGM, and to help them understand such things as the history and cultural beliefs about the practice, the different types of FC/FGM, treatment and prevention, medical complications, and legal issues. It also offers additional resources available regarding FC/FGM. Contact: La Maestra Family Health Center, Inc. 619-584-1612. Contact: la_maestra@att.net.

10. 1996 Lipson, Juliene G.; Dibble, Suzanne L.; Minarik, Pamela A. *Culture & Nursing Care: A Pocket Guide*. UCSF Nursing Press: 521 Parnassus Avenue, San Francisco, CA 94143. Tel. 415-476-2626.

Abstract:

The editors of this book assume that no one person can describe the entire tapestry of human experiences. The processes of this book were to bring together the knowledge of many people about themselves and their strands of the tapestry. The purpose of this book is to offer practicing nurses a snapshot of human diversity. We are not providing a cookbook, but a set of general guidelines to alert nurses to the similarities as well as differences within and among the groups that compromise the tapestry. We urge readers to use this book as a starting point for individualizing their nursing care.

11. 1999 Nash, Kimberleigh A. Cultural Competence – A Guide for Human Service Agencies. CWLA Press, Washington, D.C. CWLA Press is an imprint of the Child Welfare League of America. Contact CWLA at 440 First Street, NW, Third Floor, Washington, D.C. 20001-2085 or E-mail: books@cwla.org. Visit their web site at: <http://www.cwla.org>.

Abstract:

The child welfare field is undergoing rapid and dramatic change as it struggles to provide quality services to children and their families. One of the most critical challenges the field faces is the need to understand and respond effectively to changes in the multicultural nature of American society – changes brought about by the mixture of racial, ethnic, social, cultural, and religious traditions of the children and families who make up their diverse society. Given the range of pressures that have an impact on agencies, executives of human service agencies face the dilemma of whether to include cultural competence as an organizational goal.

12. 2001 The National Alliance for Hispanic Health. *A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics*. For information, contact: The National Alliance for Hispanic Health at 1501 Sixteenth Street, NW, Washington, DC 20036. Tel. 202-387-5000. www.hispanichealth.org.

Abstract:

The book is a guide to providing health care to Hispanics. The primer is a distillation of information health care providers may need to assure delivery of the best possible care to Hispanic clients in a variety of clinical, prevention, and social service settings. The National Alliance for Hispanic Health also offers a newsletter, *Vacunadas para la familia: Immunization for All Ages*.

13. 1992 The National Hemophilia Foundation. *Chapter Outreach Demonstration Project: Reaching Out to Culturally Diverse Hemophilia Populations*.

Abstract:

The manual was created to assist in outreach efforts to culturally diverse hemophilia populations. It provides concrete information on how to implement an outreach project over a four-year period. The manual includes chapters on case studies, program set-up, training and evaluation, planning and outreach interventions.

14. National Maternal and Child Health Resource Center on Cultural Competency, Texas Department of Health. *Journey Towards Cultural Competency: Lessons Learned*.

Abstract:

The publication discusses the National MCH's role on cultural competency, as well as guiding principles and factors to consider in developing cultural competency. It focuses on lessons learned and offers some sample guidelines and assessment tools.

15. 1995 New York Task Force on Immigrant Health, New York School of Medicine. *Cross-Cultural Care Giving in Maternal and Child Health: A Trainer's Manual*. Contact NY Task Force at 550 First Avenue, New York, NY 10016. Tel. 212-263-8783.

Abstract:

The training manual will aid the trainer in developing cross-cultural awareness in maternal and child health care. It is also intended to equip the trainer with the knowledge and techniques to be able to conduct an immigrant health training for maternal and child health care providers. The training program consists of four modules: (1) Training introduction and working with interpreters; (2) Cross-cultural medical interview and epidemiological issues; (3) Health beliefs, attitudes, and practices in maternal and child health; and (4) Family dynamics and domestic violence.

16. 2000 Paez, Kathryn, A.; Gunter, Margaret, J. of the Lovelace Clinic Foundation for the Centers for Medicaid and Medicare Services. *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Organizations*. <http://cms.hhs.gov/>.
17. 2002 Paez, Kathryn A.; Gunter, Margaret, J. of the Lovelace Clinic Foundation for the Centers for Medicaid and Medicare Services. *Providing Oral Linguistic Services: A Guide for Managed Care Organizations*. <http://cms.hhs.gov/>.
18. 1989 Randall-David, Elizabeth. *Strategies for Working With Culturally Diverse Communities and Clients*. For information, contact: Office of Maternal and Child Health, U.S. Department of Health and Human Services at 5600 Fishers Lane, Rockville, MD 20857. Tel. 301-443-2370.

Abstract:

The manual is designed to help health care providers increase their understanding of the cultural aspects of health and illness so they can work effectively with individual clients and with families from culturally diverse communities. Information contained in each chapter provides culturally sensitive and appropriate health education, counseling and care.

19. 2000 Salimbene, Suzanne. *What Language Does Your Patient Hurt In? A Practical Guide to Culturally Competent Patient Care*. Interface International: 3821 East State Street, #197, Rockford, IL, 61108. Tel. 815-965-7535; Fax 815-965-4960.

Abstract:

This guide is designed to assist health care professionals and staff to understand the needs, expectations and behaviors of multicultural patient populations. The information contained in the guide has been limited to “need to know” essential information and organized in an easily accessible format so that caregivers can consult it “on the spot.” Although intended for direct caregivers, the guide will also prove helpful to office personnel, particularly those responsible for setting appointments or having the initial contact with patients. Additional sources are



listed for those who wish to learn more about a particular cultural group. The guide contains general tips on communicating with persons from other cultures and specific information to improve the caregiver's ability to interact successfully with patients from specific ethnic and/or cultural groups. Also included are guidelines for using interpreters, for communicating with limited English-speaking patients, and for integrating the patients' cultural beliefs and traditional health practices with the caregiver's treatment plan in order to encourage compliance. The guide provides a useful tool for all medical personnel and institutions to understand culturally diverse populations and provide culturally appropriate high-quality care.

20. 1986 United States Department of Agriculture; United States Department of Health and Human Services. *Cross-Cultural Counseling: A Guide for Nutrition and Health Counselors*.

Abstract:

The purpose of this guide is to increase awareness of, and provide information for counseling clients with different beliefs, customs, and behaviors related to food and health. A "standard" approach to counseling that does not consider a client's cultural background can create barriers that block effective communication. To get your message across to the client requires culturally appropriate communication strategies. Some keys to counseling are understanding cultural values, understanding health beliefs, and the difference in verbal and non-verbal communication. Certain approaches to dietary change and overcoming the language barrier can open the doors to a greater awareness. The guide offers selected bibliography on cultural influences on health and nutrition, as well as a brief look at relevant sociocultural issues of four cultural minority groups.

Assessing the Cultural Competence of Organizations and Health Care Personnel

1. 2000 Abernethy, Alexis; Baars, Luisa; Luu, Quyen; Hong, Jay; Olivares, Telva; Ruiz, Leticia. *Culturally Competent Assessment and Treatment Planning Curriculum*. Monroe County, Rochester, New York.

Abstract:

The curriculum focuses on differential treatment, cultural and linguistic competency standards, training goals and objectives.

2. 2002 Anderson, Charles C. (Mike); Anderson, M.P.A. *Linguistically Appropriate Access and Services: An Evaluation and Review for Healthcare Organizations*. Working Paper Series, Vol. 6, The National Council on Interpreting in Health Care. <http://www.ncihc.org>.

Abstract:

The goal of this paper is to offer a process by which a health care organization can evaluate its existing structure and capacity for providing linguistically and culturally appropriate care and accessibility at all levels. This evaluation will help identify actions needed to improve quality of care, clinical outcomes, service delivery, cost containment and regulatory compliance. It also sets forth standard evaluation parameters and considerations that provide a nationally uniform approach to the evaluation of language access.

3. 1999 Andrulis, Dennis; Delbanco, Thomas; Avakian, Laura; Shaw-Taylor, Yoku. *The Cultural Competence Self-Assessment Protocol*. February; A Publication of the National Public Health and Hospital Institute, Washington, D.C. Project Support: The Robert Wood Johnson Foundation. Contact: Gartrell Wright at 718-270-7727 or e-mail gartrell.wright@downstate.edu.

4. 1999 Aponte, Carmen. *Cultural Competence: Self-Assessment Survey*. Western Region of New York State, New York State Office of Mental Health.

Abstract:

The report summarizes the process and results of the cultural competency self-assessment survey of the Western Region. The primary goal of the survey was to identify cultural competency training needs and existing organizational strengths/weaknesses with the intent to develop a plan for training and skill development for community mental health agencies. The survey was geared towards helping mental health programs improve services to minority populations.

5. 2001 California Pan-Ethnic Health Network. *Diverse Patients, Disparate Experience: The Use of Standardized Patient Satisfaction Surveys in Assessing the Cultural Competence of Health Care Organizations*. California HealthCare Foundation, Oakland, CA. www.chcf.org.

The purpose of this project was to examine whether standardized surveys of consumers' experience and satisfaction with health care could provide useful information on certain dimensions of the cultural competence of health care organizations. Specifically, the project had three aims:

- To assess the potential usefulness of standardized consumer surveys for evaluating the cultural competence of health providers and plans. Their hypothesis was that a subset of items on these surveys would have the potential to contribute to this assessment.
- To develop recommendations for enhancing the ability of existing surveys to capture the experiences and assessments of patients from communities of color.
- To begin identifying alternatives to standardized surveys for assessing cultural competence.

CAHPS, Picker Inpatient and Physician Value Check (PVC) reviewed and discussed. Findings and recommendations are reviewed. Very comprehensive discussion of the issues.

6. Centers for Disease Control and Prevention. *Checklist for Developing Culturally Competent Health Communication Programs*. Contact: Claudia Parvaanta 4 0 4 - 639-7281.

Abstract:

The checklist outlines some of the issues needed to be aware of at each of the five steps to cultural relevancy. Each step takes you closer to achieving culturally competent health communication. The steps discussed are language, imagery, medical recommendations or actions, related behavior and sequencing, and predisposing, enabling and reinforcing factors.

7. 1993 The Child Welfare League of America (CWLA), Inc. Cultural Competence Self-Assessment Instrument. For more information, contact the CWLA Publications Department at: 440 First Street, NW, Suite 310, Washington, D.C. 20001-2085.

The *Cultural Competence Self-Assessment Instrument* is a CWLA management tool to help organizations providing services to children, youths and their families identify, improve, and enhance cultural competence in staff relations and client service functions. The instrument, which has been field-tested, provides a practical, easy-to-use approach to address the major issues of delivering culturally competent service.

8. 2000 The Cross Cultural Health Care Program (CCHCP). Written by Naima Solomon, Principal Investigator. *Death and Dying in Ethnic America: Findings in Eritrean, Oromo, and Somali Communities*. A research study conducted by The Cross Cultural Health Care Program, Seattle Washington. Copyright 2000. For more information, contact CCHCP at 1200 12th Avenue S, Seattle, WA 98144 or call 206-621-4161.
E-mail: xculture@pacmed.org. Web site: <http://www.xculture.org>.

9. 1991 Cross, T; The Northwest Indian Child Welfare Association, Inc. Organizational Self-Study on Cultural Competence. Portland, OR. For more information, contact Terry Cross at The National Indian Child Welfare Association located at 3611 SW Hood Street, Portland, OR 97201 or call 503-222-4040.

Abstract:

This is an organizational self-study on cultural competence: governing body, administrative, service provider and consumer versions.

10. 1998 Dana, RH. *Cultural Competence In Three Human Service Agencies*. Psychological Reports, 83:107-12. For more information, contact Richard Dana with Regional Research Institute for Human Services at Portland State University at PO Box 751, Portland, OR 97207-0751 or call 503-725-4040.

Abstract:

Agency cultural competence checklist: revised form.

11. 1994 Family and Youth Services Bureau, U.S. Department of Health and Human Services. *Cultural Competence Self-Assessment: Staff Survey*.

12. 1991 Isaacs, MR; Benjamin, MP. *Screening Survey for Culturally Competent Agency/Program*. Towards A Culturally Competent System of Care Volume II: Programs Which Utilize Culturally Competent Principles. Washington, DC: CASSP Technical Assistance Center. For more information, contact the National Center for Cultural Competence, Georgetown University Medical Center, Child Development Center at: 3307 M Street, NW Suite 401, Washington, DC 20007 or call 202-687-5387.

13. 1995 La Frontera, Inc.; US Office of Minority Health. *Building Bridges: Tools for Developing an Organization's Cultural Competence*. For information, contact La Frontera, Inc. at 502 West 29th Street, Tucson, AZ 85713. Tel. 520-884-9920.

Abstract:

The manual was developed to provide a comprehensive array of behavioral health services to underserved populations in Pima County, Arizona. The assessment instrument reviews the organizational environment, public relations, human resources, and clinical issues. It provides an action planning process, a sample plan, a score sheet and also references.

14. 2002 The Lewin Group, Inc. *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*. Washington, D.C. Prepared for The Health Resources and Services Administration, U.S. Department of Health and Human Services. To view this report, visit the HRSA web site, under Minority Health at www.hrsa.gov/omh.

Abstract:

“How do we know cultural competence when we see it?” is the central question

that prompted the Health Resources and Services Administration to sponsor this project. The specific objectives were to: 1) develop an analytic framework for assessing cultural competence in health care delivery organizations; 2) identify specific indicators that can be used in connection with this framework; and 3) assess the utility, feasibility and practical applications of the framework and its indicators. The detailed assessment profile in a format that summarizes structure, process and output components of cultural competence in health care, will be very useful to organizations seeking to assess their health care delivery system in the many aspects of cultural competence.

15. 1995 Mason, James; Williams-Murphy, Tracy. *Cultural Competence Self-Assessment Questionnaire: A Manual for Users*. Research and Training Center on Family Support and Children's Mental Health; Regional Research Institute for Human Services; Graduate School of Social Work, Portland State University, P.O. Box 751, Portland, OR 97207-0751. Tel. 503-725-4040.

Abstract:

The assessment is based on the Child and Adolescent Service System Program (CASSP) Cultural Competence Model (Cross, Bazron, Dennis & Isaccs, 1989). This model describes competency in terms of attitude, practice, policy and structure. The instrument helps child- and family-serving agencies assess their cross-cultural strengths and weaknesses in order to design specific training activities or interventions that promote greater competence across cultures. There are two versions of the questionnaire. One version is for use with direct service providers and the other is for administrative staff. These different versions are useful when designing specific training interventions for either administrative or service-level personnel. A Cultural Competence Checklist and a Bibliography of Cultural Competency Resources accompany the Assessment Questionnaire.

Portland State University publishes a newsletter, *Focal Point: The Bulletin of the Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their Families*. Furthermore, the University has a Publications List, which is a compendium of publications from 1986 to present.

16. 1995 Miller, Peck, Shuman & Yrun-Calenti. Building Bridges: Tools for Developing an Organization's Cultural Competence. La Frontera, Inc.

Abstract:

Cultural Competence Assessment Instrument: Organizational Environment, Public Relations/Working with the Community, Human Resources, and Clinical Issues.

17. 1998 Missouri Department of Mental Health and the Missouri Institute of Mental Health. *Cultural Competence Self-Assessment Tool*. For further information, contact James Topolski, Ph.D., at: University of Missouri – Columbia, School of Medicine, 5400 Arsenal Street, St. Louis, MO 63139; call 314 644-8657 or e-mail: mimhjt@showme.missouri.edu.

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18. 1995 Myers. Culturally Competent Service Outcomes Assessment Tools: Guidelines for Upgrading Quality Assurance. Ohio Department of Mental Health, Consumer Services Department.
 19. National Maternal and Child Health Resource Center on Cultural Competency, Texas Department of Health. *Journey Towards Cultural Competency: Lessons Learned*. Contact: Don Lawson 512-458-7111.

Abstract:

The publication discusses the National MCH's role on cultural competency, as well as guiding principles and factors to consider in developing cultural competency. It focuses on lessons learned and offers some sample guidelines and assessment tools.

20. 1998 The New York State Office of Mental Health; The Research Foundation of New York State; The Center for the Study of Issues in Public Mental Health; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. *Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs*.

Abstract:

The report presents a set of measures developed to assess the cultural competency of a mental health service delivery organization. Performance measures are identified within domains of the service delivery process in which principles and procedures reflecting cultural competency need to be in place. A worksheet and notes accompany the report.

21. 1996 Roizner, Monica. *A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations*. The Technical Assistance Center for the Evaluation of Children's Mental Health Systems at Judge Baker Children's Center. Write to them at: 295 Longwood Ave., Boston, MA 02115 or call 617-232-8390.

This manual discusses the rationale for cultural competence assessments, specific issues to consider when planning an assessment and a step-by-step protocol for designing assessments, collecting and interpreting the data and using the results. It contains an excellent, detailed review of assessment instruments from a variety of sources, some case examples of assessments performed by various agencies, and a bibliography of pertinent readings.

22. 1997 Saldana, D., et al. *Cultural Competency Scorecard for Mental Health Facilities (Pilot Instrument)*. Development of a Cultural Competency Scorecard for Mental Health Facilities: Paper presented at the Seventh Annual National Conference on State Mental Health Agency Services Research and Program Evaluation. For further information, contact Dr. Delia Saldana with the Department of Psychiatry at the University of Texas Health Science Center at 7703 Floyd Curl Drive, San Antonio, TX 78284 or call 210-531-7918. E-mail: saldana@uthscsa.dcci.com.

23. 1998 Tirado, Miguel. *Tools for Monitoring Cultural Competence in Health Care; The Health Plan Audit; Health Plan Administrator Survey. Monitoring the Managed Care of Culturally and Linguistically Diverse Populations*. Health Resources and Services Administration, Center for Managed Care. Contact: National Clearinghouse for Primary Care Information at primarycare@circsol.com or call 800-400-2742.

Abstract:

This project developed an asset-oriented continuum of increasing levels of personal and institutional cultural and linguistic competency: 1) Culturally Resistant; 2) Culturally Unaware; 3) Culturally Conscious; 4) Culturally Insightful; and 5) Culturally Versatile. Four assessment instruments were created to assist the individual health care practitioner and the plan administrator. One distinctive aspect of these tools is the combining of the health practitioner survey and the member survey to assess the climate of communication between the two.

24. 1996 Weiss, Carol; Minsky, Shula. *Program Self-Assessment Survey for Cultural Competence: A Manual*. New Jersey Division of Mental Health and Hospitals. Trenton, NJ. For more information, contact Carol Weiss with the Department of Human Services, Division of Mental Health Services, 50 East State Street, P.O. Box 727, Trenton, NJ 08625-0727 or call 609-777-0821. E-mail: cweiss@dhs.state.nj.us.

Abstract:

The manual presents a new approach to assessing the cultural competence of mental health programs or organizations. The manual first introduces a conceptual framework for cultural competence, then offers rationales for addressing competence at the program level, and describes the self-assessment survey's purpose and piloting. It provides information on administering the survey questionnaire, presents specific instructions on questionnaire scoring, and offers recommendations for how the survey results might be used to assist programs in enhancing their levels of cultural competence.

25. 1998 Western Interstate Commission on Higher Education (WICHE). Cultural Competence Report Card Items, Jan. Boulder, CO. For further information contact WICHE Mental Health Program at PO Box 9752, Boulder, CO 80301 or call 303-541-0258. Web site: www.wiche.edu.

Personal Assessments

1. 1992 Bhawuk, D.P.S., Brislin, Richard. *The Measurement of Intercultural Sensitivity Using the Concepts of Individualism and Collectivism*. International Journal of Intercultural Relations, Vol. 16:413-36. For more information, contact Dr. R. Brislin at 808-944-7111.

Abstract:

Attempts to measure the concept of intercultural sensitivity have not always been successful, and one reason is that researchers and practitioners have not specified exactly what people should be sensitive to when they find themselves in other cultures. In the study, scales were designed to measure intercultural sensitivity by examining (a) people's understanding of the different ways they can behave depending upon whether they are interacting in an individualistic or a collectivist culture, (b) their open-mindedness concerning the differences they encounter in other cultures, and (c) their flexibility concerning behaving in unfamiliar ways that are called upon by the norms of other cultures. A practical conclusion for the content of cross-cultural training programs is that people can be encouraged to modify specific behavior so that they are appropriate to the culture in which they find themselves and so that they will have a greater chance of achieving their goals.

2. 1993 Child Welfare League of America. Cultural Competence Self-Assessment Instrument. Washington, DC. For more information, contact Jean Tucker Mann with the National Task Force on Cultural Competency of the CWLA, Inc. at 440 First Street, NW, Suite 310, Washington, DC 20001, or call 202-638-2952.
3. Cross, Terry. *Cultural Competence Continuum*. For more information, contact the New York State Citizens Coalition for Children at 306 E. State Street, Suite 220, Ithaca, NY 14850, or call 607-272-0034.
E-mail: office@nysccc.org.
Web site: <http://www.nysccc.org/T-Rarts/CultCompCont.html>.
4. 1996 Culhane-Pera, K.A. *Ethnosensitivity in Medicine Questionnaire with Key*. Department of Family and Community Medicine, St. Paul Ramsey Medical Center. For more information, contact Kathleen Culhane-Pera at kathiecp@yahoo.com or 651-602-7565.
5. Culhane-Pera, K.A. *Five Levels of Cultural Competency in Medicine and Self-Evaluation of Five Levels of Cultural Competence*. Ramsey Family and Community Medicine Residency, St. Paul Ramsey Medical Center. For more information, contact Kathleen Culhane-Pera at kathiecp@yahoo.com or 651-602-7565.
6. Center for Cultural Competence, Georgetown University, Washington, D.C. Contact: www.gucdc.georgetown.edu/nccc/ncc11.html.
7. 1991 D'Andrea, M.; Daniels, J.; Heck, R. *Multicultural Awareness-Knowledge-and-Skills Survey (MAKSS)*. Journal of Counseling and Development, Vol. 70:143-50. For further information, contact Michael D'Andrea with the Department of Counselor Education, College of Education, University of Hawaii-Manoa, Honolulu, HI 96822.

8. 1994 Family and Youth Services Bureau, U.S. Department of Health and Human Services. *Cultural Competency Administration Self-Assessment*.
9. 1985 Fukuyama, M.; Neimeyer, GJ. *Cultural Attitudes Repertory Technique (CART)*. Using the cultural attitudes repertory technique (CART) in a cross-cultural counseling workshop. *Journal of Counseling and Development*, Vol. 63:304-5. For more information, contact Greg Neimeyer with Department of Counseling, Psychology, at University of Florida, Gainesville or call 904-392-0613.
10. 2000 Goode, Tawara. *Promoting Cultural and Linguistic Competency*. Self-Assessment Checklist for Personnel Providing Primary Health Care Services. National Center for Cultural Competence, Georgetown University, Washington, D.C. Contact: www.gucdc.georgetown.edu/nccc/ncc11.html.

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level.

11. 1991 Ho, MK. Use of Ethnic-Sensitive Inventory (ESI) to Enhance Practitioner Skills with Minorities. *Journal of Multicultural Social Work*, Vol. 1 (1):57-67. For more information, contact Man Keung Ho, Professor of Social Work at University of Oklahoma, Ryhne Hall, Norman, OK 73019.
12. 1991 LaFromboise, TD; Coleman, HLK; Hernandez, A. *Development and Factor Structure of the Cross-Cultural Counseling Inventory-Revised*. *Professional Psychology: Research and Practice*, Vol. 22:380-8. For further information, contact Teresa LaFromboise at Stanford University, Counseling and Psychological Services at 606 Campus Drive, Stanford, CA 94305 or call 415-723-1202. E-mail: lafrom@leland.stanford.edu.
13. 1995 Mason, JL. *Cultural Competence Self-Assessment Questionnaire: A Manual for Users*. Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Portland State University. For more information, contact James Mason at Portland State University, Graduate School of Social Work, 5914 N. Commercial Avenue, Portland, OR 97217 or call 503-287-7260.
14. 1997 National Public Health & Hospital Institute. *Self-Assessment of Cultural Competence*. Washington, DC. For more information, contact Dennis Andrulis at NPHHI at 1212 New York Avenue, NW, Suite 800, Washington, DC 20005 or call 202-408-0229.
15. 1997 Ponterotto, JG. *Multicultural Counseling Knowledge and Awareness Scale (MCKAS)*. New York, NY. For further information, contact Joseph Ponterotto with the Division of Psychological & Educational Services at Fordham University at Lincoln Center, 113 W 60th Street, New York, NY 10023 or call 212-636-6480.

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16. Ponterotto, JG. Quick Discrimination Index (QDI). New York, NY. For further information, contact Joseph Ponterotto with the Division of Psychological & Educational Services at Fordham University at Lincoln Center, 113 W 60th Street, New York, NY 10023 or call 212-636-6480.
 17. 1994 Sodowsky, GR; Taffe, RC; Gutkin, TB; Wise, SL. *Development of the Multicultural Counseling Inventory: A Self-Report Measure of Multicultural Competencies*. Journal of Counseling Psychology, Vol. 41 (2):137-8. For more information, contact Gargi Sodowsky with Department of Educational Psychology, University of Nebraska, Lincoln, NE 68588.
 18. 1998 Tirado, Miguel. *Tools for Monitoring Cultural Competence in Health Care; The Health Plan Audit; Health Plan Administrator Survey. Monitoring the Managed Care of Culturally and Linguistically Diverse Populations*. Health Resources and Services Administration, Center for Managed Care. Contact: National Clearinghouse for Primary Care Information at primarycare@circsol.com or call 800-400-2742.

Abstract:

This project developed an asset-oriented continuum of increasing levels of personal and institutional cultural and linguistic competency: 1) Culturally Resistant; 2) Culturally Unaware; 3) Culturally Conscious; 4) Culturally Insightful; and 5) Culturally Versatile. Four assessment instruments were created to assist the individual health care practitioner and the plan administrator. One distinctive aspect of these tools is the combining of the health practitioner survey and the member survey to assess the climate of communication between the two.

19. 1996 Tirado, Miguel & Latino Coalition for a Healthy California. Final Report to the Office of Planning and Evaluation Health Resources and Services Administration: Tools For Monitoring Cultural Competence in Health Care. For information, contact Miguel Tirado at California State University, Monterey Bay, 100 Campus Center, Seaside, CA 93955.

1. 1989 Boyle, J.S.; Andrews, M.M. *Boyle and Andrews Assessment: Guide for the Assessment of Cultural Manifestations*. Transcultural Concepts in Nursing Care, Boston.

The assessment focuses on value orientations, interpersonal relationships and communication. It also discusses religion and magic, social systems, diet and food habits, and health and illness belief systems.

2. 1995 Campinha-Bacote, Josepha. *The Quest for Cultural Competence in Nursing Care*. Nursing Forum, Oct-Dec; Vol. 30 (4):19-25.

Abstract:

Conducting a culturally sensitive cultural assessment is a critical factor in rendering culturally relevant services to our growing ethnically diverse patient population. The author examines issues affecting the process of conducting culturally sensitive cultural assessments. A review of several cultural assessment tools is presented, along with suggestions for conducting effective cultural assessments.

3. 2002 Committee on Cultural Psychiatry. *Cultural Assessment in Clinical Psychiatry*. Washington, D.C.: American Psychiatric Publishing, Inc.

This book guides the psychiatrist in achieving cultural competence in psychiatric practice. Topics include diagnostic guidelines, psychopharmacology, collaboration with translators, immigration and cultural factors that can influence diagnosis. Many case examples.

4. 1998 Davidhizar R, Giger JN. *Transcultural Patient Assessment: A Method of Advancing Dental Care*. The Dental Assistant, Vol. 67 (6):34-43.

5. Dowd, Steven; Giger, Joyce Newman; Davidhizar, Ruth. *Use of Giger and Davidhizar's Transcultural Assessment Model by Health Professions*.

Abstract:

Nursing science is increasingly gaining recognition. Witness the growing use by other disciplines of nursing's models and ideas. One example is the adoption of the Giger and Davidhizar Model of Transcultural Assessment by non-nursing disciplines to understand and address the needs of a pluralistic multicultural society. The authors describe a model to understand culturally diverse clients and show how health professions are using it to provide culturally competent care.

6. Johnson, Rebecca. *Johnson Assessment: Considerations in Transcultural Nursing for Childbearing Families*.

The piece presents information that may guide and inform professionals in their attempts to provide more culturally relevant reproductive care from the prenatal to postpartum period.

7. 1988, 1978 Leininger. *Leininger Assessment: Leininger's Transcultural Health Model for Analyzing Health-Illness Systems in Different Cultures*.

Leininger's assessment talks about social structure, cultural and health care values, the health care system, and roles and functions of health care providers. It also presents Anderson's three-stage approach.

8. 1992 Ramer, Leah. *Nursing Issues for the 21st Century-Module 1: Culturally Sensitive Caregiving and Childbearing Families*. Further information can be obtained from: Education & Health Promotion Department, March of Dimes Birth Defects Foundation, 1275 Mamaroneck Avenue, White Plains, NY 10605.

Abstract:

Culturally Sensitive Caregiving and Childbearing Families is the first module in Series 4, *Nursing Issues for the 21st Century*. It provides information to assist the nurse in becoming more sensitive to culture-based health beliefs and practices as they affect the quality of caregiving. Self-assessment, as the first step to understanding, is described. Nursing care assessment, plans and goals for culturally sensitive nursing care are outlined. Sample case histories from several health care providers with different client populations are included along with an extensive annotated supplementary materials list.

9. 1984 Tripp-Reimer, T; Brink, P.J.; Saunders, J.M. *Tripp-Reimer Assessment: Cultural Assessment: Content and Process*. *Nursing Outlook*, 32 (2):78-82.

Abstract:

Tripp-Reimer et al compared the content of nine cultural assessment guides and presented the information in table form. The areas covered were values, beliefs, customs and social structure components. The authors discuss how cultural assessment helps nurses meet their patients' needs. They offer a comparison of cultural assessment guides and questions the health care professional may find helpful.

1. The AAN Expert Panel on Culturally Competent Nursing Care. *AAN Expert Panel Report-Culturally Competent Health Care*. Nursing Outlook, Nov/Dec; Vol. 40 (6):277-83.

Abstract:

Nurses are central to the potential of developing and maintaining programs that deliver culturally competent health care. In navigating the U.S. health care system, clients perceived as being members of minority groups tend to encounter the most difficulties. It is imperative that we give special attention to these clients by developing a health care system oriented to cultural diversity. "Sensitivity" to cultures is only one aspect of competence in providing care that is congruent with diverse heritage traditions, beliefs, values, norms, and preferences. This article provides information on strategies, workshops, and in-service education. The AAN Expert Panel has 10 recommendations to stimulate the development and implementations of knowledge related to culturally competent care.

2. 2002 Abbott, PD; Short, E; Dodson, S; Garcia, C; Perkins, J; Wyant, S. *Improving Your Cultural Awareness with Culture Clues*. Nurse Pract, Feb., Vol. 27 (2):44-7, 51.

Abstract:

When the University of Washington Medical Center (UWMC) administered a survey to gauge patient education support needs among staff, the results indicated a need for cultural competency. Using action methodology and needs assessment, the committee charged with developing a tool to meet this need launched a new concept: Culture Clues. These brief documents provide cultural specific patient information, allowing staff to approach patients according to their culture. The committee created six Culture Clues and is developing more.

3. 1999 American Family Physician, published by the American Academy of Family Physicians, Aug. *Curbside Consultation: Female Circumcision*. Includes a case scenario and commentary. Visit the AAFP web site at: <http://www.aafp.org/afp/990800ap/curbside.html>.
4. 1999 American Association for Respiratory Care (AARC); Sepulveda-Rodriguez, Enid. Individual Independent Study Package: Towards Culturally Competent Respiratory Care. For further information, write to them at: 11030 Ables Lane, Dallas, TX 75229-4593.

Abstract:

This study package will help the respiratory care practitioner begin to develop culture-specific communication and helping styles for working with diverse populations. It defines culture and discusses everything from expressions of illness, noncompliance and poor patient outcomes to negotiating a culturally competent treatment plan, cultural health practices and the use of interpreters. Self-tests are also provided.

5. 1999 Andrews, Margaret M. *How to Search for Information on Transcultural Nursing and Health Subjects: Internet and CD-ROM Resources*. Journal of Transcultural Nursing, January; Vol.10 (1):69-74.

Abstract:

With the proliferation of electronic resources available to search for subjects related to transcultural nursing and health, nurses must keep abreast of computer-based tools that enable them to quickly and efficiently obtain information on a variety of topics. This article provides suggestions for narrowing and focusing a search on transcultural nursing and related subjects using key terms indexed in the Cumulative Index to Nursing and Allied Health Literature, International Nursing Index, Medline, Index Medicus, and Psychological Abstracts/PsychLit. Information about accessing the Native American Resource Information Service, Education Resources Information Center, Infotrac/Expanded Academic Index, and Sociological Abstracts also are provided. In the article, selected examples of Internet sites of interest in transcultural nursing and health are identified with their universal resource locator, and they are annotated. Web sites for U.S. government agencies, organizations, and commercial groups that concern transcultural nursing and health are cited. Global transcultural health and nursing Internet resources also are included.

6. 1992 Barker, Judith C. *Cultural Diversity-Changing the Context of Medical Practice, in Cross-cultural Medicine-A Decade Later [Special Issue]*. Western Journal of Medicine, Sep; Vol. 157:248-54.

Abstract:

This article describes the special needs of immigrants and indigenous groups in the United States today and ways that clinical medicine and social sciences can combine to address these needs. Cross-cultural medicine is challenging, frustrating, exhilarating, and rewarding. The need for sensitivity to cultural issues as they impinge on the practice of the healing arts will only increase in the coming years, as population diversification continues. The article will assist clinicians to be more effective in their relations with ethnically heterogeneous patients and to encourage both medical social scientists and clinical researchers to expand their research activities into areas of concern to diverse cultural groups.

7. 1995 Barthwell, Andrea G.; Hewitt, Warren; Jilson, Irene. *An Introduction to Ethnic and Cultural Diversity*. Pediatric Clinics of North America, Apr; Vol. 42 (2):431-49.

Abstract:

This body of research looks at the multiple causal factors of alcoholism, including biophysical, psychological and sociocultural variables. Also, growing evidence indicates that ethnic groups differ in the rates of initiation, consequences of use, maintenance of use patterns, and cessation of use. The

literature leads to the conclusion that high rates of alcoholism exist among certain groups. These rates may have more to do with socioeconomic conditions of these groups than with culture and ethnicity. In addition to the care the pediatricians must render to their patients, understanding the addiction in the context of cultural factors can be important in the ultimate success of the intervention that focuses on issues to enhance one adolescent's efficacy in achieving his or her goals.

8. 1986 Bennett, Janet Marie. *Cross-Cultural Training and Training Skills-Modes of Cross-Cultural Training: Conceptualizing Cross-Cultural Training as Education*. International Journal of Intercultural Relations, Vol. 10:117-34. Liberal Arts Division, Marylhurst College, Marylhurst, Oregon.

Abstract:

This theoretical article provides a general overview for intercultural trainers. It provides training models and good definitions. It offers an orientation to acquaint others with the existing situation or environment. The training shows how the learner can increase effectiveness when operating in a multicultural or intercultural environment with a "how-to" and skills approach. The author discusses theoretical foundations and the ability to apply learnings and understandings in new situations.

9. Berry, John W. *Cultural and Ethnic Factors in Health: Psychological Aspects of Health and Illness*. Pp. 98-102.

Abstract:

Berry helps to conceptualize the way culture affects health. He provides a good analysis of how culture is manifested at the group and individual levels. The article contains a good discussion of ethnic groups, acculturation and acculturation stress. It provides a succinct rationale for multicultural health programs.

10. 2000 Betancourt, Joseph R.; King, Roderick K. *Diversity in Health Care: Expanding our Perspectives*. ARCH Pediatric Adolescent Medicine, Sept., Vol. 154 (9):871-2. Cornell University School of Medicine.

Abstract:

Health care providers must expand their perspectives when thinking about diversifying the workforce to include the importance of leadership, partnership, and collaboration instead of just direct patient care. In the end, achieving a diverse health care workforce will help address the challenge of eliminating racial and ethnic disparities in health. The sum of benefits that grow from diversity will improve the health care system for all Americans.

11. 2000 Betancourt, Joseph R.; Jacobs, Elizabeth A. *Language Barriers to Informed Consent and Confidentiality: The Impact on Women's Health*. JAMWA, Fall; Vol. 55 (5):294-5. Cornell University School of Medicine.

Abstract:

Obtaining informed consent and maintaining confidentiality are critical to the way one practices medicine and remains a crucial part of the medicolegal responsibility to the patient and to society. Nevertheless, little attention has been paid to these topics in populations who may have limited English proficiency. Despite research suggesting that language barriers have direct effects on health and health care delivery, many health care settings do not provide professionally trained interpreters to patients who need them. This is clearly a challenge that will only grow as the nation becomes more diverse. Perhaps nowhere is this issue more significant than in women's health, given the very personal and sensitive nature of the medical exams and interventions. Health care providers must conduct and facilitate research on how language barriers compromise quality of care, and must advocate for systems and policy change.

12. 1999 Betancourt, Joseph R.; Carrillo, J. Emilio; Green, Alexander R. *Hypertension in Multicultural and Minority Populations: Linking Communication to Compliance*. Current Hypertension Reports, 1:482-8. Copyright 1999 by Current Science Inc. ISSN 1522-6417. Cornell University School of Medicine.

Abstract:

Cardiovascular disease disproportionately affects minority populations, in part because of multiple sociocultural factors that directly affect compliance with antihypertensive medication regimens. Compliance is a complex health behavior determined by a variety of socioeconomic, individual, familial, and cultural factors. In general, provider-patient communication has been shown to be linked to patient satisfaction, compliance, and health outcomes. In multicultural and minority populations, the issue of communication may play an even larger role because of linguistic and contextual barriers that preclude effective provider-patient communication. These factors may further limit compliance. The ESFT Model for Communication and Compliance is an individual, patient-based communication tool that allows for screening for barriers to compliance and illustrates strategies for interventions that might improve outcomes for all hypertensive patients.

13. Betancourt, Joseph R.; Green, Alexander R.; Carrillo, J. Emilio. *The Challenges of Cross-Cultural Healthcare-Diversity, Ethics, and the Medical Encounter*. Bioethics Forum, Vol. 16 (3):27-32. Cornell University School of Medicine.

Abstract:

The goal of the emerging field of cross-cultural health care is to improve providers' ability to understand, communicate with, and care for patients from diverse backgrounds. Illustrative case studies include a Navajo with tongue malignancy and an elderly Japanese woman with aggressive leukemia. The

article discusses topics from cross-cultural issues in informed consent, truth telling, and trust and mistrust in patient-provider relations to devaluing sociocultural difference, the concept of negotiation, and the ethics of caring approach in medicine.

14. Bechtel GA, Davidhizar R, Tiller CM. *Patterns of Mental Health Care Among Mexican Americans*. Journal of Psychosocial Nursing and Mental Health Services, Vol. 36 (11):20-27.
15. 1997 Behui K, Bhugra D. *Cross-Cultural Competencies in the Psychiatric Assessment*. Journal of Hospital Medicine, May 21-Jun 3, Vol. 57 (10):492-6.
16. 1998 Birman D. *Biculturalism and Perceived Competence of Latino Immigrant Adolescents*. American Journal of Community Psychology, June, Vol. 26 (3):35-54.
17. 1995 Blackhall, Leslie J.; Murphy, Sheila T.; Frank, Gelya; Michel, Vicki; Azen, Stanley. *Ethnicity and Attitudes Toward Patient Autonomy*. JAMA, Sept; Vol. 274 (10):820-5.

Abstract:

The objective of this study is to examine the differences in the attitudes of elderly subjects from different ethnic groups toward disclosure of the diagnosis and prognosis of a terminal illness and toward end-of-life decision making. The conclusions drawn are that Korean-American and Mexican-American subjects were more likely to hold a family-centered model of medical decision-making rather than the patient autonomy model favored by most of the African-American and European-American subjects. This finding suggests that physicians should ask their patients if they wish to receive information and make decisions or if they prefer that their families handle such matters.

18. 2002 Briggance, Bram; Burke, Nadine. *Shaping America's Health Care Professions: The Dramatic Rise of Multiculturalism*. Western Journal of Medicine, Vol. 176:62-64. PDF version of this article is available at: <http://www.ewjm.com/cgi/content/full/176/1/62>.

Abstract:

This is the first in a series of articles addressing the major forces that will shape America's health care professions. Some summary points include: 1) The evolution of the United States toward multiculturalism will have profound and lasting effects on our health care delivery system; 2) Significant discrepancies exist between whites and nonwhites in the incidence of disease and rates of morbidity; 3) Nonwhites in the United States are more likely than whites to lack health coverage; 4) The health care industry must continue to strive to eradicate cultural and linguistic barriers to the delivery of quality health care; and 5) Racial and ethnic diversity is critical to the provision of care and the long-term sustainability of our health care system.

19. 1999 Brink PJ. *Transcultural Versus Cross-Cultural*. Journal of Transcultural Nursing, Vol. 10 (1):7.
20. 1994 Buchwald, Dedra; Caralis, Panagiota V; Gany, Francesca; Hardt, Eric J; Johnson, Thomas M; Muecke, Marjorie A; Putsch, Robert W. *Caring for Patients in a Multicultural Society*. Patient Care, June; 105-23.

Abstract:

Some patients' beliefs about the causes and cures of illness are at odds with Western biomedical training. To treat them successfully, one needs to understand their health perceptions, behaviors, and expectations. How culture influences behavior: All patients have culturally based models for explaining illness. Eliciting these perceptions can increase your understanding of their health beliefs and practices, as well as their treatment expectations. Culture defines the ranges of normal and abnormal in symptoms and function, provides ideas about causality, determines the patient's input into health decisions, and prescribes steps in care.

21. The California Endowment. The following publications and reports are available in PDF format at <http://www.calendow.org/pub/pub.htm>:

Highlights From The Promotore/Community Health Workers Grantees Convening, June 2000 - In June 2000, community health workers convened to discuss community-driven health outreach worker (promotores) models. This publication discusses the challenges and successes that frequently accompany such programs and summarizes the topics addressed at the event.

Multicultural Health: Setting the Stage for Innovative and Creative Approaches, Prepared July 1999 - The field of multicultural health has been overlooked for far too long. The California Endowment is proud to present this annotated bibliography – *Multicultural Health: Setting the Stage for Innovative and Creative Approaches* – to serve as a compass for those who strive to improve the health of California's diverse residents.

The Health Status of American Indians in California, April 1997

The Health Status of African Americans in California, April 1997

The Health Status of Asian and Pacific Islander Americans in California, April 1997

The Health Status of Latinos in California, April 1997

The Health Status of Whites in California, April 1997

Each of these five papers focuses on a significant racial/ethnic population in California. The goal of these papers is to go beyond the epidemiology in order to explain or hypothesize factors that give rise to these data and to better understand how health impacts the content and context of people's lives. This series is a five-volume set.

22. 1996 Campbell JC, Campbell DW. *Cultural Competence in the Care of Abused Women*. Journal of Nurse-Midwifery, Vol. 41 (6):457-62.

23. 1999 Campinha-Bacote, Josepha; Campinha-Bacote, Dexter. *A Framework for Providing Culturally Competent Health Care Services in Managed Care Organizations*. Journal of Transcultural Nursing, Oct; Vol. 10 (4):290-1.

Abstract:

Managed care organizations are slowly awakening to the need to incorporate diversity into their delivery of health care. This article addresses such issues as cultural competence, cultural awareness, and cultural knowledge. It also defines cultural skill, cultural encounter and cultural desire.

24. 1994 Campinha-Bacote, Josepha. *Cultural Competence in Psychiatric Mental Health Nursing – A Conceptual Model*. Mental Health Nursing, March; Vol. 29 (1):1-8.

Abstract:

The article discusses culture-bound illnesses in which symptomatology closely mimics psychiatric problems. It further concludes that psychiatric-mental health nurses must lead the way in striving toward cultural competence in nursing care.

25. 1992 Charonko, Caroline. *Cultural Influences in “Noncompliant” Behavior and Decision Making*. Holistic Nurs Pract, Vol. 6 (3):73-8.

Abstract:

Clients and nurses may not always have the same goals in mind. Cultural backgrounds do play a part in determining what their goals are and how they can be achieved. If nurses want to help clients achieve their goals and achieve their maximal level of wellness, it seems clear that part of the nursing care must include cultural assessments of nurses and their clients. Nurses should find that the term noncompliant is no longer needed since they will know that clients have a right to live their lives as they choose even when their choices are different from theirs.

26. 1998 Chesanow, Neil. *The Versatile Doctor’s Guide to Ethnic Diversity*. Medical Economics, September: 135-46.

Abstract:

Understanding cultural differences is critically important for physicians. By bridging language and culture gaps, you can improve patient satisfaction and reduce malpractice risk. This guide suggests that physicians treat patients as individuals, not stereotypes and that they should recognize that not all patients are alike. It provides information on where and how to obtain more help in training and translator/interpreter services. Making special accommodations and learning more about different cultures can mean the difference between giving the right treatment in a single office visit and having the patient repeatedly go to the ER. It’s not necessary to have a Ph.D. in cultural anthropology to improve your treatment of immigrant patients; just a few basic insights can make the difference.

27. 2000 Chrisman, N.J.; Zimmer, P.A. *Cultural Competence in Primary Care*. In P.V. Meredith & N.M. Horan (Eds.), Adult Primary Care, (pp. 65-75). Philadelphia: W.B. Saunders.

Abstract:

This chapter focuses more on how to deliver culture-sensitive care than on the characteristics of specific ethnic groups. There are a number of reasons for this approach. The most important reason is that the beliefs and behaviors of members of all cultural groups in the United States change constantly; another is that simply being a member of a particular group does not mean that the patient thinks or acts in a particular way. Individuals' beliefs are often derived from their cultural backgrounds, including their health beliefs. This chapter focuses on how to assess the individual first and foremost and explores how culture may or may not affect one's individual beliefs.

28. 1998 Chrisman, Noel. *Faculty Infrastructure for Cultural Competence Education*. Journal of Nursing Education, Jan.; Vol. 37 (1):45.

Abstract:

This paper outlines one way to facilitate system-wide change to provide an adequate infrastructure for teaching cultural and social diversity in nursing curricula. This paper describes a project to increase faculty capability to include cultural knowledge in a variety of classes. The project included a faculty seminar and the increased availability of print and video teaching materials.

29. 1991 Chrisman, Noel J. *Cultural Systems*. In Susan Baird, Ruth McCorkle, Marcia Grand (Eds.), Cancer Nursing: A Comprehensive Textbook, W.B. Saunders Co.

Abstract:

All health problems can be considered as part of a cultural system. Any time an individual is sick, cultural meanings are attributed to the sickness (by both patients and clinicians), and members of the patient's social environment are involved. It is particularly important in cancer care, therefore, that the patient's cultural system be taken into account. The meanings and social implications of cancer are such that they become an important component in the need for care, as much as if not more than the traditional biomedical aspects of the disease. In addition, nurses' holistic view of patient care vigorously supports professional attention to the peculiarly human phenomenon of culture.

30. 1982, Chrisman, Noel J. & Maretzki, Thomas W. (Eds.) *Clinically Applied Anthropology*. Boston: D. Reidel Publishing Company.

Abstract:

This book covers the teaching experiences of anthropologists in health science schools. Types and levels of students, courses and clinical specialties range widely, though commonalities in themes imply consistency in the approaches of anthropologists and the needs of their students. Each chapter contains specific and practical suggestions on how and what to teach in various settings.

31. 1997 Christenson, M., Feldman, M. *Behavioral Medicine – A Primary Care Handbook*, “Cross-Cultural Communication in Primary Care,” Appleton-Lange.
32. 1994 Chugh, U.; Agger-Gupta, N.; Dilmann, E.; Fisher, D.; Gronnerud, P.; Kulig, J.C.; Kurtz, S.M.; Stenhouse, A. *The Case for Culturally Sensitive Health Care: A Comparative Study of Health Beliefs Related to Culture in Six North-East Calgary Communities*. Citizenship & Heritage Secretariat, Alberta Community Development & Calgary Catholic Immigration Society. The University of Calgary.

Abstract:

Culturally Sensitive Health Care describes those aspects of health care, which take into account culturally influenced health beliefs, practices, behaviors and physical and biological differences of patients. This would include the following practices: eliciting and discussing cultural, religious and social values as well as health beliefs important to the patient; communicating with the patient in an empathetic manner; negotiating with the patient their preferences about health care; involving family members requested by the patient in patient health care; assisting the patient in accessing community resources; and, awareness and evaluation of the tendency toward certain health problems in certain ethnocultural groups.

33. 1992 Comas-Diaz, Lillian. *The Future of Psychotherapy with Ethnic Minorities*. Psychotherapy, Spring; Vol. 29 (1):88-94.

Abstract:

The potential scenarios in the development of psychotherapy with ethnic minorities are examined in this article. The future of psychotherapy with ethnic minorities is analyzed from two temporal perspectives. It is proposed that the immediate future will be characterized by integration while the distant future will be characterized by pluralism. A demographic avalanche resulting in the *browning of America* will generate a cultural revolution in psychotherapy. It is concluded that psychotherapy of people of color will transform general psychotherapy.

34. 1996 Cooper TP. *Culturally Appropriate Care: Optional or Imperative*. Advanced Proactive Nursing Quarterly, Vol. 2 (2):1-6.
35. 2001 Covington, LW. *Cultural Competence for Critical Care Nursing Practice*. Critical Care Nursing Clinic of North America, Dec., Vol. 13 (4):521-30. School of Nursing, Middle Tennessee State University, Murfreesboro, Tennessee, USA. lcovingt@mtsu.edu.

Abstract:

Cultural information should be critically examined and appropriately used in the context of individual relationships. The increased ethnic minority population in the health care system mandates that differences be recognized and responded to. Further more, the linear and technologic environment of the critical care unit

intensifies the potential for cultural dissonance and disempowerment of ethnic minorities. CCNs must be creative and willing to transform nursing care to meet the needs of all. Knowing one's self, being aware of limitations, and understanding the influence of culture on others are essential to being culturally competent and an effective CCN. Because nursing remains dominated by individuals from the majority culture, many have little experience with person of diverse ethnicity. Increasing cultural knowledge and the numbers of minority nurses and translators in the ICU are only the start to providing holistic care to this country's diverse population. Patient outcomes should improve and nurses are greatly enriched from an understanding and achievement of cultural competency.

36. 1999 Coye, Molly; Alvarez, Deborah. *Medicaid Managed Care and Cultural Diversity in California*. The Commonwealth Fund, Mar. http://www.cmwf.org/programs/minority/Coye_Medicaid_managed.pdf.

Abstract:

Approximately 48 percent of all Medicaid beneficiaries in the United States are now enrolled in a managed care program. California operates the nation's largest and most diverse Medicaid managed care program: 36 percent of residents who were eligible for Medi-Cal (the state's Medicaid program) as of October 1997 were enrolled in a managed care plan. By the close of 1998, more than 3 million Medi-Cal eligibles will be enrolled in a commercially or county-operated plan. This mass transfer of culturally and ethnically diverse Medicaid populations into managed care has led federal and state agencies across the country to address concerns about the cultural competency of plans in delivering health care services to their patients. Public and private officials alike are asking, "Can managed care, designed to meet the needs of commercially insured and Medicare populations, adequately serve the more specialized needs of its diverse new members.

37. 1997 de Melker, Ruut A; Touw-Otten, Fransje WMM; Kuyvenhoven, Marijke M. *Transcultural Differences in Behaviour and Outcome: An Underestimated Aspect of General Practice?* Family Practice – An International Journal, Vol. 14 (6):472-7.

Abstract:

The authors' goal was to assess international differences in illness behavior and clinical outcome for patients in Europe with an episode of acute tonsillitis. It is concluded that the duration of illness was primarily influenced by country. The countries in Eastern Europe especially were characterized by a longer duration of illness. Transcultural differences may influence the duration of illness and need more attention in daily practice.

38. 1980 Demers, Raymond Y; Altamore, Rita; Mustin, Henry; Kleinman, Arthur; Leonardi, Denise. *An Exploration of the Dimensions of Illness Behavior*. The Journal of Family Practice, Vol. 11 (7):1085-92.

Abstract:

Illness behavior is typically studied from the perspective of medical care practitioners. Problems for which people seek medical care are often deemed to be the universe of such ailments whereas actually they represent a small percentage of total illness experienced. This paper describes the rest of the iceberg of health problems. By using a health diary, all problems recorded by 107 participants over a three-week period were analyzed. A total of 348 problems (3.25 per person) were recorded with less than six percent of the problems receiving professional medical care. Stated differently, individuals were experiencing at least one health problem on approximately half of all study days. Health beliefs regarding selected problems were also obtained, along with non-orthodox practitioner (e.g. chiropractors and naturopaths) utilization patterns.

39. 1999 Department of Health and Human Services, U.S. Public Health Service. *Executive Summary – Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General*. For more information, visit: <http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-1.html>. At this web site, you can read the summary, main findings and main message. You will also find personal health recommendations, organization of supplement and major topics covered and references.

Abstract:

This report is a Supplement to the first-ever Surgeon General's Report on Mental Health, *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services [DHHS], 1999). That report provided extensive documentation of the scientific advances illuminating our understanding of mental illness and its treatment. It found a range of effective treatments for most mental disorders. The efficacy of mental health treatment is so well documented that the Surgeon General made this single, explicit recommendation for all people: *Seek help if you have a mental health problem or think you have symptoms of a mental disorder.*

40. 1998 Denboba, Diana L.; Bragdon, Judith L.; Epstein, Leonard G.; Garthright, Karen; McCann Goldman, Thurma. *Reducing Health Disparities Through Cultural Competence*. Journal of Health Education, Sept/Oct; Vol. 29 (5):47-53.

Abstract:

Activities relating to “cultural diversity” and “cultural competence” have gained a greater audience with the increase in culturally diverse populations in the United States. In the area of health care, issues range from managing and caring for a more diverse workforce to eliminate disparities in health outcomes ensuring

access and utilization of services by culturally diverse communities. Cultural competence is inextricably important to quality of care and is a cross-cutting issue affecting all service delivery systems and providers, including health educators. Health educators need to have an awareness of their own cultural values and beliefs with recognition for how they influence attitudes and behaviors.

41. 2001 DeSantis, Lydia. *Health-Culture Reorientation of Registered Nurse Students*. Journal of Transcultural Nursing, Oct.; Vol. 12 (4):310-18.

Abstract:

There is a need for a health-culture reorientation of nurses from acute care to community-based care if the profession is to respond effectively to sociocultural, political, economic and educational forces moving health care and decision making back into the community. Concepts from anthropology, international health and transcultural nursing provided the basis for initiating a health-culture reorientation of acute care-oriented (RN-BSN) students enrolled in a population-based community health nursing course given in a weekend format. The course centered on developing a primary health care project from assessment data gathered via the community-as-partner model. Problems encountered, methods of evaluation and ongoing project developments are discussed.

42. 1994 DeSantis L. *Making Anthropology Clinically Relevant to Nursing Care*. Journal of Advanced Nursing, Vol. 20 (4):707-715.
43. 2000 Donini-Lenhoff, FG; Hedrick, HL. *Increasing Awareness and Implementation of Cultural Competence Principles in Health Professions Education.* Journal of Allied Health, Vol. 29 (4):241-245.
44. 2000 Dreachslin, Janice L; Hunt, Portia L; Sprainer, Elaine. *Workforce Diversity: Implications for the Effectiveness of Health Care Delivery Teams*. Social Science and Medicine, Vol. 50: 1403-14.

Abstract:

This paper examines the implications of racial diversity for the self-perceived communication effectiveness of nursing care teams. A Registered Nurse leads the nursing care team (NCT) and delivers care in collaboration with two or more nonlicensed caregivers. Overlap is intentionally designed into the roles of NCT members and the range of duties the team performs is generally expanded to include functions previously performed by personnel from centralized departments. NCTs are highly reliant on mutual respect and effective communication among team members. Team conflict and miscommunication can be exacerbated by the strong correlation between role on the nursing care team (NCT) and race. Verbatim transcripts of fourteen focus groups from two study hospitals were used to develop a grounded theory of the role that race plays in the self-perceived communication effectiveness of nursing care teams. Two themes that emerged from the focus group discussions constitute

the overarching framework within which realities. Three additional themes, social isolation, selective perception and stereotypes, that serve as reinforcing factors were also identified, i.e., these factors deepen the conflict and dissatisfaction with team communication that occurs as a natural consequence of the overarching framework of different perspectives and alternative realities. Leadership emerged as a powerful mitigating factor in the model of how race influences the self-perceived communication effectiveness of nursing care teams. Leaders who can transcend racial identity as evidenced by the ability to validate alternative realities and appreciate different perspectives appear to moderate the potential negative effects of racial diversity on team communication processes and strengthen the positive aspects of diversity.

45. 1998 Erlen, Judith A. *Culture, Ethics, and Respect: The Bottom Line Is Understanding*. Orthopedic Nursing, Nov/Dec; 79-81.

Abstract:

As the world becomes smaller, there is increasing recognition of cultural diversity. People within a particular group share customs, habits and values; however, these individuals may share few, if any, beliefs and practices with people from other cultural groups. This increasing cultural diversity raises questions about ways to deliver appropriate and respectful health care to patients from other cultures. This article discusses culture, culture and health care, and respect for culture. There is a description of means that nurses can use to provide culturally relevant care. Ethical practice requires recognition of one's biases, sensitivity to cultural differences, the avoidance of generalizations about cultures, and the provision of culturally relevant care.

46. 1991 Fineman, Norman. *The Social Construction of Noncompliance: Implications for Cross-Cultural Geriatric Practice*. Journal of Cross-cultural Gerontology, Vol. 6:219-27.

Abstract:

Research data suggest that noncompliance is a subjective, provider-constructed category of unacceptable patient behaviors. Providers define noncompliance broadly as the extent to which patients' behaviors deviate from expectations of appropriate, proper and reasonable patient behavior. In addition, providers assess the intent underlying their patients' noncompliant acts. Their assessments, in turn, serve as the bases for the strategies they construct to manage patients' noncompliant behaviors. Viewing noncompliance as a provider-constructed category of unacceptable patient behaviors has two implications for cross-cultural geriatric practice: (1) It suggests that ethnic minority elders, particularly those whose behaviors deviate from providers' expectations, are likely to be perceived and treated by providers as being noncompliant; and (2) It suggests that remedying noncompliance is as much a matter of changing providers' expectations as it is of changing patients' behaviors.

47. 1990 Finucane, Thomas; Carrese, Joseph. *Racial Bias in Presentation of Cases*. Journal of General Internal Medicine, Mar./Apr., Vol. 5:120-1.

Abstract:

To investigate whether medical housestaff report race information differently during case presentation of black patients and white patients, a prospective observational study was performed. Without informing housestaff, a chief resident recorded data during consecutive case presentation over two months. For each presentation, the data included: 1) whether, where, and how often race was identified; 2) whether certain prospectively selected, “possibly unflattering characteristics” were mentioned; and 3) whether any “justifying” diagnoses were considered during presentation or subsequent discussion. Justifying diagnoses were those in which a patient’s race was important in considering the likelihood of possible diagnoses. Twenty-three house officers presented 18 black and 35 white patients. A single East Indian patient was excluded from analysis. Race was specified more often during presentations of black than of white patients (16 of 18 for blacks vs. 19 of 36 for whites; $p < 0.01$). For two black patients, a justifying diagnosis was considered, but excluding these patients did not change the results. Two other differences did not achieve statistical significance. Race was more often specified prominently and repeatedly during presentations of black patients. Among patients to whom “possibly unflattering” characteristics were attributed, race was more likely to be specified for blacks (10 of 10) than for whites (4 of 9). These case presentations appeared to show a subtle bias.

48. 1988 Fitzgerald, Faith T. *Patients From Other Cultures-How They View You, Themselves, and Disease*. Consultant, Mar; Vol. 28 (3):65-77.

Abstract:

As the number of Americans of non-European origin grows in the United States, physicians are seeing more and more patients from diverse cultural backgrounds. Especially in California and the western states, immigrants from Southeast Asia and Hispanic people comprise a very large proportion of the population. To communicate with these people and to diagnose and treat them effectively, cultural differences must be appreciated. The physician needs to understand potential problems that may arise from differing language, contrasting views of the physician’s role, and diverging perspectives on the meaning of illness. Patients may even wish to supplement the doctor’s recommendations with traditional remedies or the services of a folk healer.

49. 2000 Flores, Glenn. *Culture and the Patient-Physician Relationship: Achieving Cultural Competency in Health Care*. The Journal of Pediatrics, Vol. 136 (1):14-23.

Abstract:

The purpose of this article is to describe how culture affects clinical care. Cases are presented that detail the impact of culture on health care processes, outcomes, quality, and satisfaction in order to provide a general framework for

understanding the clinical consequences of culture. It cautions the culturally competent clinician to beware of the dangers of stereotyping. The article offers interpreter options available to the health care provider as well as guidelines for the effective choice and use of interpreters in clinical settings.

50. 2000 Flores, Glenn; Abreu, Milagros; Schwartz, Ilan; Hill, Maria. *The Importance of Language and Culture in Pediatric Care: Case Studies from the Latino Community*. The Journal of Pediatrics, Vol. 137 (6):842-8.

Abstract:

Few studies have examined culture's effect on pediatric care. The objective of these case studies is to analyze three cases illustrating the importance of culture in pediatrics. It is concluded that culture can have a significant impact on pediatric care; use of a simple model can ensure that pediatricians provide culturally competent care. The authors' objectives in sharing these cases are to (1) provide an educational resource for training and course development; (2) illustrate the significant impact that language issues and culture can have on pediatric care, including health care processes and outcomes, satisfaction with care, and the costs of care; and (3) present a practical model for culturally competent pediatric care.

51. 1996 Forman, Ruth Lindeck. *Communication is More Than Just Talking...10 Steps to Successful Personal and Multicultural Communication for the Medical Professional*. Communication Enhancement, Inc., Woodland Hills, CA.

52. 2001 Franzini, Luisa; Ribble, John; Keddie, Arlene. *Understanding the Hispanic Paradox*. Ethnicity and Disease, Vol. 11:496-518.

Abstract:

The purpose of this article is to review the literature on the health of Hispanics in the United States and to observe how it is influenced by socioeconomic variables.

53. 1997 Freda, Margaret Comerford. *Cultural Competence in Patient Education*. MCN Patient Teaching, July/Aug; Vol. 22: 219-20.

Abstract:

It is no longer sufficient to be "culturally sensitive;" one must now be "culturally competent." The concept of cultural competence suggests that no one culture is superior to another. Health care providers cannot just be sensitive to immigrant patients; they must be competent in working with individuals of many cultures. The author provides many invaluable suggestions to help provide patient education in a culturally competent manner.

54. 2002 Fuller, K. *Eradicating Essentialism from Cultural Competency Education*. Academic Medicine, Mar., Vol. 77 (3):198-201. Center for the Study of Race and Ethnicity in Medicine, University of Kansas School of Medicine, Kansas City, Kansas, USA. kfuller@anthrohealth.net.

Abstract:

An increasingly diverse society requires physicians to be able to competently treat those with whom they do not share ancestry and/or culture. Therefore, medical school educators need to train physicians who are capable of interacting appropriately and effectively with individuals from a broad array of populations and cultures. Such education cannot be simply a list of traits about other groups, as this may merely reinforce stereotypes. Instead, this education must expose and eradicate the existing essentialist biases in medicine. Essentialism, by focusing on differences, artificially simplifies individual and group identities and interactions. The essentialist viewpoint needs to be replaced with an ethnogenetic one, which recognizes that groups, cultures, and the individuals within them are fluid and complex in their identities and relationships. The ethnogenetic perspective must be fully integrated into medical education if medical schools are to produce physicians who will be truly qualified to give competent patient care in our increasingly complex societies.

55. 1994 Gardano, Ana C.; Davis, Ruth M.; Jones, Eric. *Promoting Receptivity to Issues of Cultural Diversity in Mental Health Services at Health Maintenance Organizations*. The Family Psychologist, Spring; 15-8.

Abstract:

In this article, the authors address some of the issues they confront daily while working with families of different cultures in an HMO setting. They include some practical suggestions for practitioners and researchers to promote cultural sensitivity. They believe that the therapists' success in treating culturally-diverse populations may well be linked to their ability to recognize different cultural exigencies manifested in culturally-diverse family functioning. They conclude that the therapist's receptivity to cultural difference may well determine the success of his/her treatment.

56. 1998 Gavagan, Thomas; Brodyaga, Lisa. *Medical Care for Immigrants and Refugees*. American Academy of Family Physicians, March 1. Go to: <http://www.aafp.org/afp/980301ap/gavagan.html>.

Abstract:

Refugees and other immigrants often present with clinical problems that are varied as their previous experiences. Clinical presentations may range from unusual infectious diseases to problems with transition. This article describes medical conditions associated with immigrants, as well as specific screening recommendations, including history, physical examination and laboratory tests, and some of the challenges encountered by family physicians caring for refugees.

57. 2001 Gaw, Albert C. *Concise Guide to Cross-Cultural Psychiatry*. American Psychiatric Publishing, Inc., Washington, D.C.

Abstract:

The *Concise Guide to Cross-Cultural Psychiatry* is a practical introductory guide for students and practitioners of mental health to address cultural issues in psychiatric care. The contents are derived from the author's experience in providing cross-cultural psychiatric service, teaching, and research in cross-cultural psychiatry for the past three decades. In this book, the author weaves cultural understanding into the biopsychosocial framework in psychiatric care. Although modern psychiatry is grounded in both neuroscience and psychology, there have been recent efforts to enrich psychiatry by integrating into it various sociological and cultural materials. Understanding the context of the patient's experience is critical for enhancing greater precision in diagnosis and treatment. A clearer understanding of the concept of culture and its integration into medicine and psychiatry not only can increase clinicians' cultural sensitivity but also can sharpen their diagnostic acumen and aid in the formulation of treatment plans more congruent with the patient's cultural background.

58. 2001 George, M. *The Challenge of Culturally Competent Health Care: Applications for Asthma*. Heart Lung, Sept./Oct., Vol. 30 (5):392-400. Division of Nursing and Pulmonary, Allergy and Critical Care Medicine, University of Pennsylvania Health System, Philadelphia 19104, USA.

Abstract:

To better serve the increasingly diverse ethnic and racial communities in the United States, health care professionals must develop a knowledge base of cultural health practices. In asthma, a common disease, ethnic minority populations experience poorer outcomes when compared with whites. It is, therefore, imperative that providers have an improved understanding of how patients make decisions concerning their health. Cultural health practices, in concert with conventional treatments, often form a comprehensive asthma explanations for disease, as well as the role of diet and botanical supplements is explored in this article in an effort to increase providers' sensitivity to nonbiomedical models of disease causality. This sensitivity is the first step in developing cultural competency.

59. 2001 Geiger, H. Jack. *Racial Stereotyping and Medicine: the Need for Cultural Competence*. Canadian Medical Association, June, Vol. 164 (12):1699-1700.
60. 1991 Giger, Joyce Newman; Davidhizar, Ruth Elaine. *Transcultural Nursing: Assessment and Intervention*. Mosby-Year Book, Inc., St. Louis, MI.

61. 2001 Group for the Advancement of Psychiatry (GAP). *Cultural Assessment in Clinical Psychiatry*. Dr. Lu is a member of the Gap Committee. He can be contacted at Francis.Lu@sfdph.org.

Abstract:

GAP focuses on a concise clinical tool that appears in Appendix I. The five sections include: 1) Cultural Identity of the Individual; 2) Cultural Explanations of Illness; 3) Cultural Stressors and Supports; 4) Cultural Elements of the Relationship between the Clinician and the Individual; and 5) Overall cultural Assessment for Differential Diagnosis and Treatment Planning. Six detailed clinical cases from diverse cultures illustrate how the use of the Outline influences the differential diagnosis and treatment plan.

62. 1982 Goldfield, Norbert; Lee, Winston. *Caring for Indochinese Refugees*. *AFP*, Vol. 26 (3):157-60.

Abstract:

A refugee camp in Hong Kong and a health center in Los Angeles provide data on patterns of health care among Indochinese refugees. American physicians need to be aware that incoming refugees use both Western and traditional Chinese models of medical care. In addition, they are subject to special psychological problems resulting from their past ordeals and their resettlement in a different country. Increased emergency aid should be provided to geographic areas with large concentrations of refugees.

63. Gonzalez-Calvo J, Gonzalez VM, Lorig K (1997 December 10). *Cultural Diversity Issues in the Development of Valid and Reliable Measures of Health Status*. *Arthritis Care Research*, Vol. 6: 448-456.

64. 1993 Groce, Nora Ellen; Zola, Irving Kenneth. *Multiculturalism, Chronic Illness and Disability*. *Pediatrics*, May, Vol. 91 (5):1048-55.

Abstract:

Many ethnic and minority populations, reflecting their own unique and long-standing cultural beliefs, practices and support systems, do not define or address disability and chronic illness in the same manner as “mainstream” American culture. Their concerns are not necessarily identical, their solutions are not always the same, and the strengths shown in many ethnic and minority groups may present alternative ways of addressing needs that merit our careful attention. We strongly argue that to better service children and adults who have a chronic illness or disability within our multicultural society, it is imperative that we understand the cultural beliefs and attitudes that determine behaviors, guide decisions, and effect interactions with the broader society. This should include the fact that our own traditional “American” way of addressing issues of chronic illness and disability is, in itself, not culture-free, but a unique product of our nation’s history, legal system and social structure.

65. 1998 Gropper, Rena C. *Cultural Basics and Chronic Illness*. Advances in Renal Replacement Therapy, Apr; Vol. 5 (2):128-33.

Abstract:

Cultural factors have significant impact on the clinical encounter between health care professionals and their patient-families. A good continuing relationship is essential for successful management of potential hazard. This review outlines some possible problems and concludes by making eight suggestions for culturally sensitive and medically effective communication in the care of patients with chronic illness.

66. 1998 Haloburdo, Esther P; Thompson, Mary Ann. *A Comparison of International Learning Experiences for Baccalaureate Nursing Students: Developed and Developing Countries*. Journal of Nursing Education, Jan; Vol. 37 (1):13-21.

Abstract:

As faculty seeks creative learning opportunities for students in a changing social, political and health care environment, knowledge about international learning experiences can provide critical information for decision-making. This study sought the answer to two questions: What are the learning outcomes of an international experience for baccalaureate nursing students and what are the similarities and differences in what students learn in developed and developing countries? Using grounded theory methodology, 14 students who had participated in international learning experiences were interviewed. Three major categories emerged from the data analysis: personal and professional growth, empirical knowledge, and the learning experience. More similarities than differences were identified among the students who had traveled to developing versus developed countries. The findings suggest that international experiences need to include the opportunity to provide direct nursing care. A proposed model for such experiences is presented.

67. 2001 The Healthcare Collaborator, [Special Issue]. *A Newsletter on Communication Strategies for Health Care Professionals*. Nov., Vol. 1 (11).

Abstract:

In this issue, they provide strategies, ideas and new perspectives to help you (and your health care organization) communicate with even greater “cultural competence” than you do now, and turn challenges into new opportunities to increase intercultural understanding.

68. 1990 Hill, Robert F.; Fortenberry, Dennis; Stein, Howard F. *Culture in Clinical Medicine*. Southern Medical Journal, Sept; Vol. 83 (9):1071-80.

Abstract:

Many clinicians recognize that culture affects medical care in numerous ways. It mediates the communication between patient and provider, thereby affecting the quality and quantity of information exchanged. It shapes a particular way of life for those under its influence and, by its emphasis on certain values and

attitudes, culture governs the societal response to illness by the choices its administrative representatives make concerning the definition of problems, the training of providers, etc. Research based on an understanding of culture consistent with contemporary society's highly variable nature is essential to the maintenance of the therapeutic art form we call clinical medicine.

69. 2000 Hines, Silvia E; Frate, Dennis A; Kountz, David S; Levy, Richard A; Strickland, Tony E; Williams, Richard A. *Intelligent Prescribing in Diverse Populations*. Patient Care, May; 135-49.

Abstract:

The authors suggest that clinicians consider race or ethnic background when choosing medications since both can affect disease pathophysiology and drug metabolism. Learning about the health beliefs of different groups may also improve adherence - and thus, clinical outcomes. Equal treatment may not be optimum treatment if it means that every patient is given the same medications, at the same dosages, with the same instructions, and is expected to adhere in the same way.

70. 1983 Hiok-Boon Lin, Elizabeth. *Intraethnic Characteristics and the Patient-Physician Interaction: "Cultural Blind Spot Syndrome."* The Journal of Family Practice, Vol. 16 (1):91-8.

Abstract:

Ethnic variation in the beliefs, expectations and illness behavior of patients has dominated cultural studies of medical care. A widespread supposition, referred to as "cultural blind spot syndrome," assumes that similarities in the ethnic backgrounds of patient and physician invariably enhance clinical communication, thereby resulting in improved outcomes. The author's experience as a Western-trained Chinese physician attending to a wide spectrum of Chinese patients challenged this simplistic assumption. The cultural identity of the Western-trained physician and intraethnic variation among people of a common cultural heritage emerged as two key considerations from this analysis of patient-physician interaction. Two cases representing extremes in patient-physician interaction were chosen and analyzed with respect to each of six essential elements of patient-physician interaction. Common ethnicity does not ensure a positive patient-physician interaction. A good match among intraethnic descriptors of patient and physician enhances communication and thereby may improve outcome. However, the match between the patient's explanatory model and expectations of the physician and the physician's actual persona and practice is equally important in determining outcome.

71. 1995 Huth, Edward J. *Identifying Ethnicity in Medical Papers*. Annals of Internal Medicine, Apr; Vol. 122 (8):619-21.

Abstract:

The author suggests that “racial” terms such as “black” and “white” be dropped when presenting case descriptions and that more attention be paid to detailed history taking that can actually yield invaluable information on ethnic background and possible risks for certain diseases and potentially important cultural information.

72. 2002 Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care [Summary]. Copyright by the National Academy of Sciences. To access this summary online, go to: [http://www4.nationalacademies.org/news.nsf/\(ByDocID\)/4393A314660B9CE885256B820](http://www4.nationalacademies.org/news.nsf/(ByDocID)/4393A314660B9CE885256B820). For more information about the Institute of Medicine, visit the IOM home page at: www.iom.edu.

73. 1995 Jecker, Nancy; Carrese, Joseph; Pearlman, Robert. *Caring for Patients in Cross-Cultural Settings*. Hastings Center Report, Jan./Feb.

Abstract:

A caregiver from the dominant U.S. culture and a patient from a very different culture can resolve cross-cultural disputes about treatment, not by compromising important values, but by focusing on the patient’s goals.

74. 1996 Johnson, Amy E.; Baboila, George V. *Integrating Culture and Healing: Meeting the Health Care Needs of a Multicultural Community*. Minnesota Medicine, May; Vol. 79:41-5.

Abstract:

Delivering health care to culturally diverse patients is fast becoming an integral part of patient care – a change driven by shifting demographics in Minnesota and especially in the Twin Cities metro area. At United Hospital and Children’s Health Care – St. Paul, ethnographic research is being used to create cross-cultural health care information systems that address the needs of providers and patients. These include an easy-to-use computer-based information system, brown bag seminars and cross-cultural skills training. This article discusses the hospitals’ efforts to identify provider needs, collect cultural information and disseminate that information in a manner that supports quality and cost-effective health care delivery.

75. 1998 Jones, Mary Elaine; Bond, Mary Lou; Cason, Carolyn L. *Where Does Culture Fit in Outcomes Management?* Journal of Nursing Care Quarterly, Oct; Vol. 13 (1):41-51.

Abstract:

The authors describe the concept of cultural competence and ways in which culture, a structure of care variable, is important to the delivery of culturally

competent care. The role of culture in outcomes assessment and management is explored. The culture of the patient, the health care professional and the organization is examined as it influences the potential to deliver culturally competent care. Strategies for developing a culturally competent work force are proposed with examples from ongoing projects in a large metroplex in the southwestern part of the United States.

76. 2001 Kagawa-Singer, Marjorie; Blackhall, Leslie. *Negotiating Cross-Cultural Issues at the End of Life*, "You Got to Go Where He Lives." JAMA, Dec., Vol. 286 (23):2993-3001.

Abstract:

Culture fundamentally shapes how individuals make meaning out of illness, suffering and dying. With increasing diversity in the United States, encounters between patients and physicians of different backgrounds are becoming more common. Thus the risk for cross-cultural misunderstandings surrounding care at the end of life is also increasing. Studies have shown cultural differences in attitudes toward truth telling, life-prolonging technology, and decision-making styles at the end of life. Using 2 case studies of patients, one of an African American couple in the southern United States and the other of a Chinese-American family in Hawaii, we outline some of the major issues involved in cross-cultural care and indicate how the patient, family and clinician can navigate among differing cultural beliefs, values, and practices. Skilled use of cross-cultural understanding and communication techniques increases the likelihood that both the process and outcomes of care are satisfactory for all involved.

77. 2002 Kaiser, Henry J. Kaiser Family Foundation. *National Survey of Physicians, Part I: Doctors on Disparities in Medical Care*. Kaiser Family Foundation Headquarters located at 2400 Sand Hill Road, Menlo Park, CA 94025. Tel. 650-854-9400. This report can be downloaded from their web site: <http://www.kff.org>.

Abstract:

The Henry J. Kaiser Family Foundation *National Survey of Physicians*, conducted by mail from March 26 through October 11, 2001, is based on a nationally representative random sample of 2,608 physicians whose major professional activity is direct patient care. The sample frame was developed from two sources, the American Medical Association's Physician Masterfile and a related file developed by the Association of American Medical Colleges that included additional information on the race and ethnicity of physicians. These two files are linked by a common identifier and were merged for the purposes of selecting this sample. African American, Latino and Asian physicians were oversampled to increase the number of responses from these physicians. Results were then weighted by race and other factors to reflect the actual distribution of physicians in the nation. Foundation staff designed and analyzed the survey, and fieldwork was conducted by the Research Triangle Institute. Data on public perceptions are from the Kaiser Family Foundation October 1999 *Survey of Race, Ethnicity*

and *Medical Care: Public Perceptions and Experiences* conducted by telephone from July to September 1999 with 3,884 adults. Foundation staff designed and analyzed the survey, and fieldwork was conducted by Princeton Survey Research Associates.

78. 1992 Kavanagh, Kathryn Hopkins; Kennedy, Patricia H. Promoting Cultural Diversity: Strategies for Health Care Professionals. For information, contact: SAGE Publications, Inc. at 2455 Teller Road, Newbury Park, CA 91320.

Abstract:

This book is especially valuable for its conceptual first chapter that outlines a framework for underlying the social processes that underlie significant cultural differences and outlines a set of strategies for communication and intervention to bridge the gaps created by those differences. Equally valuable are the numerous case studies that allow the reader to apply the conceptual framework.

79. 1991 Kavanagh, Kathryn Hopkins. *Invisibility and Selective Avoidance: Gender and Ethnicity in Psychiatry and Psychiatric Nursing Staff Interaction*. Culture, Medicine and Psychiatry, Vol. 15:245-74. Copyright © 1991 Kluwer Academic Publishers. Printed in the Netherlands.

Abstract:

This research-based article analyzes institutionalized inequity and discrimination in the forms of sexism and racism within a large, busy, contemporary medical center's Department of Psychiatry. Within that context, issues of control and mechanisms of avoidance served to perpetuate contradictions inherent in what professes to be a psychologically therapeutic and empowering milieu. Despite cognizance of the roles that culture and gender play in care and treatment of patients, psychiatric and mental health professionals at "central" tended to avoid critical examination of their own and co-workers' ethnicity and gender as those characteristics influenced life experiences, occupational roles and statuses, and hierarchical relationships.

80. 1997 Kaufert, Joseph M.; Putsch, Robert W. *Communication through Interpreters in Healthcare: Ethical Dilemmas Arising from Differences in Class, Culture, Language, and Power*. The Journal of Clinical Ethics, Spring; Vol. 8 (1):71-87.

Abstract:

This article considers the problems of communication, day-to-day workplace pressures and ethical dilemmas that interpreters face. There are major gaps between ethical codes of conduct for interpreters in health care and the realities of medical interpretation. The authors found that the interaction between a patient and an interpreter often involves significant trust relationships, and may be bound by cultural constraints. Since a patient's trust in an interpreter may not always be transferred to the health care professional, this relationship may need to be reflected in institutional process and recognition of the interpreter's roles in relating to patients, families, health care providers and institutions.

81. 1999 Kavanaugh, Kathryn; Absalom, Kathleen; Beil, William Jr.; Schliessmann, Lucia. *Connecting and Becoming Culturally Competent: A Lakota Example*. Advances in Nursing Science, Mar; Vol. 21 (3):9-31.

Abstract:

Addressing how nurses become culturally competent is essential for knowledge development beyond why sociocultural understandings are important. This article reports participatory research conducted during intercultural immersion learning experiences of non-native nurses on an Indian reservation. Emphasizing collaborative relationships within unfamiliar social, political and economic circumstances, and using Diekelmann's "concernful practices" as an organizing scheme, prompted participants to explicate practices that promote intercultural connecting. Suggesting integral shifts in value orientations with changes in cultural competence, the findings argue for attending to associations between those dynamics and potential for developing co-responsibility (with consumer groups) for advocating improved health and health care.

82. 1989 Kirmayer, Laurence J. *Cultural Variations in the Response to Psychiatric Disorders and Emotional Distress*. Social Science Medicine, Vol. 29 (3):327-39.

Abstract:

Culture influences the experience and expression of distress from its inception. While Western psychiatry has identified several universal patterns of distress, there are significant geographical variations in the prevalence, symptomatology, course and outcome of psychiatric illness. Indirect evidence suggests that cultural differences in the recognition, labeling and interpretation of deviant behavior affect the outcome of major psychiatric disorders as well as milder forms of distress. Emotion theory and the cultural concept of the person provide links between social and cognitive processes that contributes to the natural history of emotional distress. However, many current studies of ethnopsychology confound psychology (mechanisms of behavior) and meta-psychology (theories of the self). Further advances in understanding the impact of culture on distress depend on the development of psychological and social theory that is neither ethnocentric nor naïve about the wellsprings of action. Three arenas for further study are identified: (1) the handling of the gap between experience and expression; (2) the labeling of deviant behavior and distress as voluntary or accidental; and, (3) the interpretation of symptoms as symbols or as meaningless events. Attention to these themes can guide re-thinking the assumptions of Western psychological and social theory.

83. 1978 Kleinman, Arthur; Eisenberg, Leon; Good, Byron. *Culture, Illness, and Care - Clinical Lessons from Anthropologic and Cross-Cultural Research*. Annals of Internal Medicine, Feb; Vol. 88 (2):251-8.

Abstract:

Major health care problems, such as patient dissatisfaction, inequity of access to care, and spiraling costs, no longer seem amenable to traditional biomedical solutions. Concepts derived from anthropologic and cross-cultural research may

provide an alternative framework for identifying issues that require resolution. A limited set of such concepts is described and illustrated, including a fundamental distinction between disease and illness, and the notion of the cultural construction of clinical reality. These social science concepts can be developed into clinical strategies with direct application in practice and teaching. One such strategy is outlined as an example of a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application. The implementation of this approach in medical teaching and practice requires more support, both curricular and financial.

84. 1995 Kohn, Sally. *Dismantling Sociocultural Barriers to Care*. Healthcare Forum Journal, May/June; 30-3.

Abstract:

The author of this article discusses the current demographic trends relevant to today's health care system. It is of interest for health care institutions to be aware of the increasingly diverse patient population. The article discusses potential sociocultural barriers to health care, additionally, suggesting new strategies as ways to overcome the barriers.

85. 1990 Kraut, Alan M. *Healers and Strangers, Immigrant Attitudes Toward the Physician in America – A Relationship in Historical Perspective*. JAMA, Apr., Vol. 263 (13):1807-11.

Abstract:

The current wave of immigration to the United States – mostly Asians and Latin Americans – may well be the largest in the 20th century. Many newcomers practice habits of health and hygiene deficient by American standards. Some prefer the shaman to the physician and traditional herb remedies to modern medical therapies. Physicians find themselves practicing at an invisible border separating them from their foreign-born patients, where differences of language and culture can lead to misunderstanding and frustration, impeding a physician's ability to gain cooperation with prescribed therapy. Similar issues faced physicians at the turn of the century. Newly arrived Italians, East European Jews, and Chinese were often ambivalent toward physicians and their therapies. Quacks further undermined the physician's credibility among immigrants. Today, some physicians try collaborating with shamans and herbalists to accommodate patients' cultural preferences. Respect for the customs and taboos of immigrant patients pays dividends in physician effectiveness and efficacy.

86. 1999 Kudzma, Elizabeth Connelly. *Culturally Competent Drug Administration*. American Journal of Nursing, Aug.; Vol. 99 (8):46-51.

Abstract:

It is common knowledge that a patients' age, gender, size and body composition influence their responses to a drug. This variation in response is called *drug*

polymorphism. Ethnicity affects how people react to drugs. As providers become more culturally competent and research methods more refined, studies of additional drug classes and their clinical applications are expected. The author suggests physicians should carefully observe patients for adverse drug effects, and question any failures in medications that are usually effective for a given condition.

87. 1997 Larson, Laurie. *Access with Honor*. Trustee, Sept; Vol. 51 (8).

Abstract:

Many Asian and Pacific Island cultures in the United States face linguistic, financial and cultural barriers. They often suffer from the trauma of relocation and also have a deep-seated fear of the Western health care system, which is opposed to their philosophy of treating illness. Those who work with non-English-speaking patients agree that the most important quality of health care professionals is their true understanding, by virtue of shared ethnicity and background, of the widely varied Asian immigrant experience.

88. 1994 Leininger, Madeleine. *Transcultural Nursing Education: A Worldwide Imperative*. Nursing & Health Care, May; Vol. 15 (5):254-61.

Abstract:

Providing culturally congruent care should be one of the highest priorities of nursing organizations and educational institutions as they plan for universal health care reform and to function in a multicultural world. Thus, it is crucial to develop, test and refine culturally based models of leadership development among multilingual and multicultural nursing students.

89. Lester, Nora. *Cultural Competence: A Nursing Dialogue, Part One*. American Journal of Nursing, Aug.; Vol.98 (8):26-34.

Abstract:

A panel of nurses discussed how dramatic shifts in U.S. demographics are increasing the diversity of patients. They explore the critical role cultural competence plays in making patients comfortable, improving health outcomes, and positioning health care organizations to attract and serve a diverse population.

90. 1998 Lester, Nora. *Cultural Competence: A Nursing Dialogue, Part Two*. American Journal of Nursing (AJN), Sept.; Vol.98 (9):36-42.

Abstract:

The nurses address the racism of color experience, the difficulties of providing culturally competent care in the HMO environment, and nursing education. The panelists agree that the amount of attention given to cultural issues in formal nursing education varies considerably. They also believe that overall, nursing education does not adequately prepare nurses to work with a diverse patient population. A 1997 study cited in AJN confirms this. The authors concluded

“nurses aren’t being provided with experiences that prepare them to care for patients with culturally diverse backgrounds and that they lack confidence when delivering care to patients from these populations.”

91. 1999 Like, Robert C. *Culturally Competent Managed Health Care: A Family Physician’s Perspective*. Journal of Transcultural Nursing, Oct; Vol. 10 (4):288-9.

Abstract:

Health care organizations, providers and policy makers are becoming increasingly interested in the delivery of more culturally responsive services to our diverse population groups. Important influences include the nation’s changing demographics, racial/ethnic disparities in health care access, service utilization and outcomes, etc. Transcultural nurses, physicians and other health care professionals need to remember that cultural humility and cultural competence must go hand in hand.

92. 1999 Lister P. *A Taxonomy for Developing Cultural Competence*. Nurse Education Today, Vol. 19 (4):313-318.

93. 1987 Lloyd, Arthur P. *Stimulus Paper: Multicultural Counseling: Does It Belong in a Counselor Education Program?* Counselor Education and Supervision, Mar; 164-7.

Abstract:

Multicultural counseling has the support of various groups, including accreditation bodies. Counselor education programs may, however, be adopting a movement that is not consistent with previously held beliefs about counseling. Is information about a specific subculture helpful in counseling a client who is labeled as being from that subculture? Or, are the differences within groups possibly as great as the differences between groups? The author’s experience in one multicultural setting suggests that counseling is more effective with clients of another culture when it is unaided by the use of generalized information about that culture.

94. 1984 Low, Setha M. *The Cultural Basis of Health, Illness and Disease*. Social Work in Health Care, Spring; Vol. 9 (3):13-23.

Abstract:

The cultural basis of health, illness and disease is reviewed in terms of its applicability to social work practice. Theories and perspectives from cultural and medical anthropology are applied to health care contexts and related to patient-practitioner interaction. The culture of medical bureaucracies as well as particular ethnic groups is explored through examples and brief case studies.

95. 1999 Ma, Grace Xuequin. *Between Two Worlds: The Use of Traditional and Western Health Services by Chinese Immigrants*. Journal of Community Health, Dec; Vol. 24 (6):421-37.

Abstract:

This study examined the use of traditional and Western health services by Chinese immigrants, as well as the cultural and socioeconomic factors affecting health-seeking behaviors and health service utilization patterns among the study population from the perspectives of consumers and Chinese health care providers. Two instruments were used for data collection. The first, a consumer instrument, was designed for interviews of service recipients; the second, a health provider instrument, was designed to elicit information from traditional and Western providers. A few topics in the former instrument were cross-examined from the perspectives of health care providers. The investigation employed a combination of qualitative and quantitative research methods for data collection. Qualitative ethnographic methods used included: (1) participant-observation; (2) face-to-face interview; and (3) case study. To complement the qualitative data, structured quantitative survey were conducted with all selected informants. A total of 105 informants participated in the study: 75 Chinese consumers and 30 Chinese health professional practitioners. Results revealed several patterns of health-seeking and service utilization behaviors among the Chinese of Houston and Los Angeles. These included high rates of self-treatment and home remedies (balanced diets and other alternative medicines); medium rates of utilization of integrated Western and traditional health services, including travel to country of origin for care; and low rates of exclusive utilization of Western or traditional Chinese treatments.

96. 1988 Marcus, Lotte. *From Soma to Psyche: The Crucial Connection Part 2 – ‘Cross-Cultural Medicine’ Decoded: Learning About ‘Us’ in the Act of Learning About ‘Them.’* Family Medicine, Nov; Vol. 20 (6):449-57.

Abstract:

The scorpion's bite – a culturally inept response to a medical emergency. Margaret Clark's criteria – keys to cultural barriers in medical care. Clifford Geertz's injunction: to view the culturally "different" as mirrors of the unacknowledged self. The case of Jose – a scandal of his "compartmentalized" treatment. Question: How much context may a physician be willing to absorb? Shawcross's *The Quality of Mercy*: western medical teams in Cambodian refugee camps – their good intentions versus their ethnocentric gaffes. The elderly as avatars of a "culture within a culture." Their beliefs, fears, dreams and intimations – a "terra incognita" for service providers. Sardonic recoil against them (as in Shem's novel *House of God*) by residents – a professionally sanctioned response deflecting what might otherwise be unendurable demands on their varied quotas of pity. Sisela Bok's moral claims: (1) for the integrity of decision making among the sick; and (2) for the autonomy of the "dying response" among the aged. Steinberg's *The Ethnic Myth*: indictment of those using cultural difference to "explain" (or rationalize) health – and other – deficits rooted in historic, social, or economic inequity.

97. 1996 Moffic, H. Steven. *The History and Future of Cross-Cultural Psychiatric Services*. Community Mental Health Journal, Dec; Vol. 32 (6): 581-92.

Abstract:

With cultural issues prominent in the United States today and with ongoing rapid changes in health care management and delivery, this paper discusses the shift from a generic-type psychiatry (i.e., assuming that humans the world over are no different, and will react to given stressors in life in the same manner) to one recognizing that cultural beliefs, mores, peer pressure, family expectations and other ingredients operate in unique combinations in various cultures and ethnic groups. These social and cultural factors can and will impact treatment modalities and outcomes. Literature reviewed herein illustrates the progressive stages of awareness and incorporation of cultural differences and the many ways they impact treatment. Unfortunately, the rise in managed, rationed health care threatens the future of this progression. It is essential that culturally-based managed care programs be developed and funded to ensure the availability of cost-effective treatment, through an integrated system of services, to patients of all cultural and economic backgrounds.

98. 2000 Muirhead, Greg; de la Cancela, Victor; Green, Alexander. *Cultural Issues in Substance Abuse Treatment*. Patient Care, May; 151-9.

Abstract:

Attention to the sensibilities of patients from different cultures is key to successful substance abuse treatment. Avoid preconceived notions and explore each patient's beliefs, values, and concerns.

99. 2001 Mull, J. Dennis; Mull, Dorothy S.; Nguyen, Nghia. *Vietnamese Diabetic Patients and Their Physicians: What Ethnography Can Teach Us*. Western Journal of Medicine, Nov., Vol. 175:307-11.

Abstract:

The authors' objectives are to describe the cultural context of type 2 diabetes mellitus among Vietnamese immigrants in the United States, including people's ideas about cause and proper treatment; and to suggest ways in which better control of the disease can be achieved in this population. They concluded that the Vietnamese community and physicians serving that community need culturally appropriate education about type 2 diabetes and modern therapy for the disease.

100. 1981 Mull, J. Dennis; Mull, Dorothy S. *Residents' Awareness of Folk Medicine Beliefs of Their Mexican Patients*. Journal of Medical Education, June; Vol. 56 (6):520-2.

Abstract:

Since so many Mexican nationals live and work in the U.S. without official sanction, many receive health care from resident physicians. The present study documents widespread unfamiliarity with traditional health beliefs among 30

residents who had been caring for Mexican patients in a Southern California clinic for periods ranging from one to three years. The study shows a consistent disparity between the residents' limited awareness of their patients' folk medicine beliefs and the actual high prevalence of such beliefs as measured in the patient survey. The authors suggest that a formal curricular material on traditional health beliefs and practices should be provided, at least in clinical facilities serving substantial numbers of Mexican patients.

101. 1995 Nance, Teresa A. *Intercultural Communication: Finding Common Ground*. JOGNN (Journal of Obstetrics, Gynecology and Neonatal Nursing), Mar/Apr; Vol. 24 (3):249-55.

Abstract:

Diversity has become a leading topic of discussion in virtually all sectors of our society. This is certainly true in health care; the nursing profession has long been dealing with issues of cultural appropriateness. This article looks at the relationship of culture to communication. The current approach to intercultural communication discussed in much of the nursing literature is judged to be shortsighted. An alternative approach based on the development of a functional cultural communication perspective is offered.

102. 1998 Navarre SE. *Salvador Minuchin's Structural Family Therapy and its Application to Multicultural Family Systems*. Issues in Mental Health Nursing, Vol. 19 (6):557-570.
103. 1994 Nora, LM; Daugherty, SR; Mattis-Peterson, A; Stevenson, L; Goodman. LJ. *Improving Cross-cultural Skills of Medical Students Through Medical School-Community Partnerships*. Western Journal of Medicine, Vol. 161 (2):144-147.
104. 2000 Nunez, AE. *Transforming Cultural Competence into Cross-Cultural Efficacy in Women's Health Education*. Academic Medicine, Nov; Vol. 75 (11):1071-80. Correspondence can be sent to Dr. Nunez at nuneza@drexel.edu.

Abstract:

To prepare students to be effective practitioners in an increasingly diverse United States, medical educators must design cross-cultural curricula, including curricula in women's health. One goal of such education is cultural competence, defined as a set of skills that allow individuals to increase their understanding of cultural differences and similarities within, among, and between groups. In the context of addressing health care needs, including those of women, the author states that it is valid to define cultural groups as those whose members receive different and usually inadequate health care compared with that received by members of the majority culture. The author proposes, however, that cross-cultural efficacy is preferable to cultural competency as a goal of cross-cultural education because it implies that the caregiver is effective in interactions that involve individuals of different cultures and that neither the caregiver's nor the patient's culture offers the preferred view. She then explains why cross-cultural education needs to expand the objectives of women's health

education to go beyond the traditional ones, and emphasizes that learners should be trained in the real-world situations they will face when aiding a variety of women patients. There are several challenges involved in both cross-cultural education and women's health education (e.g., resistance to learning; fear of dealing openly with issues of discrimination; lack of teaching tools, knowledge, and time). There is also a need to assess the student's acquisition of cross-cultural efficacy at each milestone in medical education and women's health education. Components of such assessment (e.g., use of various evaluation strategies) and educational objectives and methods are outlined. The author closes with an overview of what must happen to effectively integrate cross-cultural efficacy teaching into the curriculum to produce physicians who can care effectively for all their patients, including their female patients.

105. 1983 Nydegger, Corinne N. *Multiple Causality: Consequences for Medical Practice*. The Western Journal of Medicine, Mar; Vol. 138:430-6.

Abstract:

When a scientifically trained health professional is called upon to deal with patients holding differing causal views of illness, the resulting lack of communication is frustrating to both. This discussion traces some implications for medical practice of significant cultural differences in two aspects of causal paradigms of illness: (1) terms accepted and (2) dimension or level of causality typically sought. The second is the more pervasive and intractable problem, having distinctive consequences for the role of the curer, symptomatology, diagnosis and treatment.

106. 2001 Office of Minority Health, U.S. Department of Health and Human Services. National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report. March, 2001. Washington, D.C. Prepared by: IQ Solutions, Inc. 11300 Rockville Pike, Suite 801, Rockville, MD 20852.
107. 1999 Oomen JS, Owen LJ. *Culture Counts: Why Current Treatment Models Fail Hispanic Women with Type II Diabetes*. Diabetes Education, Vol. 25 (2):220-225.
108. 1996 Orr, Robert D. *Treating Patients from Other Cultures*. American Family Physician, May; Vol. 53 (6):2004-6.

Abstract:

Culture refers to the complex range of beliefs, values and attitudes shared and perpetuated by members of a social group. An individual's cultural heritage profoundly affects his or her understanding and beliefs about life, health, illness, death, and life after death. This article makes recommendations to facilitate cross-cultural communication in the medical setting.

109. 2002 Ottani, PA. *Embracing Global Similarities: A Framework for Cross-Cultural Obstetric Care*. J Obstet Gynecol Neonatal Nurs, Jan./Feb., Vol. 31 (1):33-8.

Abstract:

In this era of consistent global migration, cultural competency is necessary in all aspects of the care nurses provide to families. Cultural competency is particularly significant in maternal-newborn nursing because childbirth, as one of life's most significant events, is culturally shaped and socially constructed. In this article, a framework is provided to enable nurses to focus on several global phenomena and thus provide care that is more culturally sensitive, congruent with the client's needs and competent. Suggestions for integrating cultural issues into nursing curricula are offered.

110. 1996 Pachter, Lee M. *Cultural Issues in Pediatric Care*. In Nelson WE, senior ed; Behrman RE, Kliegman RM, Arvin AM, eds. Nelson Textbook of Pediatrics. 15th ed. Philadelphia, PA: WB Saunders Co.

Abstract:

The physician who takes care of children and families from diverse ethnic backgrounds needs to be aware of cultural variations in the ways in which individuals deal with health, illness and the health care system. Special attention to these issues is needed when working with patients and families from ethnic minorities because as the "cultural distance" between patient and physician increases, the chance for miscommunication and harm increases. The author offers three necessary steps for pediatricians to provide health care that is culturally sensitive.

111. 1996 Pachter, Lee M.; Harwood, Robin L. *Culture and Child Behavior and Psychosocial Development*. Developmental and Behavioral Pediatrics, June; Vol. 17 (3):191-8.

Abstract:

This paper provides an overview of the relationship between cultural beliefs, values, practices, behavior, and psychosocial development. A framework for analyzing this relationship is presented, illustrated with studies from the cross-cultural literature. We then present a review of the literature concerning the cultural influences on one specific behavioral issue, temperament. We conclude with a critical discussion of the unique methodological issues encountered in the study of child behavior and psychosocial development in a cross-cultural and/or culturally diverse perspective.

112. 1994 Pachter, Lee M. *Culture and Clinical Care: Folk Illness Beliefs and Behaviors and Their Implications for Health Care Delivery*. The Journal of the American Medical Association Chicago, Mar; Vol.271 (9):690-4.

113. 1999 Pacquiao, Dula F; Archeval, Ludovina; Shelley, Ellen E. *Transcultural Nursing Study of Emic and Etic Care in the Home*. Journal of Transcultural Nursing, Apr; Vol. 10 (2):112-9.

Abstract:

This study describes 18 informants' experiences with home care by multi-disciplinary health care providers using participant observation as research methodology. Study findings support the salience of culture as the context for interpreting, valuing and defining satisfaction with care. In contrast to hospital care, home care was perceived by informants as enhancing their ability to remain in their valued setting, supportive of their restorative and health maintenance needs. In particular, all informants viewed their home as the milieu that allows for continuity of their lifestyles, family relationships, and cultural values.

114. 2001 Padilla, Ricardo; Gomez, Veronica; Biggerstaff, Stacy; Mehler, Philip. *Use of Curanderismo in a Public Health Care System*. Archives of Internal Medicine, May, Vol. 161 (10): 1336-40. A PDF version of this article is available at <http://archinte.ama-assn.org/issues/v161n10/abs/loi00445.html>.

Abstract:

The authors' objective is to evaluate the rate of use of curanderismo among Hispanic subjects seeking medical care at the Denver Health Medical Center, Denver, Colorado.

115. 2000 Palinkas, Lawrence. *Social, Cultural, and Clinical Dimensions of Traumatic Experiences of Primary Care Patients*. Archives of Family Medicine, Sept./Oct., Vol. 9 (9). PDF version of this article can be downloaded at <http://archfami.amaassn.org/issues/v9n9/ffull/fed0004.html>.

Abstract:

A majority of individuals in the United States experience a traumatic event at some point in their lifetime. Moreover, while previous studies have documented a clear dose-response relationship between such events and the risk of posttraumatic stress disorder, this study demonstrates that victims of traumatic experiences are also more likely to have a psychiatric disorder other than posttraumatic stress disorder.

116. The Park Ridge Center for the Study of Health, Faith, and Ethics. *Religion, Sexuality, and Public Policy: Overview of World Religions*. For more information, call 877-944-4401 or visit their web site: www.parkridgecenter.org.

Abstracts:

This chart provides a summary of religious perspectives on sexuality. Includes views on reproductive health, marriage and family, adolescent sexuality, homosexuality and the role of women. Religious traditions covered are Protestantism, Catholicism, Judaism, Islam, Buddhism and Hinduism. Easy-to-read chart makes an excellent handout or wall poster. It is a great reference tool for educational or institutional use. It's an 11 x 17" color chart and costs \$2.50.

117. 1996 Pasick, Rena J; D Onofrio, Carol N; Otero-Sabogal, Regina. *Similarities and Differences Among Cultures: Questions to Inform a Third Generation for Health Promotion Research*. Health Education and Behavior, Dec; Vol. 23:S142-61.

Abstract:

The increasing diversity of U.S. communities raises an important question about the efficiency, appropriateness and feasibility of tailoring messages and intervention strategies to target groups identified by race and ethnicity. The authors suggest that effective health promotion will tailor interventions by culture as necessary, but reach across cultures when possible and appropriate.

118. 1998 Pernell-Arnold A. *Multiculturalism: Myths and Miracles*. Psychiatric Rehabilitation Journal.
119. 2001 Perot, Ruth T.; Youdelman, Mara. *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices*. The Commonwealth Fund, Sept; Publication 492.
http://www.cmwf.org/programs/minority/perot_raceethnic_492.pdf.

Abstract:

Over the past two decades, persistent evidence of differences in medical treatment and health outcomes has focused attention on how race, ethnicity and English proficiency can affect access to quality health care. Indeed, the issue of racial and ethnic health disparities has taken center stage in the national health care debate. This, in turn, has led to a greater recognition of the importance of collecting and reporting health data broken down by individuals' race, ethnicity and primary language.

Data collection and reporting by race, ethnicity and primary language across federally supported health programs are essential for identifying, monitoring and eventually eliminating health disparities. These data are vital to develop and implement effective prevention, intervention, and treatment programs and enforceable standards to ensure nondiscrimination; facilitate the provision of culturally and linguistically appropriate health care; and identify and track similarities and differences in performance and quality of care in various geographic, cultural, and ethnic communities. The collection and reporting of these data, however, encompasses a wide array of policies and practices that influence why, how, when, and with what success data are collected, reported, and used. Further, considerable confusion remains among health care providers, insurers, and administrators about the legality of collecting racial, ethnic, and primary language data.

This study was conducted to delineate the context in which health-related data collection and reporting by race, ethnicity, and primary language take place at the federal level, particularly within the U.S. Department of Health and Human Services. With a grant from The Commonwealth Fund, the Summit Health Institute for Research and Education, Inc., in partnership with the National Health Law Program, Inc., conducted a survey of the statutes, regulations, poli-

cies, and procedures of federal agencies to identify when the collection and reporting of data on race, ethnicity, and primary language are required. The study also assessed current understanding and implementation of existing laws and regulations as expressed by 60 respondents associated with the administration of health care services.

120. 1998 Perry CM, Shams M, DeLeon CC. *Voices From an Afghan Community*. Journal of Cultural Diversity, Vol. 5 (4):127-131.
121. 2000 Porter, Sheri. *Contemplating Cultural Competency*. American Academy of Family Physicians, Aug., Vol. 6 (8). Go to: <http://www.aafp.org/fpr/20000800/04.html>

Abstract:

Bullock makes a compelling case for upgrading cultural awareness because doing so will: 1) help eliminate health care disparities among ethnic groups; 2) improve the quality of health care and outcomes; 3) help FPs gain a competitive edge in the marketplace; 4) meet accreditation mandates; and 5) decrease their liability and malpractice claims. As an assistant clinical professor in Georgetown University Medical Center's Department of Family Medicine, Bullock wants the residents and medical students on her watch prepared to face the challenges of America's burgeoning diversity. She points out current demographic data and shares journal articles highlighting health care disparities among minority groups. She wants to impress upon them the impact that cultural competency will have on their practices.

122. 1996 Porter-O'Grady, Tim. *Building Toward True Culturally Sensitive Health Care*. Advanced Practice Nursing Quarterly, Fall; Vol. 2 (2):85-6.

Abstract:

Cultural diversity is a reality in America. Nurses must accommodate diversity within their own ranks and in the populations they serve. Nursing services must be inclusive of the cultural practices of others in undertaking the work of the profession. Advance practice nurses can serve as models and have much to offer the health system as they move toward the continuum of care as the foundation for the future of health service in America. Nurses have the responsibility to expand current narrowly defined illness services to broader, culturally specific practices whose focus is attaining and maintaining the community's health.

123. 1998 Putsch, Robert. *Truth Telling, Disclosure and Informed Consent*. Across Cultures (newsletter of the Cross-Cultural Health Care Program), January.

Abstract:

The author discusses changes in policy in the health care field and the difficult duty of truth telling, disclosure and informed consent.

124. 1998 Putsch, Robert. *Language and Meaning in Health Care: What's in the Message? Across Cultures* (newsletter of the Cross-Cultural Health Care Program), January.

Abstract:

Putsch gives various examples of how understanding and translating/interpreting language can be quite a challenge. Some meaning can be lost or misunderstood altogether. I.e., some cultures don't have a word for "allergy" or have never seen a telephone so there is no way to translate those words without lengthy explanations.

125. 1999 Salimbene S. *Cultural Competence: A Priority for Performance Improvement Action*. *Journal of Nursing Care Quality*, Vol. 13 (3):23-35.

126. 1995 Salimbene, Suzanne; Graczykowski, Jacek W. *What Language Does Your Patient Hurt In? When Two Cultures Meet: American Medicine and the Cultures of Diverse Patient Populations*. Inter-Face International. Contact: IF14you@aol.com or call 818-282-2433.

127. 2002 Schneider, Eric; Zaslavsky, Alan; Epstein, Arnold. *Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care*. *JAMA*, Mar., Vol. 287 (10):1288-94.

Abstract:

Substantial racial disparities in the use of some health services exist; however, much less is known about racial disparities in the quality of care. The authors' objective is to assess racial disparities in the quality of care for enrollees in Medicare managed care health plans.

128. 1998 Scott, Carol Jack. *Ethnicity, Culture, and the Delivery of Health Care Services: Enhancing System Outcomes in a Multicultural Environment*. *Behavioral and Societal Problems*, Chapter 176, Part 7:2921-30.

Abstract:

To improve clinical and nonclinical outcomes in the provision of emergency care services, it is imperative to consider three population-related health issues: (1) health beliefs and cultural values; (2) disease incidence and prevalence; and (3) treatment efficacy. A curriculum of intercultural medicine should be incorporated into medical school and residency training programs. The scope of this new educational forum must encompass physician training, methods of practice, and patient care.

129. 2000 Shapiro, Johanna; Yu, Roginelli; White, Maysel Kemp. *Conflicting Doctor and Patient Agendas: A Case Illustration*. *JCOM*, Vol. 7 (10):41-6.

Abstract:

The case presents transcribed excerpts from a single, audio taped "difficult" doctor-patient encounter, illustrating how conflicting agendas can occur over the

course of a visit and how a failure to reconcile them can impede patient care. At key points in the interview, an analysis of the exchange and suggestions are provided showing alternative approaches the physician might have used to advance a common agenda. The goal is a mutually acceptable agenda that would reduce physician frustrations and patient fears while promoting a more satisfying, authentic exchange.

130. 1998 Shaw-Taylor; Benesch, Brenda. *Workforce Diversity and Cultural Competence in Healthcare*. Journal of Cultural Diversity, Winter; Vol.5 (4):138.

Abstract:

This paper presents a discussion of work force diversity in health care and its attendant requisite of cultural competency. The first section of the paper argues that self-assessments and diversity training are integral to work force diversity management. This paper maintains that diversity training should be a part of overall strategic goals, and that the development of management goals should be based on self-assessments. The second section of the review offers a framework of cultural competency in health care delivery based on the relationship between patient and provider, and the community and health system. For this relationship to be successful, this review argues that health systems should foster providers that can also be cultural brokers. The cultural broker role is seen as core to achieving cultural competency.

131. 1997 Spector, Rachel E. *Health Traditions*. Hoechst Marion Roussel, Inc.

Abstract:

This large “quilt” of health traditions contains symbolic illustrations of substances or objects used within selected, representative traditions to maintain, protect and restore health.

132. 1995 Spring, Marline; Ross, Paul; Etkin, Nina; Deinard, Amos. *Sociocultural Factors in the Use of Prenatal Care by Hmong Women, Minneapolis*. American Journal of Public Health, July; Vol. 85 (7):1015-7.

Abstract:

Understanding the sociocultural context of prenatal care underuse by an immigrant population can suggest programmatic changes that result in more effective health care delivery. Ethnographic survey interviews of female Hmong clinic patients conducted in 1987/88 revealed that they objected to biomedical procedures and to being attended by several doctors; the women also reported poor communication with staff as a problem. Clinic reforms implemented in 1989/90 included hiring a nurse-midwife, reducing the number of pelvic examinations, expanding hours of operation, creating a direct telephone line to Hmong interpreters, and producing a Hmong-language prenatal health care education videotape. Women interviewed in 1993 reported a more positive clinic experience.

133. 2001 Stork, Elizabeth; Scholle, Sarah; Greeno, Catherine; Copeland, Valire Carr; Kelleher, Kelly. *Monitoring and Enforcing Cultural Competence in Medicaid Managed Behavioral Health Care*. Mental Health Services Research, Sept., Vol. 3: 169-177.

Abstract:

In recent years cultural competence has expanded beyond language provisions to include understanding and factoring into services provision the cultural perspectives clients may have that are different from the majority culture. The federal government requires state Medicaid programs to offer culturally competent services, but little is known about how states implement such mandates and monitor and enforce them. We reviewed the origins and implications of cultural competence mandates and conducted a brief case study of 5 states to learn about the implementation of cultural competence provisions in behavioral managed care contracts. We found that states and managed behavioral health organizations (MBHOs) vary in their definitions and implementation of standards to ensure mental health care access for vulnerable populations. Although states had a variety of oversight mechanisms, varying contractual requirements ranging from optional to required, vague contract language, no existing standardized indicators or definitions, and scant data on the cultural characteristics of the populations enrolled in Medicaid managed care hamper monitoring and enforcement of cultural competence by states. Implications for MBHOs, states, and the federal government, as well as services researchers, follow.

134. 1995 Susser, Mervyn. *Editorial: Social Determinants of Health-Socioeconomic Status, Social Class, and Ethnicity*. American Journal of Public Health, July; Vol. 85 (7):903-5.

Abstract:

There is a stable pattern in the distribution of mortality and morbidity among social groups. The more advantaged groups tend to have better health than the other members of their societies. The social patterning of health is important because the size of the gap between the mortality rates gives some indication of the potential for improvement in a nation's health. The article addresses numerous areas to be identified that are important for future studies of the social determinants of health.

135. 2000 Sutton, Marla. *Cultural Competence – It's Not Just Political Correctness. It's Good Medicine*. Family Practice Management, Oct. This contains a cultural competence self-test that you can download as a PDF file. For more information, please go to: <http://www.aafp.org/fpm/200001000/58cult.html>.

136. 1994 Svehla, Trisha; Gardenswartz, Lee; Rowe, Anita; Greenwald, Howard P.; Jessamy, Howard T. *Frontiers of Health Services Management – Managing Diversity in Health Care Organizations: A Challenge and Strategic Opportunity*. Health Administration Press.

137. 1992 Ware, Norma C; Kleinman, Arthur. *Culture and Somatic Experience: The Social Course of Illness in Neurasthenia and Chronic Fatigue Syndrome*. Psychosomatic Medicine, Vol. 54:546-60.

Abstract:

An anthropological view of culture and somatic experience is presented through elaboration of the notion that illness has a social course. Contemporary anthropology locates culture in local worlds of interpersonal experience. The flow of events and processes in these local worlds influences the waxing and waning of symptoms in a dialectic involving body and society over time. Conversely, symptoms serve as a medium for the negotiation of interpersonal experience, forming a series of illness-related changes in sufferers' local worlds. Thus, somatic experience is both created by and creates culture throughout the social course of illness. Findings from empirical research on neurasthenia in China, and chronic fatigue syndrome (CFS) in the US, corroborate this formulation. Attributions of illness onset to social sources, the symbolic linking of symptoms to life context, and the alleviation of distress with improvement in circumstances point to the sociosomatic medication of sickness. Transformations occasioned by illness in the lives of neurasthenic and CFS patients confirm the significance of bodily distress as a vehicle for the negotiation of change in interpersonal worlds. An indication of some of the challenges anthropological thinking poses for psychosomatic medicine concludes the discussion.

138. 1997 Wright F, Cohen S, Caroselli C. *Diverse Decisions: How Culture Affects Ethical Decision-Making*. Critical Care Nursing Clinic of North America, March, Vol. 9 (1).
139. 1998 Various. *Special Section on Multicultural Issues: Melting Pot to Multicultural Society*. Psychiatric Rehabilitation Journal, Winter.
140. Various authors. *Health and Medicine in the Faith Traditions*. The Park Ridge Center for the Study of Health, Faith, and Ethics. For more information, contact 877-944-4401 or visit their web site at www.parkridgecenter.org.

Abstract:

This series of books serves a practical, accessible reference to the beliefs and moral positions of different religious traditions with respect to specific clinical issues and procedures. Written with the health care worker in mind, each volume contains a historical synopsis, the fundamental beliefs of each tradition as they relate to health care, and positions on selected medical procedures. Each book is 6 x 9" and over one hundred pages. The cost of the books ranges from \$15.95 to \$24.95.

The series of books includes:

- Anabaptist Tradition
- Anglican Tradition
- Catholic Tradition
- Christian Science Tradition
- Hindu Tradition
- Islamic Tradition
- Latter-day Saints
- Methodist Tradition

- Eastern Orthodox Tradition
- Evangelical Tradition
- Native North American Religious Tradition
- Reformed Tradition

141. Various authors. *Religious Traditions and Healthcare Decisions Handbook Series*. The Park Ridge Center for the Study of Health, Faith and Ethics. For more information, contact 877-944-4401 or visit their web site at www.parkridgecenter.org.

Abstract:

Designed for health care workers, this collection serves as a practical, easily accessible reference on the beliefs and moral positions of fifteen religious traditions regarding various clinical issues and procedures. Each handbook contains a historical synopsis, the tradition's fundamental beliefs about health care issues, and a discussion of the observances and practices that relate to care of the sick. The series costs \$79.95 and all 8.5 x 11" handbooks are included in an 11 x 11.5" binder. Individual handbooks are available for \$5.95 each.

The series of books includes:

- Anabaptist Tradition
- Buddhist Tradition
- Christian Science Tradition
- Episcopal Tradition
- Islamic Tradition
- Jehovah's Witness Tradition
- Latter-day Saints Tradition
- Lutheran Tradition
- Orthodox Christian Tradition
- Presbyterian Tradition
- Roman Catholic Tradition
- Seventh-day Adventist Tradition
- United Church of Christ Tradition
- United Methodist Tradition

1. *“African-American Health Issues: A Guide to Healthy Living.”*

Length of video in minutes: 2:25

This video is sponsored by Pfizer U.S. Pharmaceuticals and Kaiser Permanente.
Contact: The Ebony National Medical Association.

The intended audience for this video is health care providers.

Content and Structure:

Risk factors include a lack of access to preventive health care, eating an unhealthy diet, teen pregnancy resulting in high rates of infant mortality, high rates of asthma, and social ills, such as environmental toxins in the community, violence, and drugs.

Many diseases African-Americans get in their 40s and 50s started when they were younger.

2. *“Anemia Falciforme: Los Rostros de Nuestros Ninos” (“Sickle Cell Disease: The Faces of Our Children”)* From the Minority Coalition of the United Food and Commercial Workers Union

Cost: \$145.00 each, English or Spanish; \$220.00 for both versions

Length of video in minutes: 14:00

Spanish Language Version available

Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131.

Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.

E-mail address: fanlight@fanlight.com. Web address: <http://www.fanlight.com>.

“This Spanish language video examines the devastating impact of sickle cell disease on young people and their families and caregivers. The children and young people seen in this moving documentary appear healthy, yet they live with the daily threat of excruciating pain and hospitalization.” –Fanlight Productions.

3. *“The Angry Heart: The Impact of Racism on Heart Disease Among African Americans”* By Jay Fedigan

Cost: \$195.00

Length of video in minutes: 57:0

Available from Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131. Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.

E-mail address: fanlight@fanlight.com. Web address: <http://www.fanlight.com>.

“Spotlights the epidemic of heart disease among African Americans through the story of 45-year-old Keith Hartgrove, who has already experienced two heart attacks and quadruple bypass surgery. Together with experts, he analyzes the impact of a wide variety of factors that contribute to this disease including

depression, stress, diet, smoking and other lifestyle issues, but makes clear that, for African-Americans, such factors are inseparable from racism, and from the discrimination, poverty, segregation, substandard education, and day-to-day tensions which racism engenders. Also profiled are the powerful family, church and community ties which have supported him through his recovery.” –Fanlight Productions.

4. *“Between Two Worlds: The Hmong Shaman in America.”*

Length of video in minutes: 26:33

The video was directed by Taggart Siegel.

The intended audience for this video is all health care providers.

Content and Structure:

- Native-Americans believe the mountains have a spirit, the animals are their relatives, and there are unseen spirits all around.
- Ordinary men looked to their Shaman to act as the middleman between them and the spirits. Their tradition was lost when white man came to this land, but now it’s resurfacing with the coming of Southeast Asian refugees.
- Displaced refugees are America’s most recent immigrants with the war in Southeast Asia.
- Shamans have a crucial role in religious practices.
- Many Southeast Asians, especially Hmong, have died from “Sleeping Death,” or “Nightmare Death.” Sudden Death Syndrome usually occurs with young, healthy men, but no cause has been found, making this a very mysterious syndrome.
- St. Paul Medical Center in Minnesota recently completed its Final Report with the SUNDS Planning Project. They recommend that future researchers look into refugee stress, anxiety, tension, delayed grief, and culture shock as one of the potential contributing factors.
- One Hmong leader reports that many Hmong elders believe that these deaths are caused because man has lost their faith and no longer continue their traditional religious practices.

Vignettes/Case Studies:

- There was a husband and wife Shaman team in Minneapolis that originally came from Laos. Now that they are in America, they’re afraid that the sacred way of the Shaman could be lost.
- A 22-year old Hmong man, who’s been in the U.S. five years, works at Burger King to support his wife and two babies, while studying Chemistry at Chicago’s Northeastern University. His second son was born two months premature and he and his wife brought a Shaman to the
- Intensive Care Unit to see the baby. The mother and father were hurt that many of their recently converted Christian relatives refused to attend because

their Christian minister forbade them to eat the meat of sacrificed animals. The family is sad that their faith is being lost because they're converting to another religion.

- A Shaman for thirty years, a Laotian man went from respected leader in his farming village to an elementary student to learn the basics of literacy.
- A missionary speaks of how many Southeast Asians he works with and teaches about Christ as the true, living son of god and that Buddha is ancient history. The missionary tells them that if they sin and do bad things, they'll die and go to hell.

5. *"The Bilingual Medical Interview."* Boston City Hospital.

Length of video in minutes: 31:15

Prepared by The Faculty and Staff of the Primary Care Training Programs in Internal Medicine and Pediatrics at Boston City Hospital. The Boston University School of Medicine and Office of Interpreter Services, Department of Health and Hospitals, Boston, MA and The Boston Area Health Education Center. Written and directed by Eric J. Hardt, M.D. Video Post Production: CF Video/Watertown © 1987.

The intended audience for this video is health care providers.

Content and Structure:

- Primarily designed to improve the skills of the viewer in the bilingual medical interview.
- The video discusses the problem areas in cross-cultural communication:
 - i. Cross-cultural medicine - epidemiology, health belief systems, family, religious, class, ethnic group relations, social, economic, and political relatives
 - ii. Translation - medical jargon, idioms, nonverbal and unspoken messages, paraphrasing, editing, summation, complex/confusing/lengthy comments
 - iii. Triadic interviewing - control, interpersonal issues, team function (goals, roles and procedures)
 - They suggest role-playing in areas of your own ethnic interest.

Skills taught:

- Assess the patient's background and take it into consideration when providing care.
- Provides Arthur Kleinman's "Tool to Elicit Health Beliefs," which is made up of nine questions to ask that will help clarify patients' problems.

Vignettes/case studies richly illustrate many aspects of clinician/patient interpreter interaction and the do's and don'ts involved.

6. *“Building a Diverse Workforce for the Global Millennium.”*

Cost for Preview: Free

Rental: \$225 for the first program

Rent each additional program for \$100

Sale: \$395 for the first program, \$175 for each additional program

Purchase the entire 20-program series: \$3, 450

Length of video in minutes:

For questions, free previews or orders, call 800-423-6021 or visit their web site at www.enterprisemedia.com/diversity.html.

These videos focus on workforce diversity, but may be useful for health care managers. This is a 20-volume series that covers a huge variety of diversity issues. Each program also presents critical business concepts like building trust and respect, performance appraisals, team building and leadership. Each program comes with a detailed Facilitator’s Guide. You can also purchase enhanced print material, participants workbooks and more.

- Program 1: Do We Speak the Same Language? Should Language and Cultural Style Impact Performance Evaluations?
- Program 2: Double Standards in Performance Appraisals
Balancing Work, Family and global Travel
- Program 3: Why Can’t We Attract and Keep People of Color?
Recruiting and Retaining People of Color
- Program 4: Will My Mentor Make A Difference? Mentoring People of Color for Successful Careers
- Program 5: Is It the Cement Ceiling or Is It Me? Career Issues for Non-Management People of Color
- Program 6: What About Me? Diversity’s Impact on The Careers of Non-Management White Males
- Program 7: I Deserved It Didn’t I? Diversity’s Impact on The Careers of White Male Managers
- Program 8: Disbanding The “Good Old Boy Network” The Inclusive Vs. Non Inclusive Organization – BEST SELLER
- Program 9: Old School vs. New School: How Much Change Is Too Much, Too Fast?
- Program 10: But We’ve Always Done It That Way! How Much Change Is Too Much, Too Fast? (Management Setting)
- Program 11: The Fatal Interview: Recruiting People of Color
- Program 12: The Balancing Act Gender Issues and Career Development...Work Versus Family
- Program 13: Worlds Apart: Building Effective Teams Globally
- Program 14: Making A Good Impression: Cross-Cultural Conflicts in Global Interviews and Recruitment
- Program 15: It’s All in the Presentation: A Double Standard for Women?
- Program 16: You Don’t Fit My Style: Cross-Cultural Challenges in Performance Evaluations

- Program 17: You're Making Me Uncomfortable: Gender Conflicts in Cross-Cultural Global Communications
- Program 18: Sexual Harassment? Are You Serious? Gender Issues in the Plant and in the Office
- Program 19: The Skip-Level Meeting: When You Want to Talk to the Manager's Manager
- Program 20: Building Teams in the Global Marketplace: Overcoming Cultural Conflicts in the European Community

7. *"Communicating Effectively Through An Interpreter: Barriers to Communication."*
CCHCP – The Cross Cultural Health Care Program.

Length of video in minutes: 28:14

Contact: PacMed Clinics, 1200 12th Avenue S, Seattle, WA 98144.

Call 206-621-4161 or (206) 326-4161 or visit their web site at www.xculture.org.

This is an instructional video. The intended audience for this video is health care providers.

Content and Structure:

- Unscreened, untrained and unqualified interpreters make many mistakes, which can lead to longer appointments, more diagnostic tests, multiple visits, inappropriate treatments, and, in some cases, the office for civil rights has sighted some health care institutions for not providing appropriate language services.
- Interpreters transmit the word they hear in one language into another language
- Translators transmit a written message from one language into another
- Using an interpreter may take practice, but health care providers can still offer the same amount of sensitivity and efficiency they give their English-speaking patients.

Vignettes/Case Studies:

- A few health care providers discuss the difference between well-trained interpreters and untrained interpreters.
- A physician and a Spanish-speaking patient tried to communicate through an untrained interpreter, namely, a receptionist.
- A professionally trained interpreter interprets for a physician and a Cambodian patient. The interpreter had a pre-session with both the doctor and patient, introducing him and the two to one another. The pre-session provided some ground rules for effective communication and also established a professional relationship between doctor and patient.
- The health care provider in the first interview tried to improve the communication between herself and the patient, through the interpreter. The physician began with a pre-session, wherein she introduced herself to the patient, then the interpreter. This way, her expectations of the interpreter were clear because she knew the interpreter was a bilingual receptionist.

8. “*Community Voices Exploring Cross-Cultural Care through Cancer*” By Jennie Greene, MS and Kim Newell, MD, for the Harvard Center for Cancer Prevention, Produced at the Harvard School for Public Health

Cost: \$245.00

Length of video in minutes: 69:0

Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131.

Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.

E-mail: fanlight@fanlight.com. Web site: <http://www.fanlight.com>.

“Hear the voices and perspectives of nurses, doctors, outreach workers, medical interpreters, and patients - people from a range of backgrounds, who make up today’s health care system. This innovative video offers a window into the challenges and rewards of cross-cultural health care and explores the many ways that differences in culture, race and ethnicity affect health and the delivery of health care services. With an extensive Facilitator’s Guide, it helps to integrate cultural awareness and skill building into training programs for all health professionals.” –Fanlight Productions.

9. “*Cultural Assessment.*” American Journal of Nursing Company.

Length of video in minutes: 28:37

Cultural Assessment CNE #7633; Hospital Satellite Network, 1986.

The intended audience for this video is nursing professionals.

Content and Structure:

- Describes how unique the U.S. is because of all the different people and cultures; provides statistics on different diseases that affect various cultures and ethnicities.
- They identify seven variables of health in different cultures: ethnic/racial identity, value orientation, language communication process, family system, healing beliefs and practices, religious beliefs and practices, and nutritional behavior and cultural influences.
- It defines cross-cultural communication and gives examples of what certain things mean to different cultures.
- A demonstration of an effective nursing assessment follow-up is given.

Skills taught:

- Assess the patient’s background and take it into consideration when providing care.
- Ignoring cultural beliefs/values or showing a lack of respect for them can prove detrimental to effective patient care.
- Respecting beliefs enhances recovery
- Accommodate patient and incorporate their cultural values and beliefs into their nursing plan of care.

- Treat patients equally, but take their differences into consideration for optimum care

10. *“Culture and Religion: Impact on Health Care.”*

Length of video in minutes: 37:0

The Director/Producer of the video is Brad Taylor, R.N.; The Associate Producer is Garin Granata. This is a video by Wasatch Media.

The intended audience for this video is health care providers.

Content and Structure:

Our cultural beliefs and practices come from a tradition of long ago; they tell us how we should perceive things, especially our health and illness. The following are short excerpts wherein medical staff gives case studies and their experiences with different patients:

- During childbirth in ancient times, the men were outside while the woman was delivering, whereas now, they are inside and take an active role.
- Some cultures believe that shortly after someone dies, their spirit is still present. This is why a family member must see the body and say something to the person who just died before the body is taken away.
- Native Americans usually don't like seeing doctors because they don't know what's going to happen and they don't like to undress in front of doctors.
- The poor and African-Americans sometimes don't think of going to the doctor; instead, they rely on prayer and home remedies.
- Polynesians have a high tolerance for pain, so they don't usually request pain medication. In these cases, the medical staff should offer it to them.
- A nurse offered ice to a Mexican woman after her epidural, but she refused, wanting hot tea instead.
- A Social Worker recalls a Native American man who died and his family was wailing in the emergency waiting room. A new ER nurse called for a Social Worker and tried to sedate them and gain control of the situation, but couldn't. The Social Worker realized he needed to let them grieve in their own way. He got them into a room where they could grieve the way they needed to.
- An Ethnic Health Program Specialist says Asians and many refugee groups tend to somatise their mental illness by saying they have a headache or are in physical pain instead of saying they're depressed, unhappy, etc. Many Asian groups also believe it's improper or disrespectful to touch someone on the head.
- A Clinical Dietician doesn't discourage African-Americans from using fatty meats or salt because she knows it's impossible for them to do so. Instead, she encourages them to cut back a little by using a smaller piece of meat and only using half a teaspoon of salt per person, per day. This can be done by taking an empty saltshaker and, for two people in the house, putting one teaspoon of salt in the shaker and using that the whole day.

- A Staff Development Specialist contacts Orthodox churches for help with translation for Far Easterners, like Laotian, Thai, Vietnamese, Cambodians, Serbs, and Croatians.
- A Physical Therapist tells us that many Polynesians, especially Samoans and Tongans, tend to speak in their own language when talking to their families. This is not to offend anyone; they're just more comfortable speaking their own dialect and they understand each other better.
- A nurse found out that her Polish female patient, who was a housewife, didn't understand or speak any English. This patient was very quiet, to herself, and becoming depressed. She made an effort to ask her neighbor to teach her some Polish greetings, like "hello," "good morning" and "how are you?" Her efforts turned the patient around and it brightened up the remainder of her stay at the hospital.
- A nurse recalls a 70-year old Mexican woman who had hip replacement surgery. Initially, her son was with her, but had to leave for business. She was the only Spanish-speaking nurse in her department and when caring for her, the woman pointed to her I.V. and blood hanging by her bed and asked, in Spanish, why people keep taking her life's liquids away. The nurse explained that they are giving her blood and fluids because she lost some in surgery and that they're not taking it away from her.

There are so many different beliefs, but we must remember that religion and culture go hand in hand. Many religious beliefs intersect with health care delivery. The following religious discuss each of their beliefs and practices concerning health care and birth, diet, clergy, healing, death, and special conditions: Jewish, Islamic, Catholic, Seventh Day Adventist, Mormon, Jehovah's Witness, Baptist, and Buddhist.

Skills taught:

- You must learn to open your mind to culture and religion and its impact on health care.
- You should be aware that different hand gestures and different ways of pointing might inadvertently offend your patient.
- Individualize each patient; become aware of who they are and what's important to them.
- You might try to incorporate cultural and religious questions into your assessment.
- Don't make any assumptions. Instead, ask how you can best care for each patient.

Vignettes/Case Studies:

- 1857, Utah Territory – Several Native Americans heal a wounded man. They spread a powder substance on the wound and pray over the injured man all night. In the morning, the medicine man leaves and the wounded man is now healed.

- 1889, Tennessee – A man works in the fields while his wife is in labor inside the house. There is a woman inside helping the wife deliver. She’s getting wet towels to wipe the pregnant woman’s face and massaging her back. The man is waiting outside with his son when they hear the newborn baby cry.

11. *“Cultural Diversity of 4 Cultures – Understanding Cultural Diversity: The Perspectives of Minority Professionals.”*

Length of video in minutes: 7:30

Contact: Thomas Hixon, Director of the National Center for Neurogenic Communication Disorders, University of Arizona.

The intended audience for this video is sojourners.

It discusses features that successful sojourners possess as well as characteristics that people who are unsuccessful sojourners possess.

Skills taught:

- It’s important to know the language of the culture and its subtleties.
- Syntactic and pragmatic rules of language influence how certain meanings are expressed.
- Stereotypes about appearance of individuals from other cultures are common and often inappropriate.
- Social forces operate on language and cause us to shift how we talk in different situations.
- Shifting between two languages by bilingual speakers is called “code switching.”
- Many African-Americans are very verbal and upfront about what they’re thinking.
- No dialect of a language is better than another.
- Too often, assumptions are made about what a person’s status and role is from their skin color.
- To understand the Japanese-American culture, it’s essential to know that the culture is collectivist.
- It’s important to have information about the roles of people within the Japanese-American culture. Japanese-Americans are stereotyped as being secretive, less emotional, and overly driven.

12. *“The Culture of Emotions. A Cultural Competence and Diversity Training Program.”*

Scientific advisors: Francis C. Lu, M.D. and Juan E. Mezzich, M.D., Ph.D.;
Producer: Harriet Koskoff 415-864-0927.

Length of video in minutes: 66:0

The Culture of Emotions is a video program with companion study guide designed to teach cultural competency and diversity skills to professionals in the behavioral health and primary health care sectors. This striking, well-produced and conceptualized video features didactic interviews and skill building exercises. The interviewees are eloquent and distinguished researchers and clinicians from ethnically diverse populations. They introduce the Outline for Cultural Formulation, the most advanced, comprehensive and inclusive diagnostic system ever developed for assessment and treatment of psychiatric distress across cultural boundaries and diagnostic categories. The companion study guide can be duplicated at will. It is based on "Issues in the Assessment and Diagnosis of Culturally Diverse Individuals," by Dr. Francis C. Lu, Russel Lim and Juan Mezzich in *Review of Psychiatry*, Vol. 14, 1995.

13. "Despair" Produced by Harriet Koskoff in association with PBS affiliate Connecticut Public Television. To order, contact: (415) 864-0927.

Length of video in minutes: 57:0

"Despair" is the first documentary about depression to consider the pervasive mood disorder from multicultural viewpoints. In personal portraits and interviews with experts from diverse racial and ethnic backgrounds, the documentary explores depressive illness from traditional and nontraditional perspectives.

14. "Doctoring II." Farsi Interpreter Tape.

UCR/UCLA Biomedical Sciences © 1995 UCLA School of Medicine.

This video is intended for health care providers and interpreters.

Vignettes/Case Studies:

The Cousins. A patient comes into a clinic and is seen by a male physician. Since the patient speaks only Farsi, she brought her cousin to interpret. The cousin is an interference and a distraction many times because she insists the doctor hurry with the exam, she speculates what her cousin's answers will be, and she ignores the doctor's questions to the patient and the patient's comments to the doctor.

15. "Female Circumcision/Female Genital Mutilation: Clinical Management of Circumcised Women." The American College of Obstetricians and Gynecologists, 1999. You can order this video from the ACOG Bookstore at: http://sales.acog.com/acb23/showdetl.cfm?&DID=6&Product_ID=540&CATID=17.

Cost of video: \$125 (\$95 for ACOG members)

Length of video in minutes: 60:0

This video is intended for undergraduate medical education and ob-gyn residency programs students.

As physicians increasingly encounter patients from diverse backgrounds, they

are likely to come upon women who have undergone some form of female circumcision/female genital mutilation (FC/FGM). To help obstetrician-gynecologists and other health care providers deliver optimum care to affected women, the ACOGT Task Force on Female Circumcision/Female Genital Mutilation has developed a slide-lecture kit. This educational module is intended for us as a formal 60-minute presentation in undergraduate medical education and ob-gyn residency programs. It includes 56 slides, of which nearly 50% are photographic or illustrative images, accompanying speaker's notes, learning objectives, and a resource listing. Learning more about FC/FGM and its concomitant consequences can help physicians play a vital role in preventing this harmful and unnecessary practice.

16. "Grief in America" By Bert Atkinson, with narration by Anthony Edwards

Cost: \$245.00

Length of video in minutes: 55:0

Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131.

Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.

E-mail: fanlight@fanlight.com. Web site: <http://www.fanlight.com>.

"A comprehensive, multi-ethnic perspective at the ways Americans deal with grief and loss in all their forms." –Fanlight Productions.

17. Kaiser Permanente CARE Actors award-winning (Finalist Award, New York Festival) cultural issues videos. Contact: Gus Gaona (323-259-4776) at Kaiser Permanente MultiMedia Communication, 825 Colorado Boulevard, Suite 301, Los Angeles, California 90041.

The brief but dramatic vignettes are accompanied by support materials for facilitators and participants. These materials can be sent electronically and are included in the nominal price of \$15.00. The vignettes, scripted with the help of physicians, nurses and medical anthropologists, raise numerous issues around differing health beliefs and practices, values in conflict, stereotyping, overt and covert prejudices and language barriers as they occur in health care settings. The format of the tape allows for pauses for facilitated discussion of each vignette, and the support materials provide questions and discussion point for each vignette. This format lends itself equally well to a series of short modules (30 minutes) or incorporation into a longer workshop.

Length of video in minutes: 70:0

Series A: Cultural Issues in the Clinical Setting contains 10 vignettes

- Diabetic Compliance: Latino. Deals with how not to and how to handle an encounter interpreted by an inexperienced interpreter. Include numerous family issues.
- Sickle-Cell Case in the E.R.: An African American adolescent is in crisis and needs pain medication; the E.R. staff is not so sure.

- Pediatric Asthma: A Middle-Eastern doctor and an aggressive mother tangle over the care of a young girl and values clash made more problematic by diverse communication styles.
- A Somatic Complaint: Long buried painful memories manifest in diffuse symptoms that are not well understood by this physician.
- A Gay Adolescent: An adolescent football player comes out to his family doctor. The doctor deals with the situation both knowledgeably and sensitively.

Series B: Birthing Issues (on the same tape)

Goes through a day in the life of a young OB/Gyn physician coping with a diverse group of patients. Good advice from another, more experienced physician is at first spurned then sought as the doctor is confronted by many special needs and circumstances.

- Lesbian Parents: The physician is caught off-guard when she learns that the two women before her are both the prospective parents and have some special concerns.
- The Hmong Way: The physician is upset when a young woman's mother wishes to incorporate unusual birthing practices in the care of her pregnant daughter.
- A Middle Eastern Dilemma: A conversation between the more experienced physician and one of her Middle Eastern patients reveals conflicts and familial concerns around acculturation in an immigrant family.
- A Big Baby is Coming: A non-English speaking woman from Mexico is delivering a very large baby with macrosomia. She is diabetic and has lost several babies at birth. Her husband is very uncomfortable in the labor room. A nurse reveals her tendency to stereotype through prejudicial remarks.
- A Circumcised Somali Mother in Labor: A by now tired and concerned physician discovers that the woman presenting for childbirth, having had no prenatal care, must have her vaginal opening enlarged in the presence of thick scar tissue or have a C section.

18. *"Lost in the Interpretation."*

Length of video in minutes: 14:40

This is a co-production of Kaiser Permanente's Member Language Services and the Advisory Team; sponsored by Northern California Diversity Steering Committee and Regional Medical Group Administration, 1997.

This video is intended for health care professionals.

Content and Structure:

- California's work force is changing; therefore, KP members are changing.
- KP needs to provide quality health care and access to all members

- KP has developed brochures in different languages, has a language line, and has increased the number of qualified, bilingual employees

Skills taught:

- The ability to care for members in a language other than English increases efficiency; it shows patients KP is trying to accommodate them and make them feel comfortable
- The wrong interpretation can lead to bad patient care

Vignettes/Case Studies:

- An English-speaking woman cannot find her way around a medical center and all the staff she asks for help from speaks only non-English languages.
- An English-speaking female with a fever cannot communicate with a Cantonese physician.
- An English-speaking female picks up her prescription, but needs to know how to take her medicine according to the doctor's orders. A Spanish-speaking pharmacist can't help and neither does the Cantonese man from the computer department who speaks very little English.
- A doctor can't even see an English speaking man because the Spanish-speaking receptionist couldn't communicate with him effectively.

19. *"Mental Health Interpreting: a Mentored Curriculum."* Pollard, Robert. Accompanied with workbook.

Length of video in minutes: 32:02

University of Rochester, School of Medical and Dentistry. Produced in association with the Monroe County Office of Mental Health and the Department of Psychiatry at the University of Rochester Medical Center © 1997-2000 University of Rochester.

Contact: Robert Pollard, Ph.D. 716-275-3544 or Robert_Pollard@urmc.rochester.edu.

The intended audience for this video is mental health professionals and mental health interpreters.

Content and Structure:

- This video and its accompanying curricular guide was developed as an aide to foreign language interpreters
- The video was meant to be used in a one-to-one learning relationship with an experienced mental health interpreting mentor.

Vignettes/Case Studies portrayed:

- Introduction: the interpreter and clinician meet for the first time. It's important to have a pre-session so that the interpreter knows what to expect and the clinician learns about how professional interpreters do their work.
- Cultural Bonds: sometimes, immigrants feel a bond with the interpreter since they share the same language. They tell the interpreter something privately that they don't want translated, but this interferes with the interpreter's role and challenges their boundaries.

- Cultural Attitudes Toward Mental Illness-Part 1: a Vietnamese mother speaks with a doctor about her daughter's suicide attempt. The doctor tries to explain that her daughter is serious about killing herself, but the mother does not believe that her daughter wants to kill herself and thinks that if she stays at the mental health hospital she'll only become more ill.
- Cultural Attitudes Toward Mental Illness-Part 2: in the post-session with the doctor and interpreter, the interpreter explains the cultural differences. She tells him that Vietnamese people are very private and like to keep issues like mental illness in the family. They usually only share this problem with a priest, Buddhist monk, or other relative.
- I Can't Do Your Job For You: sometimes mental health clinicians feel uneasy working with mental health patients who speak a different language and so they ask interpreters to do something that may not be within their realm.
- It's A Small Community: the interpreter is meeting with her supervisor and tells her that the patient she interpreted for was lying to and withholding information from the clinician. She knows the patient and has interpreted for him in the past and felt like pulling the clinician aside and telling him the truth about this patient. The supervisor expresses the importance of confidentiality in the job and stresses the possible repercussions of divulging any information.
- Gender, Age, and Culture: in this pre-session, the female clinician and female interpreter get acquainted and discuss the family who is waiting to come in. The clinician tells the interpreter that there is a teenage girl, her mother, and her grandfather waiting to see them. The interpreter says they may have a problem with cooperation from the grandfather because she, herself, is a young interpreter and the doctor is a young female.
- Linguistic and Cultural Barriers to Translation: a mental status exam is in progress and the interpreter identifies language and cultural factors that the clinician needs to understand. The interpreter provides helpful guidance, allowing the clinician to do his job more effectively.
- Language and Psychosis-Part 1: language can be affected by a patient's mental status, due to the illness affecting certain brain functions.
- Language and Psychosis-Part 2: the clinician can't do his job with absolutely no help from the interpreter. This vignette shows the interpreter trying a more flexible approach.
- Embarrassing Moments-Part 1: mental health work involves a lot of emotions and the patients sometimes act in unexpected ways.
- Embarrassing Moments-Part 2: if the interpreter is not comfortable being very forthcoming, there's an alternative.

20. *“Nuestra Salud: Lesbianas Latinas Rompiendo Barreras”* A video series on *Lesbian Latina Health*. Produced by Teresa Cuadra, MD & Suzanne Newman

Cost: \$99.00 each or \$299.00 for 4-part series

Length of video in minutes: 4-part series, 15 minutes each

In Spanish, with English subtitles

Fanlight Productions: 4196 Washington St., Suite 2, Boston, MA 02131.

Tel: 800-937-4113 or 617-469-4999. Fax: 617-469-3379.

E-mail: fanlight@fanlight.com. Web site: <http://www.fanlight.com>.

“Nuestra Salud is a compassionate, peer-based, Spanish-language video series aimed at promoting preventive care and wellness for Latina Lesbians. Each video is made up of vignettes, stories, and anecdotes told and shared by women who have faced challenges within the health care system and gained knowledge through their struggle. Professionals in the field add their insights and put these issues in a broader context.” –Fanlight Productions.

21. *“Peace Has Not Been Made.”*

Length of video in minutes: 25:20

The video was produced by Doua Vang and John Finck; directed and edited by Peter O’Neill; still photos by Ellen Kuras.

The intended audience for this video is health care professionals.

This is a case history of a Hmong family’s encounter with a hospital from their father’s perspective and the hospital’s perspective. It shows, in detail, the hospital’s records and then provides details through the father’s perspective.

22. *“The Psychological Residuals of Slavery.”*

Length of video in minutes: 15:48

This is a video by Kenneth V. Hardy, Ph.D.

The intended audience for this video is therapists and human services specialists.

Content and Structure:

- African-Americans are a very diverse group and they share the following attributes:
 - i. All belong to a group that’s been devalued in society
 - ii. All have at one time or another been targeted with racial or prejudice discrimination
 - iii. All, regardless of class, religion, or geographic location, have the legacy of slavery
- What does slavery have to do with African-American people today? The official end of slavery was only 130 years ago; that’s only three generations ago. However, it African-American people were subjugated for 300 years.

- People still struggle from the emotional and psychological trauma of slavery. The descendants of those enslaved remain enslaved emotionally and psychologically.
- It's essential for therapists and human services specialists to understand the history of slavery when working with African-Americans.
- Silence is a precursor of rage. Since they feel they have no voice, many African Americans struggle with the management and expression of rage.
- Rage can turn into violence. Some people express rage through sports, social events, music, and activism, but others use violence.
- Many physical and psychological conditions are directly tied to rage, like high blood pressure, heart disease, mental stress, alcoholism, hopelessness, performance anxiety, anger, psychological homelessness, and abbreviated life expectancy.
- The legacy of slavery continues to shape the experience of African-Americans and the relationship they have with white people. Therapist and human service specialists must examine and validate this aspect of their collective past.

23. *"Quality Care for Diverse Populations."* The American Academy of Family Physicians.

The program is available in two formats to suit group training and self-learning needs. Both formats can be ordered either online (www.aafp.org/catalog/) or via telephone (1-800-944-0000). The item number is Cs 723 and the title is Cultural Competency Videotape.

The group-training program includes the video vignettes on VHS videotape included in a binder containing the written materials separated into facilitator and user guides. The group training program package is priced at \$150. The self-learning program is packaged on a single, all-inclusive CD-ROM and is priced at \$100.

Quality Care for Diverse Populations is a new training program developed by the American Academy of Family Physicians to assist physicians and other health care professionals in becoming more culturally proficient in the provision of care to their patients. The program, which was partially funded by the Bureau of Primary Health Care, Health Resources and Services Administration, includes five video vignettes depicting simulated physician-patient visits in an office setting as a means to explore ethnic and sociocultural issues found in today's diverse health care environment. Written collateral materials, including learning objectives, tools/tips, discussion questions and cultural determinants for each vignette complement the video elements.

24. 1991 “*Racial and Cultural Bias in Medicine.*”

Length of video in minutes: 30:00

Contact: American Academy of Family Physicians at 8880 Ward Parkway, Kansas, MO 64114.

This video program is designed for medical students, resident physicians, and practicing physicians, consisting of 30+ dramatized situations on a variety of issues, each of which is relevant to racial or cultural bias. Emphasis is on prejudice and stereotyping rather than clinical cultural competence.

25. “*Refugee Mental Health: Interpreting in Mental Health Settings.*” Benhamida, Laurel; Downing, Bruce; Egli, Eric; Yao, Ahu.

Length of video in minutes: 33:34

One in a series of videotapes produced by the University of Minnesota’s Refugee Assistant Program – Mental Health Technical Assistant Center; funding provided through a contract (Contract No. 278-85-0024 CH) with the National Institute of Mental Health in conjunction with The Office of Refugee Resettlement; distributed by Great Tapes of Minneapolis, MN. Written materials accompany.

This video is an introduction to interpretation in refugee mental health. The intended audience for this video is interpreters for refugee mental health professionals.

Content and Structure:

- Language and communication are key and the main task of the interpreter
- Work, role, tasks, and modes of the interpreter are discussed
- Sometimes elaborating is necessary to the well being of the patient, but interpreter needs to make both parties aware when he/she is stepping out of the interpreter role to elaborate so as to avoid a breakdown in interpretation.

Skills taught:

- Effective interpretation requires highly developed skills, careful preparation, intense concentration, split-second decision-making, an understanding of both cultures, continuous education, etc.

26. “*The Shaman’s Apprentice.*” Bullfrog Films: Box 149, Oley PA 19547. Tel. 610-779-8226. Fax (610) 370-1978. For further information, contact them via e-mail at video@bullfrogfilms.com or visit their web site at www.bullfrogfilms.com.

Length of video in minutes: 54:0

VHS video Public Performance Purchase \$250, Rental \$85.

Directed by Miranda Smith and written by Abigail Wright.

The intended audience for this video is students in grades 10-12, college and adults. Renowned ethnobotanist Dr. Mark Plotkin first traveled to the Amazon twenty years ago seeking a cure for diabetes. There he found extraordinary biological riches and a mysterious world of shape-shifting shamans who healed with sophisticated plant medicines. Mark was to learn that these indigenous people have an astonishing ability to understand and manage their fragile rainforest environment – but they are disappearing faster than the forests themselves. Could he save their world from extinction? Beautifully filmed in the rainforests of Suriname, *The Shaman's Apprentice* is a luminous and powerful story of one man's quest to preserve both the rainforest and the ancient wisdom of our species.

“Dazzling visuals, cutting edge science and a compelling story make *The Shaman's Apprentice* a feast for the eyes, the heart, and the mind...one of the most stunning rainforest films ever made.” —Ken Cook, President, Environmental Working Group.

27. *“Spirit Doctors.”*

Length of video in minutes: 26:20

This is a film by Monica Delgado and Michael Van Wagener. The Associate Producer is Anthony N. Zavaleta, Ph.D.

The purpose of the video is to keep a record of folk healing as we move into the new millennium. The intended audience for this video is health care professionals.

Content and Structure:

- Those perceived as controlling the balance between health and sickness, life and death have been revered and feared throughout time.
- While many people believe the technological advances improve health care, others find Western medicine to be financially prohibitive and culturally alienating.
- Mexican-Americans tend to retain their traditional beliefs and values, especially when it comes to folk healing.
- A new belief emerged that combined Spanish Catholicism with Indian Shamanism and the cultural system flourishes even now.
- They use ancient healing techniques mingled with elements of Christianity and modern medicine to heal the sick.
- Midwives aiding in childbirth is a tradition in Mexican-Americans, but recently, the government has stepped in to control and regulate this practice.
- Midwives must now pass state exams to practice this birthing method. They're very well trained in first aid and CPR and they don't hesitate to call a medical professional at the first sign of a problem.
- Midwives are important in this area of economic hardship, as they provide an economic way to obtain prenatal care, deliver the baby, and have follow-up

visits. Many of them view their job as a spiritual calling; they believe only god can help them through each delivery, since he called them to do this for women.

- Folk healing represents a link to ancient heritage and spirit doctors are a part of ethnic identification and symbolize the cultural perseverance of Mexican-Americans.

Vignettes/Case Studies:

This video offers various vignettes/case studies showing many folk healers who cure the sick for no charge because they believe theirs is a gift from god. They use spiritual and herbal remedies, prayer, desert plants, and other forms of spirit healing techniques to heal those who are sick with disease, physically or mentally.

28. *“Through the Eyes of Others” Tape 1: General Sessions.* ROWAY Productions – 7317 Cahill Road #229, Edina, MN 55439 612-941-9337.

Length of video in minutes: 2:00:35

Jointly sponsored by Hennepin County Medical Society, United Way of Minneapolis Area, Hennepin County Medical Center Staff, and University of Minnesota.

This video is intended for health care professionals, particularly physicians and nurse practitioners.

Content and Structure:

- Their mission is to make an impact in the way they deliver health care and look at their attitudes and perceptions towards people from other cultures-both new immigrants as well as those traditionally underserved populations
- Take time to learn about the differences in cultures and to see health care through the eyes of others
- Patient outcomes are not as good if health care providers are not culturally competent.
- Defines culture, diversity, sensitivity, and competence.
- Cultural competence involves different levels, including doctors, nurses, administration, institution, patients, training, and research.
- Poor interpretation can lead to poor outcomes
- A lawyer discusses mistreatment, informed consent, battery, negligent nondisclosure, patient bill of rights, Human Rights Act, reporting of maltreatment of minors, consumer protection laws, and Title VI of Civil Rights of 1964.
- Defined the role of interpreter and compared it to that of translator.
- A skilled, qualified interpreter must be trained; being bilingual is just barely the minimum requirement of being an interpreter.

- Interpreters' Code of Ethics is guidelines for interpreters, but they're not the written word; sometimes interpreters need to make a judgment call within the code.
- A demonstration of appropriate interpreting is provided.

Skills taught:

- Be supportive and believe your patient if they tell you they're doing something traditional and it's working
- Trust in the physician-patient relationship is important. Small gestures to make the patient trust the doctor include: smiling, talking, looking at patients in the eye, and treating patients the way they'd like to be treated.
- Doctor should respect cultural, religious and traditional beliefs, remedies and cures.
- There is no absolute knowledge or reality; try to become culturally competent in your own arena, consider who the majority of your patients are and who you primarily serve.
- Formulate treatment plans that are culturally effective
- Be understanding, empathetic, patient, and respectful
- Provider should talk to and look at the patient; interpreter is merely the middleman in the background.
- Interpreter needs to know when communication is not working and must address the provider.

Vignettes/Case Studies:

- SUDS (Sudden Unexpected Death Syndrome) generally occur in young Hmong men who have been in the U.S. approximately one year. While asleep, the man will suddenly wake up, give a brief shout, and then die. A 22-year old Hmong man with SUDS was brought in with ventricular fibrillation. He had experienced SUDS and then was revived. He refused to be monitored by the doctor and died six months later. The doctor initially wanted to have an autopsy done, but decided against it after speaking with his family about his religious beliefs.
- A Hispanic woman came in and, during the interview with the clinician, told the interpreter that she likes to try different Western medicines from different doctors and that she also uses traditional medicines as well, but asked the interpreter not to tell the doctor this.
- A 35-year old obese, insulin-dependent woman, who was identified on her chart as a lesbian, went to the Emergency Department because she was feeling ill.

29. *“Training for Cultural Competence in the HIV Epidemic.”*

Length of video in minutes: 45:45

Presented by: Hawaii Area AIDS Education and Training Center, University of Hawaii, John A. Burns School of Medicine. Funded in part by grant No. 5-T01 MH19263-02 with the National Institute of Mental Health.

The teaching tape is intended only as a supplement to professional training to generate discussion about issues related to HIV and culture. The intended audience for this video is health care professionals.

Vignettes/Case Studies:

These case studies portray two very different ways in which patients are treated by physicians and staff. The first vignettes show dissatisfied patients, while the following vignettes show patients who are pleased with the service and treatment they received.

Culture and Communication

- What’s wrong with you people anyway? Ms. Santiago went in to the clinic for a pregnancy test. Doctor Kennedy remembered that she was in last time for treatment for a venereal disease, at which time she mentioned that her boyfriend was HIV positive.
- Not that GOMER again! A male patient, John, went to the clinic for a shot because he thought he had the clap. The doctor began interviewing him and asked him what his symptoms were, when they started, and how why he thought he had the clap. He told her he had it before and he knew the symptoms well. Then, when she asked him if he had sexual relations after experiencing the symptoms, he became annoyed.
- She needs to eat. A woman complained to a health care provider that her sister no longer wanted to eat. She explained that she had been trying to feed her, but she refused to eat. The health care provider clarified that she doesn’t need to eat food because she was given medicine and food intravenously. She further explained that the doctor told her that her sister would not be hungry and that she should stop feeding her.

Culturally Effective Intervention

- What’s important to you? Dr. Kennedy met with Ken, a male patient, and told him that his condition was very good at the moment. She then continued to tell him that she wanted to get to know him better as a patient and wanted to know what was important to him as far as his health was concerned. He mentioned that it was difficult being around his family because he hadn’t told them of his HIV status yet. He also told her that his lover had been pushing him to tell them, but he was still hesitant.

Culture and Professionals/Systems

- Why can’t they be team players? There was a planning committee meeting made up of two state workers and two local Hawaiian representatives of the community. The state presented a contract, offering \$30,000 for

HIV education for minority populations. The two state workers said they planned to use the radio and newspapers to promote the outreach program and that they would be using the statistics they gathered for research purposes. The Hawaiian woman mentioned that typical grants didn't take into consideration culture, lifestyle, geographic areas, or the specific needs of different cultures. She explained further that if they were going to address this population, they would need to look at those areas to make it work best. The Hawaiian man became upset because he felt that \$30,000 was just a drop in the bucket and a waste of their time.

- This feels like reverse racism. Five physicians, two Asians and three Caucasians, met to discuss new ideas for their clinic. An Asian woman suggested they reach out to more Asian women to discuss, educate, and help prevent the spread of HIV through sexual contact. The Caucasians all disagreed, saying that their patients were comfortable with them and that they already knew everything they needed to know through pamphlets and video provided by the clinic.
- Why do we always have to change? Three clinic staff members discussed their opinions about the new clinic hours.

30. *“What Language Does Your Patient Hurt In?”* A Three-Tape Video Training Course for Nurses of Patients from Other Cultures. Suzanne Salimbene, Ph.D.; Inter-Face International. Workbook provided. To contact Dr. Salimbene, e-mail her at: IF14you@aol.com or call 818-282-2433.

Length of video in minutes: 1:42:22

This video describes how to best serve the increasing number of diverse patients coming into the health care system. The intended audience for this video is nurses.

Content and Structure:

- Part 1: Immigration, Culture, and The Patient/Caregiver Relationship
 - i. PowerPoint Presentation and lecture given by Dr. Suzanne Salimbene.
 - ii. She shows the present (2000) ethnic demographics in comparison to projected demographics of 2050, describing how it will impact the patients' nurses see and the care they give.
 - iii. Asians are the largest, fastest increasing group to migrate to the U.S.
 - iv. She shows where immigrants are settling; many are now in the Midwest.
 - v. 1 of every 10 patients will come from another culture or language.
 - vi. Iceberg Theory: we've been focusing too much on what's on the surface (food, language, and appearance), but what impacts health care even more are the communication style, beliefs, attitudes, values and perception of people.

- vii. Culture cements a group of people together and distinguishes and separates members of one culture from another.
- viii. Culture acts as a Gatekeeper. It determines how patients expect to be treated, it tells people when it's appropriate to seek care, and it sometimes dictates that females can only see female physicians.
- ix. Culture determines the definition a patient gives to health and illness.
- Part 2: Culture's Impact Upon Surgery, Childbirth, and Death and Dying
 - i. Many Asian cultures don't have a tradition of surgery, transplants, animal transplants, or organ donation.
 - ii. Many cultures have taboos about organ removal, organ donation, and autopsies because they believe you need to return the body whole.
 - iii. Many Asians believe that once blood is lost, it is never replenished, therefore, don't like blood transfusions or blood withdrawal.
 - iv. Life support or turning off life support can be thought of as interfering with the will of God to many Middle-Easterners.
 - v. Even consent forms, to Middle-Easterners, are an insult because they believe their word is stronger than some signed document. While Navajo people believe signing a form explaining what may possibly go wrong, means that these things will go wrong.
 - vi. Childbirth is also determined by culture. Some believe men shouldn't be involved in labor and delivery. In Russian, the average length of stay in the hospital after giving birth is 2 weeks.
 - vii. In most cultures, the patient is rarely told that he's dying. It's usually the oldest male relative that's told and he makes the decision on how much the patient's told.
 - viii. In Middle-Eastern cultures, no grieving is allowed while the patient's still alive because it's considered 'tempting Allah's will' to grieve before death.

Skills taught:

- Dr. Salimbene defines *Culture* as the shared worldviews, values, beliefs, traditions, and patterns of communication of a group of people.
- You need to work with the patient within their culture
- Hispanic cultures generally like to be touched (hold hands, comfort them), while you should never touch an Asian's head without permission.
- AMA defines *Cultural Competence* as a set of knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals of cultures other than their own.
- Part 3: Becoming a Culturally and Linguistically Competent Caregiver
 - i. Understand and accept different cultures

- ii. You need a cultural self-awareness (know your biases and beliefs)
- iii. Develop and understanding and basic knowledge of your patient demographics in your service area
- iv. Have the ability to adopt your nursing skills so they're appropriate to the patient's beliefs and values
- v. Learn to be a keen observer of different communication styles
- vi. Don't treat the patient, as you'd like to be treated! Find out how they'd like to be treated
- vii. Always begin by using the patient's family name; better to be more formal than too casual
- viii. Don't be 'put off' if the patient doesn't look you in the eye; it may be considered disrespectful for them to look such an authority figure in the eye
- ix. Don't make any assumptions; ask questions and try to get open, honest answers.
- x. Find out if the patient uses any other means besides Western medicine
- xi. Don't discount the patient's beliefs/values
- xii. Find out who the decision-maker is in the family
- xiii. Be restrained in relaying bad news
- With limited English proficiency patients, speak slowly, not loudly!
 - i. Face the patient and read their facial expressions and body language.
 - ii. Avoid difficult, uncommon, and unnecessary words or information be brief.
 - iii. Organize what you say, rephrase and summarize often.
 - iv. Don't ask yes or no questions.
 - v. Don't burden the patient with decisions that he/she is not prepared to make.

31. *"Where's Shirley?" A Video Production About Breast Cancer*

Available from the Women's Cancer Screening Project, 3 Cooper Plaza, Suite 220, Camden, New Jersey 08103; Tel. 609-968-7324, Fax 609-338-0628.

32. CD-ROM: Ohio Department of Health, Columbus, OH; Medical College of Ohio, Toledo, OH. Contact: Olga Alvarez-Ott, PROFED and QA Coordinator at Breast and Cervical Cancer Project, Ohio Department of Health, Columbus, OH.

Abstract:

This CME Program is intended for primary care physicians (including obstetrics and gynecology), nurses, and other health care providers involved in detection, diagnosis and treatment of breast cancer.

33. CD-ROM: 2000 Ohio Department of Health and Medical college of Ohio. *Cultural Competence in Breast Cancer Care*. Vertigo Productions LTD., 3634 Denise Drive, Toledo, OH 43614. Tel. 877-385-6211, Fax 419-385-7170.

1. Academic Medicine
 May 2001, Vol. 76 (5):
 This special issue contains the following articles on cultural competency in medicine:
 - a. Kamaka, Martina. *Cultural Immersion in a Cultural Competency Curriculum*. Pp. 512.
 - b. Brainin-Rodriguez, Jo Ellen. *A Course about Culture and Gender in the Clinical Setting for Third-year Students*. Pp. 512-13.
 - c. Godkin, Michael; Weinreb, Linda. *A Pathway on Serving Multicultural and Underserved Populations*. Pp. 513-14.
 - d. Altshuler, Lisa; Kachur, Elizabeth. *A Culture OSCE: Teaching Residents to Bridge Different Worlds*. Pp. 514.
 - e. Takayama, John; Chandran, Chitra; Bernard-Pearl, Deirdre. *A One-month Cultural Competency Rotation for Pediatrics Residents*. Pp. 514-15.
 - f. Goleman, M. Jane. *Teaching Pediatrics Residents to Communicate with Patients across Differences*. Pp. 515-16.
 - g. Esfandiari, Adeleh; Wilkerson, Luann; Gill, Gus. *An International Health/Tropical Medicine Elective*.

2. Cross Cultural Psychology
<http://www.fit.edu/CampusLife/clubs-org/iaccp/JCCP/jccp.html>
 Cross Cultural Psychology publishes papers that focus on the interrelationships between culture and psychological processes.

3. Cultural Diversity and Mental Health
 Cultural Diversity and Mental Health provides psychologists, social workers, psychiatrists, counselors, and other mental health professionals with the knowledge base and therapeutic tools to effectively assess and treat clients from diverse backgrounds. This periodical features lively topical articles, comprehensive reviews, clinically relevant research reports, and timely book reviews. In addition, the journal includes case reports reflecting the ethnocultural and social factors clinicians should be aware of when treating specific groups of clients.

4. Ethnicity & Disease
http://www.ishib.org/main/ed_main.htm
 Ethnicity & Disease is an international, interdisciplinary journal devoted to the study of population differences in disease patterns. They focus on work examining the interaction of biologic, social and economic factors as they affect disease rates. Back issues can be ordered and a table of contents is also available online.

5. Folk Medicine at UCLA
<http://www2.humnet.ucla.edu/humnet/folkmed/default.html>

Started in the 1940s, the UCLA Archive of Folk Medicine consists of information from the writings of medical practitioners dating to the late 18th century. Wayland D. Hand, students, and colleagues also obtained data from scientific journals, popular magazines, newspapers, and historical sources over the past 200 years. While most of the information concerns ethnic and regional groups in the U.S., there is also data from Europe, Latin America and parts of Africa and Asia. The information is organized according to disease, injury or condition and different therapies are filed with each illness. The database consists of about 210,000 distinct cures.

6. Social Science & Medicine
<http://www.healthabstractsonline.com/healthab/show/>

Social Science & Medicine was established to aid the dissemination of important research and theoretical work in all areas of common interest to the socio-behavioral sciences and medicine, including psychiatry and epidemiology. This journal covers all those aspects of anthropology, economics, education, geography, psychology, social work and sociology which directly relate to any of the problems of mental and physical health, and all those aspects of medicine, including epidemiology, medical education and practice, psychiatry, public health and nursing, which directly relate to any of the social sciences. The online journal allows access to their table of contents, author index, and provides online abstracts as well.

7. Society for Medical Anthropology
http://www.cudenver.edu//sma/medical_anthropology_quarterly.htm

Medical Anthropology Quarterly: International Journal for the Analysis of Health publishes research and theory in the field of medical anthropology. This field is broadly taken to include all inquiries into health, disease, illness, and sickness in human individuals and populations that are undertaken from the holistic and cross-cultural perspective distinctive of anthropology as a discipline—that is, with an awareness of species' biological, cultural, linguistic, and historical uniformity and variation. It encompasses studies of ethnomedicine, epidemiology, maternal and child health, population, nutrition, human development in relation to health and disease, health-care providers and services, public health, health policy, and the language and speech of health and health care. The purpose of the journal is to stimulate debate on and development practice and the parent discipline of anthropology. This journal offers a table of contents and article abstracts online.

8. Transcultural and Multicultural Health Links
<http://www.iun.edu/~libemb/trannurs/transban219.htm>

9. Transcultural Nursing
<http://www.sagepub.co.uk/journals/details/j0292.html>

The Journal of Transcultural Nursing is a forum for cultural competence in health care. It serves as a peer-reviewed forum for nurses, health care professionals, and practitioners in other disciplines to discuss issues related to the advancement of knowledge in areas of culturally congruent health care delivery and to promote the dissemination of research findings concerning the relationship among culture, nursing and other disciplines and the delivery of health care. This journal is available electronically via ingenta to members of institutions with a print subscription and subscription information is also available online.

The July, 2002 (Vol. 13, No. 3) contains the Andrew & Boyle, Camphina-Bacote, Giger & Davidhizar, Purnell, Spector, and Leininger models of cultural competence curriculum for nurses.

10. Transcultural Psychiatry
<http://www.sagepub.co.uk/journals/details/j0183.html>

Transcultural Psychiatry provides a channel of communication for psychiatrists, other mental health professionals, and social scientists concerned with the social and cultural determinants of psychopathology and psychosocial treatments of mental and behavioral problems in individuals, families and human groups. This journal is available electronically via ingenta to members of institutions with a print subscription and subscription information is also available online.

11. Western Journal of Medicine
1983 *Cross-Cultural Medicine [Special Issue]*. [The Western Journal of Medicine](#), Dec; Vol. 139 (6).
1992 *Cross-Cultural Medicine, A Decade Later [Special Issue]*. [The Western Journal of Medicine](#), Sept; Vol. 157 (3).
<http://www.ewjm.com>

The Western Journal of Medicine is a peer-reviewed educational resource for primary care practitioners in the West. It strives to be a journal that sets the standard for synthesis of clinical research and fosters discussion and debate on issues related to health care and the diversity of cultures in the West. Themed issues consist of *Cross-Cultural Medicine: A Decade Later*, *Caring for Patients at the End of Life*, *Complementary and Alternative Medicine*, *Adolescent Medicine*, *Physician Well-Being*, and *Chronic Disease*. The journal carries a cross-cultural article each month. Title pages and articles can be downloaded from their web site. You can sign up and receive a table of contents via e-mail and abstracts and full text articles are available online.

Web Sites

Web sites are generally quite dynamic and, therefore, tend to change or update content, navigational tools, and structure on a regular basis. In addition, the web sites listed below offer varying degrees of information related to cultural competency—some are, of course, more comprehensive than others.

1. Accreditation Council for Graduate Medical Education
www.acgme.org

“The Accreditation Council for Graduate Medical Education is a private professional organization responsible for the accreditation of post-MD medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.”

The site includes general standards in which cultural competence is embedded.

2. Administration on Aging. *Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families.*

<http://www.aoa.dhhs.gov/minorityaccess/guidebook2001/default.htm>

This guidebook is designed for use by providers of services to racially and ethnically diverse older populations. There is growing interest in learning how effective, culturally appropriate services can be provided by professionals who have mastered culturally sensitive attitudes, skills, and behaviors. It is only an introduction and not intended to substitute for more rigorous and on-going study. For readers who have taken more formal courses to acquire cultural competence, this guidebook might serve as a review. The guidebook is divided into six chapters and five appendices. Each of the first three chapters takes a particular perspective or point of view critical to understanding cultural competence. For example, in Chapter Two they explore the meaning of cultural competence. Part A provides a definition of culture and discusses the intervening factors that determine the impact of culture. Part B provides a definition of cultural competence, Part C outlines the barriers to accessing services experienced by minority elders, and Part D gives an overview of research accomplished in this area.

3. American College of Emergency Physicians
www.acep.org/1,4890,0.html

The American College of Emergency Physicians (ACEP) exists to support quality emergency medical care and to promote the interests of emergency physicians.

This web site discusses Cultural Competence and Emergency Care and also recent policy statements. It contains valuable links to practice resources, government and advocacy, news and publications, meetings and CME, and health information.

4. The American College of Obstetricians and Gynecologists (ACOG) – Women’s Health Care Physicians
<http://www.acog.org>

a. *When An Infant Dies: Cross Cultural Expressions of Grieving and Loss.*
http://www.acog.org/from_home/departments/dept_notice.cfm?recno=10&bulletin=797.
The panel and this Bulletin were produced in partnership with the Association of the SIDS and Infant Mortality Programs (ASIP). For more information, contact: Kathleen at kbuckley@acog.org or Amy at ahereford@acog.org.

This bulletin summarizes a panel presentation at the National Fetal and Infant Mortality Review Program, Third National Conference, held July 16-18, 1998, in Washington, D.C. The bulletin reviews cultural traditions of Latino, African American, North America tribal and Muslim families grieving the loss of an infant. It identifies simple strategies health care providers can use to begin the process of providing culturally competent support to them. It also aims to encourage networking and sharing among providers who assist the bereaved.

b. *Female Circumcision/Female Genital Mutilation (FC/FGM) Fact Sheet.*
http://www.acog.org/from_home/departments/dept_notice.cfm?recno=18&bulletin=1081. For further information, contact: Lisa at lgoldstein@acog.org or Janet at jchapin@acog.org.

Female Circumcision/Female Genital Mutilation (FC/FGM) is culturally determined ritual that has been practiced on an estimated 130 million women and girls worldwide. Because of global immigration patterns, obstetrician-gynecologists in the United States and Canada will increasingly encounter women who have been circumcised.

5. American Medical Association – Cultural Competence Compendium: Contents
www.ama-assn.org/ama/pub/category/4848.html

The contents of the Cultural Competence Compendium include cultural competence articles in American medical news and related cultural competence links. There is a link to the table of contents for the Cultural Competence Compendium. You can also find links to physician professional organizations, resources emphasizing communication skills, and curriculum and training materials. Needs and resources for specific populations can be found, specifically for underserved and underrepresented racial, ethnic, and socioeconomic groups. You can find information on complementary and spiritual practices and their impact on effective care, relevant materials from nursing and other health professions, patient support materials, including self-help group resources, and representative cultural competence publications.

6. American Psychological Association: APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. Guidelines approved by the APA Council of Representatives in August 1990. www.apa.org/pi/guide.html

This public interest directorate consists of guidelines, illustrative statements and references. The Guidelines represent general principles that are intended to be aspirational in nature and are designed to provide suggestions to psychologists in working with ethnic, linguistic, and culturally diverse populations. There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services. This increased motivation for improving quality of psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs and cultural expectations have been introduced into educational, political, business, and health care systems by the physical presence of these groups. The issues of language and culture impact on the provision of appropriate psychological services.

The site further explains that psychological service providers need knowledge and skills for multicultural assessment and intervention, including abilities to: (1) recognize cultural diversity; (2) understand the role that culture and ethnicity/race play in the sociopsychological and economic development of ethnic and culturally diverse populations; (3) understand that socioeconomic and political factors significantly impact the psychosocial, political and economic development of ethnic and culturally diverse groups; and (4) help clients to understand/maintain/resolve their own sociocultural identification and understand the interaction of culture, gender, and sexual orientation on behavior and needs.

7. Amherst H. Wilder Foundation – Research Center Home Page www.wilder.org/research/index.html

The Wilder Foundation has grown and prospered largely because of its innovative services and commitment to continually respond to the changing needs of the community. This web site offers employment, volunteer work, a research center, publications, consulting and training, where structured educational programs and culturally-specific teaching tools are used to teach.

8. Association of American Indian Physicians Home Page www.aaip.com

AAIP members are very active in medical education, cross-cultural training between western and traditional medicine, and assisting Indian communities. This web site features legal and political information regarding Indian health care policies and current issues, herbal knowledge and workshops for traditional medicine. Current issues in Indian health are discussed, such as diabetes, fitness and nutrition, health and information resources. You can also locate traditional medicine links, services, and transcripts.

9. Beth Israel Deaconess Medical Center
www.bidmc.harvard.edu/community/cci.htm

This site consists of an institutional-wide commitment to improve organizations and to give providers the ability to supply exceptionally culturally competent health care to a diverse patient population. It describes one major medical center's cultural competence initiative.

10. The California Department of Mental Health Office of Multicultural Services
www.dmh.cahwnet.gov/multicultural

This site provides leadership guidance to DMH in promoting culturally competent mental health services.

11. The California Endowment
<http://www.calendow.org>

The California Endowment is committed to working with organizations and institutions that directly benefit the health and well-being of Californians. Their mission is to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians.

The California Endowment offers many different publications including the *Annotated Bibliography* and *Standards for Health Care Interpreters*. The Endowment also offers numerous training videos on cultural competency. On their web site, you can apply for a grant, visit their pressroom, see publications and review reports, and the web site also offers valuable links to other resources. The Endowment is committed to providing a wide-ranging variety of up-to-date resources and being a clearinghouse of information for the health community of California.

12. California HealthCare Foundation
<http://www.chcf.org>

The California HealthCare Foundation (CHCF) an independent philanthropy committed to improving California's health care delivery and financing systems. Their goal is to ensure that all Californians have access to affordable, quality health care. Their work focuses on informing health policy decisions, advancing efficient business practices, improving the quality and efficiency of care delivery, and promoting informed health care and coverage decisions. CHCF commissions research and analysis, publishes and disseminates information, convenes stakeholders, and funds development of programs and models aimed at improving the health care delivery and financing systems. Visit their web site and browse through topics, order publications, and review their grants, RFPs, and other programs.

13. The Center for Cross-Cultural Health (CCCH)

Web site: www.crosshealth.com/index.html

E-mail: ccch@crosshealth.com

“The mission of the Center for Cross Cultural Health is to integrate the role of culture in improving health. Their vision is to ensure that diverse populations receive culturally competent and sensitive health and human service. The Center is actively involved in the education and training of health and human service providers and organizations in the State of Minnesota and beyond. The Center is also a research and information resource. Through information sharing, training and research, the Center works to develop culturally competent individuals, organizations, systems, and societies.”

14. The Center for Effective Collaboration and Practice

Web site: www.air.org/cecp or <http://cecp.air.org/cultural/resources.htm>

The Center is dedicated to improving services for children and youth with emotional and behavioral problems and to supporting effective collaboration at a local, state, and national level. They are also committed to helping communities create schools that promote emotional well-being, effective instruction and safe learning.

The web site provides a collection of online resources, which include articles, resources, and reports. It also consists of a list of resources that provides information about cultural competence health care to diverse populations.

15. The Center for the Health Professions

University of California, San Francisco

Website: <http://futurehealth.ucsf.edu/cnetwork/resources/curricula/diversity.html>

E-mail: chpnews@itsa.ucsf.edu

“The mission of The Center for the Health Professions is to assist health care professionals, health professions schools, care delivery organizations and public policy makers respond to the challenges of educating and managing a health care work force capable of improving the health and well being of people and their communities.”

On this web site, you can view, download, or order reports about California health professions work force, financing and organization of health care systems, health professions education and training, and regulation and legislation of health professions. In addition, you can learn about their programs on community-campus partnerships, leadership development, physician and nursing education, supporting innovative program models, and work force policy and research. You can also order their 170-page curriculum, which is “organized into eleven sections that focus on teaching clinicians to recognize cultural differences in patient interactions and use specific communication skills to improve patient care. The materials organized can be adapted for sequential one-hour sessions or for daylong seminars.”

16. Center for Healthy Families and Cultural Diversity
E-mail: like@umdnj.edu
Located at: Department of Family Medicine, University of Medicine and Dentistry of New Jersey – Robert Wood Johnson Medical School, 1 Robert Wood Johnson Place, New Brunswick, NJ 08903.
732-235-7662 Tel.; 732-246-8084 Fax

The Center for Healthy Families and Cultural Diversity offers customized cross-cultural training, as well as instruction in working with interpreters. Training may run from half a day to a full day or longer. Rates vary. A day's training costs up to \$5,000.

17. The Center for Research on Ethnicity, Culture and Health (CRECH)
University of Michigan, School of Public Health
www.sph.umich.edu/crech/about/

The Center for Research on Ethnicity, Culture and Health provides a forum for basic and applied public health research on relationships among ethnicity, culture, socioeconomic status and health. The Center seeks to develop new interdisciplinary frameworks for understanding these relationships while promoting effective collaborations among public health academicians, health providers, and local communities.

18. The Commonwealth Fund
One East 75th Street, New York, NY, 10021. Tel. 212-606-3800
Fax 212-606-3500.
Web site <http://www.cmwf.org/>
E-mail cmwf@cmwf.org

The Commonwealth Fund is a New York City-based private foundation supporting independent research on health and social issues. You can read, order, and download publications on various subjects, including: academic health centers, health care quality, international health policy, managed care, Medicaid, Medicare, minority health, quality of care for underserved populations, and men's and women's health. You can also sign up for an e-mail alert, obtain information for grant seekers, and learn about recent grants.

19. Chinese American Medical Society Home Page
www.camsociety.org

The Society is incorporated as a nonprofit, charitable, educational, and scientific society. This web site gives background on the Medical Society, discusses health issues and news, and offers related links and a search site. It contains information on raising awareness in health care in the immigrant community, women's health, disease in the Asian population, and Chinese diet in medicine and as medicine. It has materials on traditional Chinese medicine and other practical resources on illnesses and research. The site also discusses psychiatric care for Chinese Americans, pain management, diabetes, cancer, and advancement in therapy.

20. Cross Cultural Health Care Program
www.xculture.org

Since 1992, the CCHCP has been addressing broad cultural issues that impact the health of individuals and families in ethnic minority communities in Seattle and nationwide. Through a combination of cultural competency training programs, interpreter training programs, translation services, research projects, community coalition building, and other services, the CCHCP serves as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate. They offer assessment tools and update their site monthly with recent news. Many of the trainings and materials can be downloaded using Adobe Acrobat Reader.

The web site lists various cultural resources. Their products consist of publications and videos for purchase, while their Links and Resources section contains lists of national resources on cultural competency, interpretation and translation, and health organizations. The site also offers an online library of literature pertaining to cross cultural health information on immigrant communities, reference materials, and current government publications relating to health care of diverse communities. There is a list of books recommended by the CCHCP staff, which can be ordered directly through Amazon.com.

21. Cultural Competence Activities in the Bureau of Primary Health Care
<http://www.bphc.hrsa.dhhs.gov/cc/cc-activities.htm>

The Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) works to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and uninsured populations. This is accomplished through the involvement of a network of approximately 700 community and migrant health centers (C/MHCs). It is important to note that 65% of all C/MHC system users are from ethnic/racial/cultural groups. BPHC recognizes that fulfillment of its mission requires that it provide leadership in ensuring high quality health care for these diverse populations.

BPHC recognizes that linguistically and culturally appropriate services for ethnic, racial and cultural populations remain a significant health disparity issue for their diverse citizenry. There is a universal need to provide health services in linguistic and culturally appropriate ways. Language (to understand and to be understood by others with whom we communicate) is universal. Culture (those shared beliefs, attitudes, values and behaviors about health and illness that are shaped and influenced by our history, folklore, customs, traditions and institutions) also is universal. While many of their citizens receive linguistically and culturally appropriate health services as a matter of course, many more do not. Those populations whose language and culture of orientation are not within the dominant Western European American mainstream (often ethnic and racial populations) experience severe health service disparities.

This web site offers opportunities, definitions, lessons learned, some questions to consider in assessing cultural competency and discusses the present and near future of their work in cultural competence.

22. *Cultural Competence: A Journey*, Bureau of Primary Care, Health Resources and Services Administration, Department of Health and Human Services.
<http://bphc.hrsa.gov/culturalcompetence/#1>

The web site takes you on a cultural journey celebrating cultural and linguistic competency. It discusses seven domains of cultural competence, from values and attitudes and communication styles to policies and procedures and training and professional development. The publication summarizes the evolving experiences of community programs affiliated with the Health Resources and Services Administration's Bureau of Primary Health Care providing services to culturally diverse populations. This is geared towards professionals devoted to the promotion of health and the prevention, early intervention, and treatment of acute and chronic diseases.

23. *Cultural Competence Continuum*, Cross, Terry L.
New York State Citizens' Coalition for Children, Inc.
Web site: <http://www.nysccc.org/T-Rarts/CultCompCont.html>
E-mail: office@nysccc.org

Terry Cross, M.S.W., discusses cultural competence, cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence and advanced cultural competence. Cross concludes, "The degree of cultural competence an agency achieves is not dependent on any one factor." Cross believes that "attitudes, policies, and practice are three major arenas where development can and must occur if an agency is to move toward cultural competence."

24. Cultural Competence Standards Home Page
Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda - Recommendations for National Standards and a National Public Comment Process.
www.omhrc.gov/clas/

This project makes recommendations for national standards for culturally and linguistically appropriate services (CLAS) in health care. Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. Each standard is accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

25. Directory of Resources in Cultural Diversity and Cultural Competence
www.aucd.org

This site facilitates collaboration among people with disabilities, families, educators, and researchers and offers the opportunity to bring people together to share different perspectives.

26. Diversity Rx Home Page
www.diversityrx.org

Promotes language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities. This web site offers a table of contents, glossary, and models and practices to help you design programs that address linguistic and cultural barriers to health care, like bilingual interpreter services and interpreter practice. It discusses policy, legal issues and lets you network by signing their guest book and joining their Listserv. This site allows you to register for national conferences, view the draft agenda, and look into abstracts, biographies and contact information from previous meetings. It also offers links to web sites on health, policy, and culture. The medical interpretation resources and references guide with information on training, interpreter associations, standards, research, and policy is available to print out online. You can also sign up to be a part of their e-mail news list and stay current on Diversity Rx and cross-cultural health care news.

27. EatEthnic Home Page
www.eatethnic.com

This web site has everything about ethnic foods and ingredients, holiday food traditions, religious dietary practices, regional food customs, recipes, fun facts, and cultural nutrition resources. You can also find links and resources on the site as well. They even have enjoyable items like food quizzes, prizes and short *quizlets*. You can order food items, cultural nutrition products, browse through their food video selection, and visit their bookstore. You can even obtain resources on cultural nutrition and get ethnic health data. You can sign their guest book, receive their newsletter and read what others have to say about this site.

28. EthnoMed – Ethnic Medicine Guide
<http://healthlinks.washington.edu/clinical/ethnomed/>

The EthnoMed site contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants to Seattle, many of whom are refugees fleeing war-torn parts of the world. You can find a summary of these groups at their link, *Features of Major Refugee and Immigrant Groups Seen at Central Seattle Health Clinics*. They present cultural profiles and medical topics on Chinese, Amharic, Somalians, Vietnamese, and more. They also offer documents you can download online like, Chinese/English brochure on “*Pap Testing: A New Step to Women’s Health*,” as well as translated

patient education materials on Tuberculosis, diaper rash, fever, vomiting/diarrhea, and cough/cold. This site also features articles, or Clinical Pearls in Cross Cultural Medicine, that focus on anything from *Ramadan* and *Skin Decorations in East African Patients* to *Compliance with INH Prophylaxis for Tuberculosis* and *Naming in Cambodian Culture*. They discuss cross-cultural health and immigration issues while presenting their research and programs they're working on. The site offers an A to Z search link, as well as links to library, online, journal, textbook, and course references, and numerous links (*Toolkits*) for care providers, grantseekers, patients, students and more.

29. George Washington University – Module 2: Cultural Competence

<http://learn.gwumc.edu/iscope/Cultcomp.htm>

This web page details a specific outline, for the George Washington University School of Medicine students. It provides learning objectives, definitions, case histories, examples of potential differences in values, references and links. It presents general information about cultures, minority populations, and recently immigrated minorities, compares and contrasts non-verbal communication, such as distance, eye contact, and body language, to verbal communication and offers self-reflection and team exercises.

30. The Healthcare Collaborator

www.healthcarecollaborator.com

The Healthcare Collaborator is a monthly, online newsletter that helps health care professionals communicate more effectively with each other, their patients and other organizations — contributing to greater efficiencies, improved relationships, and smoother running practices. Subscribers may access all past issues of the newsletter — including our issue on “Intercultural Communication” — at any time. A sample issue on leadership communication is complimentary to visitors. [More information is available on the site.]

31. The Henry J. Kaiser Family Foundation

www.kff.org

“The Kaiser Family Foundation is an independent philanthropy focusing on the major health care issues facing the nation. The Foundation is an independent voice and source of facts and analysis for policymakers, the media, the health care community, and the general public. Their work is focused in three main areas: Health Policy, Media and Public Education, and Health and Development in South Africa.”

32. Indiana University

Tran cultural and Multicultural Health Links

<http://www.lib.iun.indiana.edu/trannurs.htm>

33. Institute for Diversity in Health Management Home Page
www.institutefordiversity.org

The Institute's web site is made up of information, education and value-added products, programs and services. It reflects the institute's commitment to expanding leadership opportunities to ethnic minorities in health services administration by increasing the number of qualified minorities in the field and improving opportunities for professionals already in the health field.

The web site is linked to a new career development resource from the Institute, DiversityConnection.org™, providing candidates and health care organizations a new way to reach one another. Diversityconnection.org™ is a user-friendly highly interactive web site with a searchable database of abstracted confidential resumes from qualified minority candidates. You can even access an electronic version of the Institute's Newsletter, Bridges.

34. La Frontera Center, Inc.
www.lafrontera.org/competence-tool.asp

La Frontera is a nationally recognized leader in providing culturally competent behavioral health services. In 1995, with funding from the U.S. Office of Minority Health, the agency developed and published Building Bridges: Tools for Developing an Organization's Cultural Competence. Now in its second printing, the manual is available for \$2.50 per copy, which includes shipping and handling. To purchase copies, send check or money order to Director of Communications, La Frontera Center, Inc. at 502 W. 29th Street, Tucson, AZ 85713.

35. Landon Pediatric Foundation
Located at: 3400 Loma Vista Road, Suite 1, Ventura, CA 93003
Fax number: 805-289-3310
www.rain.org/~landon/Cultural%20Competence/

The Landon Pediatric Foundation's web site discusses what cultural competence is to them and how they provide and promote it. A section describing lay healers details things such as *curanderos*, *sobadors*, and *parteras*, while other sections talk about illnesses, like *empacho*, *ojo*, *caida de la mollera* and *susto*. The site also offers resources, definitions, and even a checklist for communities.

36. McGill Home Page – Search “Transcultural Psychiatry”
<http://www.mcgill.ca> or <http://ww2.mcgill.ca/Psychiatry/transcultural/tpr.html>

Transcultural Psychiatry provides a forum of communication for psychiatrists and other mental health practitioners as well as social scientists around the world concerned with the relationship between culture and mental health. The journal is committed to the most comprehensive coverage of the social and cultural determinants of psychopathology and psychosocial treatments of the

entire range of mental and behavioral problems in individuals, families and communities.

You can find recent issues, see highlights of recent issues, take a look at upcoming thematic issues, view recent thematic issues, subscribe to the publication on-line and see the Editorial Board.

37. Medical Hispanic Center of Excellence
The University of Texas Health Science Center at San Antonio
www.uthscsa.edu/hcoe/page4.html

Medical Hispanic Center of Excellence (MHCOE) is collaborating with the Departments of Family Practice and Internal Medicine. Together they are developing and implementing a strategic plan to 'infuse' cultural competence into the medical school curriculum. As part of this project, the MHCOE is developing information resources such as a library of case vignettes that can be requested by all UTHSCSA faculty.

38. Medical Mutual of Ohio
Located at: 01-5B-3983 2060 East 9th Street, Cleveland, OH 44115-1355
Fax number: (216) 687-6558
www.mmoh.com/provider/provnet/culturalcomp.asp

The Medical Mutual of Ohio (MMO) web site has a section on cultural competence and provides an example of how a health plan announces its intention to provide culturally competent care. Medical Mutual proposes to provide culturally sensitive services to help ensure access of both clinical and non-clinical services to covered persons. In countries or regions where there is a large population who speak a primary language other than English, MMO will seek to provide health plan information in that language. Other than English, primary languages in the State of Ohio are Spanish, German, Italian, Polish and Slavic. Further, MMO will attempt to link covered persons with practitioners who can address their special cultural needs and preferences by developing and maintaining a network appropriate to the population.

39. Michigan State University College of Human Medicine
Center of Excellence in Minority Medical Education and Health
Consortium for Institutional Cooperation's Health Web Project
<http://www.msu.edu/user/coemmeh/>
40. Minority Health Program
University of North Carolina at Chapel Hill
<http://www.minority.unc.edu>

41. The National Alliance for Hispanic Health
www.hispanichealth.org

The National Alliance for Hispanic Health is the oldest and largest network of health and human service providers servicing over 10 million Hispanic consumers throughout the U.S. Their mission is to improve the health and well-being of Hispanics in the United States. Since 1973, they have represented all Hispanic groups, they do not accept funds from tobacco or alcohol companies, and they are dedicated to community-based solutions.

To bring the community closer together, this site can connect you to a chat room that is available 24-hours a day. The web site also offers resources, such as health facts, help lines, publications, and web links dedicated to health.

42. National Council on Interpreting in Health Care (NCIHC)
<http://www.ncihc.org/index.html>

The National Council on Interpreting in Health Care is a multidisciplinary organization whose mission is to promote culturally competent professional health care interpreting as a means to support equal access to health services for individuals with limited English proficiency. NCIHC's goals include: 1) establishing a framework that promotes culturally competent health care interpreting that includes standards for provision of interpreter services in health care settings and a code of ethics for interpreters in health care; 2) developing and monitoring policies, research, and model practices; 3) sponsoring a national dialogue of diverse voices and interests on related issues; and 4) collecting, disseminating and acting as a clearinghouse on programs and policies to improve language access to health care for LEP patients. Some of their working papers include: The Role of the Health Care Interpreter: An Evolving Dialogue, Guide to Initial Assessment of Interpreter Qualifications (May 2001), The Terminology of Health Care Interpreting: A Glossary of Terms (October 2001), A Code of Ethics for Health Care Interpreters: A Working Paper for Discussion (October 2001), Recommendations for the Ethical Involvement of Limited English-Speakers in Research, Models for the Provision of Health Care Interpreter Training (March 2002), Models for the Provision of Language Access in Health Care Settings, and Linguistically Appropriate Access and Services: An Evaluation and Review for Healthcare Organizations.

43. National Hispanic Medical Association Home Page
www.home.earthlink.net/~nhma

The National Hispanic Medical Association was organized in 1994 to address the interests and concerns of licensed physicians and Hispanic medical faculty dedicated to teaching medical and health services research. As a rapidly growing national resource, NHMA provides policymakers and health care providers with expert information and support in strengthening health service delivery to Hispanic communities across the nation. In their Resident Physician Database Project they are interested in recruiting young Hispanic physicians into their

organization and you can complete an online application. They also discuss their non-profit, student-run free clinic. There are links to other Hispanic medical sites on their web site, they announce upcoming conferences, and provide information on prior conferences as well.

44. National Asian Women's Health Organization
www.nawho.org

NAWHO was founded in 1993 in order to achieve health equity for Asian women and families. The site discusses women's health issues, domestic violence and Asian American cancer, substance abuse, and mental health. There is also information on the NAWHO leadership network, partnership initiatives, and policy and advocacy. There is even a career center with listings of current job openings and also information on events and links to resources.

45. National Center for Child Health and Mental Health Policy
Georgetown University Child Development Center
<http://www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html>.

46. National Multicultural Institute, Washington, DC
<http://www.nmci.org>

The National Multicultural Institute's (NMCI) mission "is to work with individuals, organizations, and committees in creating a society that is strengthened and empowered by its diversity. Through its initiatives, NMCI leads efforts to increase communication, understanding and respect among people of diverse backgrounds and addresses some of the important issues of multiculturalism facing our society. We accomplish this through our Conferences in the Spring and Fall, individualized Organizational Training and Consulting interventions, Publications, and Leading Edge Projects."

On the NMCI web site, information about their various projects, conferences and training programs are readily available.

47. Nova Southeastern University College of Allied Health. "Culture, Ethnicity & Health (Physician Assistant Program) Webliography 2000."
<http://www.nova.edu/~stevec/webliopa.html>

This web site provides other web sites and links as resources that contribute to the knowledge about cultural diversity in health care. The sites were researched and reviewed by members of the Class of 2002 at the Nova Southeastern University PA Program. Sites range in topics from acupuncture, herbal and traditional medicines to health care information on Cubans, Arabs, Asians, Somalians, Japanese, Gypsies, and even tribal communities.

48. Office for Civil Rights – Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency
www.hhs.gov/ocr/lep/guide.html

In the course of its enforcement activities, OCR has found that persons who lack proficiency in English frequently are unable to obtain basic knowledge of how to access various benefits and services for which they are eligible. For example, many intake interviewers and other front line employees who interact with LEP individuals are neither bilingual nor trained in how to properly serve an LEP person. As a result, the LEP applicant all too often is either turned away, forced to wait for substantial periods of time, forced to find his/her own interpreter who often is not qualified to interpret, or forced to make repeated visits to the provider's office until an interpreter is available to assist in conducting the interview. When these types of circumstances are encountered, the level and quality of health and social services available to persons of limited English proficiency stand in stark conflict to Title VI's promise of equal access to federally assisted programs and activities. Accommodation of these language differences through the provision of effective language assistance will promote compliance with Title VI. This article offers a background, legal authority, policy guidance, promising practices, a model plan, compliance and enforcement, and technical assistance.

49. Office of Minority Health - *Cultural Competence Works*.
<http://www.haa.omhrc.gov/HAASidebar/cultural3.htm>
www.omhrc.gov - provides publications and resources on minority health issues.

“HRSA offers a new tool to help health care professionals become more culturally and linguistically competent in the delivery of health care to individuals and families from diverse backgrounds. Called ‘Cultural Competence Works’ and subtitled ‘Using Cultural Competence to Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements,’ the publication shows that practicing cultural competence – the set of behaviors, attitudes, skills and policies that help organizations and staff work effectively with people of different cultures – can help expand and improve access to quality health care.” Visit <http://www.hrsa.gov/financeMC/cultural-competence.pdf> for information on this new HRSA 79-page document.

50. Office of Minority Health Resource Center
Health Resources and Services Administration (HRSA)
www.omhrc.gov or e-mail lmosby@omhrc.gov
Located at: PO Box 37337, Washington, DC 20013
800-444-6472 Toll Free; 301-589-0884 Fax

The Office of Minority Health Resource Center offers a vast repository of cross-cultural documents, books, audiovisual aids, organizations, programs, and funding opportunities, courtesy of the US Department of Health and Human Services. Documents and audiovisual aids are offered for African Americans, Asians, Hispanics/Latinos, Native Americans and Native Hawaiians/Pacific Islanders.

51. Office of the Surgeon General; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. "Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General."
<http://www.surgeongeneral.gov/library/mentalhealth/cre/>

This report is a supplement to the first ever Surgeon General's Report on Mental Health, *Mental Health: A Report of the Surgeon General* (DHHS, 1999), which is also included on this web site. The full report on Culture, Race, and Ethnicity is provided and is printable and downloadable with Adobe Acrobat. You can also order a printed copy of the report online or by telephone. This 217-page publication makes clear that the tragic and devastating effects of mental illnesses touch people of all ages, colors, and cultures. It informs us that there are effective treatments available for most disorders. It discusses the origins and purposes of the supplement, scope and terminology, and the influence culture and society has on mental health. There are sections on mental health care for African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans. The publication then addresses their vision for the future and how they plan to continue to expand the science base, improve access to treatment, and reduce barriers to treatment. They also discuss their proposal to improve the quality of care, support capacity development, and promote mental health. This supplement sets a foundation for national efforts to provide racial and ethnic minorities affected by mental disorders with effective and affordable treatments tailored to their specific needs. Culturally specific resources and links on mental health are offered on this site in English and Spanish.

52. Office Support Agency, Inc.
Substance Abuse and Mental Health Services Administration
Web site: www.samhsa.gov
E-mail: OSA1mch@aol.com

This site provides publications discussing cultural competence issues in substance abuse and mental health.

53. Ohio Department of Mental Health, Office of Mental Health Services
www.mh.state.oh.us

The department holds public forums and publication addressing the development and accomplishments of a culturally competent mental health system.

54. Pacific Interpreter
Web Site: www.pacinterp.com
E-mail: information@pacinterp.com
Located at: 1020 SW Taylor, Suite 280, Portland, OR 97205
800-870-1069 Toll Free; 503-223-8899 Tel.; 503-223-1336 Fax

Pacific Interpreters offers document-translation services and nationwide telephone and videoconference interpreting, as well as on-site interpreting in the Pacific Northwest, in more than 100 languages. Interpreters and translators are trained in clinical terminology. The rate for telephone interpreting: \$1.95 per minute – 24 hours a day, seven days a week, regardless of the language. Interpreters are usually immediately available.

55. The Park Ridge Center for the Study of Health, Faith, and Ethics
www.parkridgecenter.org/cgi-bin/showpage.dll?id=1880

The Park Ridge Center provides ethics consultation services and publications to health and human service organizations, such as health care networks, hospitals, long-term care facilities, home health and home care agencies, and child and family service agencies. The Park Ridge Center explores and enhances the interaction of health, faith and ethics through research education and consultation to improve the lives of individuals and communities. The Center is an independent, nonprofit, nonsectarian organization affiliated with Advocate Health Care. Consultation and associated educational services address patient and client care issues as well as organizational ethics concerns. Fees are structured according to hourly rates or through contractual arrangements. For information, call Mary Ann Clemens at 312-266-2222, extension 240.

This page of the web site explores “religiously informed cultural competence.” Authors examine the competencies needed to address cultural diversity in a health care setting. Religion and spirituality are significant aspects of cultures, and authors show how health care professionals address that relationship. This issue also features “After September 11,” a collection of essays by four scholars of religion who reflect on how the agenda for health, faith, and ethics has been affected by recent events.

56. Patient and Family Education Services, University of Washington Medical Center
<http://depts.washington.edu/pfes/pdf/cclue-albanian.pdf>
<http://depts.washington.edu/pfes/pdf/cclue-africanamerican.pdf>
<http://depts.washington.edu/pfes/pdf/cclue-chinese.pdf>
<http://depts.washington.edu/pfes/pdf/cclue-korean.pdf>
<http://depts.washington.edu/pfes/pdf/cclue-latino.pdf>
<http://depts.washington.edu/pfes/pdf/cclue-russian.pdf>
<http://depts.washington.edu/pfes/pdf/cclue-vietnamese.pdf>

The web sites consist of Culture Clues©, which are “tip sheets for clinicians designed to increase awareness about concepts and preferences of patients from the diverse cultures served by UWMC. Currently there are seven cultures represented, with additional ones in progress.”

57. The Provider's Guide to Quality and Culture
<http://erc.msh.org/quality&culture>

This web site is designed to assist health care organizations throughout the US in providing high quality, culturally competent services to multi-ethnic populations. It discusses quality and culture topics, defines cultural competence, provides an assessment tool, and offers a quality and culture quiz and links to additional resources.

The Guide includes: (1) full-color photographs, (2) improved navigation and visual appeal, (3) enhanced information on 5 major cultural groups in the US with pertinent links to related information in other parts of the site, (4) excerpts from selected chapters of the 10 volume Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA) and the United States Department of Health and Human Services (DHHS) Office of Minority Health (OMH) cultural competence monograph series presented in short pieces of text for easy on-screen reading with full references for all of the material, (5) additional resources and links and (6) a fully-functional search engine. In essence, the amount of information contained in the *Guide* has doubled since its release in June.

The Guide is emerging as the "one stop shopping resource" in the United States for health professionals seeking resources on cultural issues within the context of quality of care.

58. Race, Health Care and the Law
University of Dayton School of Law
<http://www.udayton.edu/~health/>
59. Society for Medical Anthropology
<http://www.people.memphis.edu/~sma/>
60. Society of Teachers of Family Medicine (STFM)
<http://www.stfm.org/corep.html>

Developed by the STFM's Task Force on Cross-cultural Experiences, Group on Multicultural Health Care and Education, and Group on Minority Health Care, these guidelines are recommended core curriculum guidelines on culturally sensitive and competent health care. They are recommendations for helping residency programs train family physicians to provide culturally sensitive and competent health care. They provide a background on their recommendations and their work in progress. They also discuss the attitudes that residents will develop, the knowledge residents will acquire, and the skills they will gain in many areas. The implementation of the core curriculum is discussed in depth. Several cross-cultural health care resources and experiential exercises, games, simulations, and videos are also recommended.

61. Stanford Geriatric Education Center (SGEC), c/o VAPAHCS, 3801 Miranda Avenue, Room A-236, (182B-SGEC), Palo Alto, CA 94304 or call 650-494-3986. <http://www.stanford.edu/group/ethnoger/target.html>.

Abstract:

Multidisciplinary ethnogeriatric education, focusing on faculty development, training for health care providers, research, and policy analysis. The Stanford Geriatric Education Center provides a variety of ethnogeriatric programs and curriculum resource materials to educate health care professionals on the cultural issues associated with aging and health. The SGEC promotes cultural sensitivity and cultural competence to improve the quality of health care delivered to the rapidly growing population of ethnic minority elders in the United States.

62. Tamanawit Unltd.
www.tamanawit.com/index.html

“Trained as a traditional Native American Storyteller, Dr. Terry Tafoya is a Taos Pueblo and Warm Springs Indian who has used American Indian ritual and ceremony in his work as a Family Therapist at the Interpersonal Psychotherapy Clinic, part of the University of Washington’s School of Medicine in Seattle. The Harbourview Community Mental Health Center, the site of the Interpersonal Psychotherapy Clinic, was responsible for having the Washington State Department of Social and Health Services designate Dr. Tafoya as the first formally recognized Native Healer for the state as an Ethnic Minority Mental Health Specialist.”

The site consists of biographies, resources and materials, scheduled events and workshops.

63. Transcultural and Multicultural Health Links
<http://www.iun.edu/~libemb/trannurs/trannurs.htm>

This web site has numerous resources and links. The bibliography includes a reading list concerning specific conditions and populations, like African Americans, Asians/Pacific Islanders, Gays/Lesbians, Hispanics/Latinos and Native Americans. There are links to resettlement agencies and refugee statistic web sites as well. There is a section on essays and surveys, which includes articles and web sites that provide topical information on multiple populations. Provided are essays, charts, links, articles, and reports on age, gender, and religious factors and research examining Vietnamese, Lebanese and Italians. Information on government offices, research institutes, and professional associations is also offered. Their health profiles describe sites providing summaries of the health beliefs and practices of multiple populations.

There are also IUN library materials online, such as encyclopedias, reference materials and journals, communication issues, workbooks and training materials. Links to and descriptions of articles addressing research issues in multicultural health research are also accessible. This site has data on ethnic

groups like African Americans, Native Alaskans, Asians and Pacific Islanders, Chinese, Cambodians, Hispanics, Hmong, Indians, Japanese, Koreans, Native Americans, Tibetans, and Vietnamese. Furthermore, it contains information on religious groups like the Amish, Buddhist, Christian Science, Hindu, Hutterite, Islam, Jehovah Witness, Judaism, Mormon, Quaker, and Seventh Day Adventist. Special populations like women, gays, lesbians, and bisexuals, are also included in this site. Web sites are recognized for their superiority in health care and cultural competence in the 'Awards' portion of the web site.

64. Transcultural Nursing Society Home Page

www.tcns.org

The Society's Mission is to ensure that the culture care needs of the people in the world will be met by nurses prepared in transcultural nursing. They discuss culture care and health beliefs, values and practices of people from diverse and similar cultures, while promoting, advancing, and disseminating transcultural nursing knowledge in education and practice worldwide. You can obtain the current issue of the Transcultural Nursing Society Newsletter and get up-to-date information from the web site. In addition, the full index for the Journal of Transcultural Nursing, 1989 to present, is available online. There is also a bookstore and an online village to browse through as well.

65. University of Pennsylvania Health System

Contact: The Institute on Aging, University of Pennsylvania Health System at
3615 Chestnut Street, Philadelphia, PA 19104

www.uphs.upenn.edu/aging/diverse/intro.shtml

The web site is devoted to exploring current developments at the Institute on Aging in the conceptualization of cultural competence for health systems. Providers, researchers and policymakers should find these materials useful to their own work in this area.

66. Window on the World

<http://www.windowontheworldinc.com/mission.html>

Window on the World's site contains information on their mission, their services, and it even includes an online training demo and tips on conducting business around the world. There is also a special section on cross-cultural teams.

www.calendow.org

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