



## Multicultural considerations in women's health

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Gender differences play a role in manifestation of disease and health outcomes. It also plays a role in health care delivery including issues associated with access. Women are perceived as the decision-makers for the source of health care for their families. Women often delay self-care as they attend to the care of their family or children. Women are not just men with reproductive capacity, and not all women are alike. Women share many experiences (eg, domestic violence) that cross economic and racial lines. Additional examples of issues that impact all women are listed as follows:

- Lack of economic parity with men
- Responsibility for childrearing
- Delay of self-care because of accessing health care for others (eg, children)
- Domestic violence
- Poverty in elderly
- Coping by using social networks
- Using relationships to identify resources

Delineating between the commonality of being a woman and the difference or uniqueness of health issues of the individual woman is key for physicians. Health care providers need to assess the global health risks of the individual patient in front of her or him. Most useful are the skills and strategies to gain information from the patient, and appropriate data collection as needed from the laboratory or radiology.

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Why invest energy exploring this issue? Most physicians have patient panels including women, and increasingly these panels are comprised of minority women. The United States is rapidly becoming more racially diverse. Currently, 40 million of the 140 million women in the United States are minority women [1]. Population growth in minority groups exceeds that of nonminorities [2]. Gender differences in health are gaining increased recognition [3]. Women fare more poorly following certain diseases and events, such as myocardial infarction, than men [4]. As a group, invasive or highly technologic diagnostic and therapeutic options are used less frequently for women [4]. Despite this, women still live longer than men. From an economic perspective, however, quantity of years does not equate to quality. Economic issues can lend considerable impact to quality of life and health outcomes. Elderly women may exist in poverty and have, in general, lower quality of lives [5]. To improve the quality of life, physicians and patients are slowly shifting their awareness and screening habits from more than just highly feared illnesses in women (eg, breast cancer) to also include those that are more likely causes of death, such as heart disease, malignant neoplasm, cerebrovascular diseases, and diabetes mellitus.

Too often, economic deprivation is misperceived as an invariable component of minority health. The health impact of limited resources, however, is not a black or brown issue. Individuals living in poverty and not covered by Medicaid (or sometimes even those who are covered), whether White, African American, Latina, Asian, or Native American, share certain characteristics. Individuals living in poverty may not receive regular care, not have a designated health care provider, or not have health screenings to prevent disease. Individuals living in poverty often use alternate access for care, such as emergency rooms and, not infrequently, delay in receiving important care. Logistical barriers to accessing limited available care, such as the need to use public transportation, which may be unreliable, limited access to or ability to pay for health insurance coverage, and the potential limited ability to pay for pharmaceutical coverage, all provide challenges. Difficult life decisions in allocating sums of money for health at the expense of rent or childcare may occur for women who are impoverished. Poverty then becomes a cofactor for lower quality of health and is a health hazard. Analysis of resources is a key component of assessing health risks.

Even if limited resources are addressed, access to care can present another barrier that negatively impacts women. Patients whose access to care is limited have an overall lower quality of care and poorer health outcomes. Although ethnicity is not the cause of reduced access, minority women are disproportionately affected. Having no health insurance is twice as common among African American women and three times as common for Latinas compared with white women. Without health insurance, women are unlikely to have a usual health care site and are more likely “to encounter other difficulties in obtaining needed care” [6].

Once they overcome access and health insurance issues, minority patients face other barriers. Two of these factors are patient trust and the quality of the patient-physician interaction. From the minority patient perspective, the American health system is not perceived to be established in their best interest and may not be trusted [7]. Trust is an essential component of the patient-physician relationship and correlates with positive health outcomes as a result of adherence and satisfaction [8]. The quality of the interaction varies greatly. Some minority patients report their physician's decision-making style as less participatory as compared with nonminority patients [9].

Certainly, the history of medicine related to minority populations, specifically surrounding Tuskegee and African American patients, has been evidence of the lack of concern that the institution of medicine has for minority patients. Although many whites are not aware of Tuskegee, most minority patients are. Unexplored racism and other barriers perpetuate common perceptions, such as being treated rudely or unfairly in the medical system. Although all patients may be treated rudely at a particular clinical site, the African American patient may be likely to assume (and may have experience to validate) this is because of her race. Patients can be attuned to differences in staffing and staff attitudes between “clinic” and “private” practices. Although discrimination may not be the intent, *de facto* differences in care result. Neither wishing that these experiences did not occur, nor denying the existence of these barriers for minority women are likely to enable institutional change. Programming and embracing assessment of quality of care delivery is an active mechanism to evaluate and rectify system-based or individual-based barriers to care.

Is ethnicity then a health risk? Although it should not be, currently it may be. Medical education is moving from a model where learners are taught about interesting diseases where the patient is coincidental, to one where the patient's story is integral. The move to integrate communication skills, professionalism, sex and gender medicine, and cultural competence is geared to teach physicians about understanding the context of care and the role of the patient and the physician in the delivery of care. One cannot generate the best fit of the patient, her life, and life influences if one does not know who she is, what risks are imparted from genetics, from lifestyle and exposure, and unless one can garner data about her and her life. If this can be done, care and consensus on goal setting, adherence, and compliance can be enhanced.

There is a growing body of knowledge regarding health care disparities and ethnicity. Dissemination of this information as it applies to the daily care of patients is essential. Accessing these data enables physicians to shift their index of suspicion for screening and diagnosing diseases in minority women patients. For example, heart disease and cancer are the two leading causes of death in all women; however, the burden of disease is not equally distributed among racial and ethnic groups [2]. Mexican Americans receive fewer cardiovascular medications and are more likely to die following a myocardial infarction than non-Hispanic whites. African Americans are less likely to

receive revascularization procedures compared with white patients [4]. Even when controlling for payor, diseased vessels, and age among patients for whom coronary artery bypass graft surgery was appropriate, African American and Hispanics were significantly less likely to have a coronary artery bypass graft as compared with white patients [10,11]. Breast cancer, coronary heart disease, hypertension, and diabetes represent illnesses where differences in health profiles exist between and within routinely observed racial categories [12]. Blacks are more than twice as likely as whites to die from hypertension, homicide, septicemia, kidney disorders, and diabetes mellitus [13]. Wong et al [14] recently reported that hypertension (15%), HIV (11.2%), diabetes (11.2%), and homicide (8.5%) contributed most of the racial disparity in potential years of life lost. When major disease categories were evaluated, cardiovascular disease emerged as the leading contributor to ethnic and racial disparities in mortality (34%) [14].

Women are not a homogeneous group and do not receive homogeneous care. Similarly, within the larger group of women, subgroups of minority women are not all the same. Components that are likely to vary depending on culture and ethnicity are outlined as follows:

- Health beliefs
- Perception of health risks
- Health practices
- Expectations from health
- Co-treatment with culturally connected health care provider
- Gender role in marital setting
- Views of modesty
- Reproductive options
- Primary language other than English
- Perception of optimal patient-physician relationship
- Expectation of physicians
- Patient role and degree of collaboration with physician
- Perception of role of male physicians in care
- Food selections and acceptable nutrition
- Attire
- Over-the-counter care products
- Dermatologic products (hair and skin care)
- Other self-care products
- Religious practices including those with fasting

Culture and ethnicity are defined more broadly than ethnic minorities but include religious belief, immigrant status, and so forth. Impact may vary with acculturation status.

Subcultural variation is important to recognize when assessing health risks. For example, breast cancer risk in Asian women depends on subcultural group membership. Women of Japanese and Filipino ancestry have twice the risk of breast cancer seen in Chinese or Korean women [15].

It is not always easy to assess what is cause and what is effect. Are the adverse health outcomes a result of ethnicity, of a genetic contribution, or of lifestyle that is inherited with the environmental expectations of normal living? As one reads about the outcomes, one must be vigilant about these questions. There are presently insufficient data to assess how ethnicity and genetics interact. Within the 30,000 genes identified in the Human Genome Project, racial and ethnic disease variability cannot be explained by genes alone. There seems to be more commonality in genetics across races, and variability may be explained by environmental issues and how a given population evolved within different environments. When interpreting data, evaluating the impact of resources, access, environment, and ethnicity is critical so as not to blur the lines and overgeneralize differential health risks associated with ethnicity. Women should be screened based on the evidence of the leading causes of morbidity and mortality (Fig. 1). When an African American woman presents with hypertension, she should be evaluated the same way a white woman is evaluated. The fact that she is more likely to have essential hypertension should not preclude an evaluation of secondary causes if clinically indicated.

### **Multicultural women: health statistics**

#### *White women*

Overall, white women have higher death rates from chronic lower respiratory diseases in those over age 55, and much higher death rates from this condition in white women over 75 compared with all other racial groups [16]. Alzheimer's disease is a major cause of morbidity and mortality [16] in elderly white women compared with other groups. In addition, white women are also more likely to experience osteoporosis and hip fractures [17,18] and have a higher incidence of breast [19–21] and uterine cancers [22] than other racial groups.

#### *African American women*

African American women experience the highest rates of mortality from heart disease, cancer, cerebrovascular disease, and HIV-AIDS compared with all other racial groups [23]. Generally, fewer medical and surgical procedures [24] are performed on African American women except for those associated with reproduction. Some of the highest rates of hysterectomy or myomectomy have been reported in black women as compared with all other groups [25]. The excess prevalence of obesity, violence, hypertension, sexually transmitted diseases, and cervical cancer negatively impact this group and contribute to excess morbidity and mortality [26]. Although heart disease is a problem for all women, African American women have a higher risk of coronary heart disease death than whites [11] and a disproportionate rate of diabetes mellitus [27], also leading to cardiovascular disease. Of the

Leading Causes of Death for Women by Race - 2000					
No.	White	Black	American Indian or Alaska Native	Asian or Pacific Islander	Hispanic
1.	Disease of the heart	Disease of the heart	Disease of the heart	<b>Malignant neoplasms</b>	Disease of the heart
2.	Malignant neoplasms	Malignant neoplasms	Malignant neoplasms	<b>Disease of the heart</b>	Malignant neoplasms
3.	Cerebrovascular diseases	Cerebrovascular diseases	<b>Unintentional injuries</b>	Cerebrovascular diseases	Cerebrovascular diseases
4.	<b>Chronic lower respiratory diseases</b>	Diabetes Mellitus	Diabetes Mellitus	<b>Unintentional injuries</b>	Diabetes Mellitus
5.	<b>Alzheimer's disease</b>	<b>Nephritis, nephritic syndrome and nephrosis</b>	<b>Cerebrovascular diseases</b>	<b>Diabetes Mellitus</b>	<b>Unintentional injuries</b>
6.	Influenza and pneumonia	<b>Unintentional injuries</b>	<i>Chronic liver disease and cirrhosis</i>	Influenza and pneumonia	Influenza and pneumonia
7.	<b>Diabetes Mellitus</b>	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases
8.	<b>Unintentional injuries</b>	<b>Septicemia</b>	<b>Influenza and pneumonia</b>	<b>Nephritis, nephritic syndrome and nephrosis</b>	<b>Certain conditions originating in the perinatal period</b>
9.	Nephritis, nephritic syndrome and nephrosis	<b>Influenza and pneumonia</b>	Nephritis, nephritic syndrome and nephrosis	<b>Essential primary hypertension &amp; hypertensive renal disease</b>	<i>Chronic liver disease and cirrhosis</i>
10.	Septicemia	<b>HIV</b>	Septicemia	Septicemia	<b>Nephritis, nephritic syndrome and nephrosis</b>

Fig. 1. Varies from other groups at level (*bold italics*); unique to all other groups in top ten causes (*bold*); seen in only one other group (*arial*). (Data from National Center for Health Statistics. Health, United States, 2002. Hyattsville, MD: Public Health Service; 2002.)

34.7 million diabetic patients in the United States, 15.3 million are adult African American women [28]. Nearly one out of every four African American women over the age of 55 has diabetes. This represents twice the rate of diabetes seen among white women [6].

Later stages of all cancer diagnoses and less aggressive treatment may contribute to disparities in cancer morbidity and mortality differences between African Americans and whites [23]. Increased mortality from breast cancer is an area of much research related to ethnic and racial expression of disease. Although the incidence of breast cancer is higher in white women, African Americans die at disproportionately higher rates [28]. Investigators have reported that breast cancer in African American women is more often diagnosed under the age of 40 and presents with a more advanced stage of disease [29]. Black women also experience lower survival rates for colorectal, lung, breast, and cervical cancers and have higher mortality from uterine cancer as compared with whites [22]. Bladder cancer among African American women is diagnosed at twice the rate of white women [30].

### *Latina women*

Overall, Latina women experience high prevalence rates of heart disease, cancer, cerebrovascular disease, diabetes, increased incidence of HIV-AIDS, increased mortality from homicide, increased rates of cervical cancer, and increased breast cancer mortality [16,26]. Death rates from diabetes are twice that of whites [23]. Latina women also have a greater likelihood of being diagnosed with late-stage breast cancer [32]. Foreign-born Latina women have fewer lower birth weight babies than American-born Latinas [31].

Of subcultural groups who are Latino, Mexican Americans represent half of the Latino population in the United States. Over 10 million Mexican American women live in the United States [28]. Mexican American women and men are more likely than non-Hispanic whites to have diabetes [4]. Additionally, women are more likely than men to have diabetes mellitus and hypertension [4]. Cervical, breast, and colorectal cancers are the most commonly diagnosed cancers in Mexican American women [28]. The underuse of screening tests for female cancers in this population may contribute to increased mortality [28].

There are 436,000 Cuban adult women in the United States [28]. Breast, colorectal, lung, and uterine cancers are most common among these women [28]. Compared with other Latinas, Cuban women are more likely to have health insurance and a routine source of health care [28].

Approximately, 2 million Puerto Rican women live in the United States [28]. Puerto Rican women tend to have higher rates of poverty and lower educational levels than their white counterparts [28]. Breast, lung, and non-Hodgkin's lymphoma are the most common cancers reported in this subgroup [28]. Among Latinas, Puerto Rican women are more likely to have health insurance [23]. Puerto Rican women, however, are less likely to obtain a Pap test than non-Latinas [28].

### *Asian and Asian Pacific Islander women*

Over 5 million Asian and Pacific Islanders live in the United States [28]. Asian and Pacific Islander women have the highest death rate from suicide in women 65 years or older (8 per 100,000) [1]. As a group, Asian women experience increased prevalence of hepatitis [26]. Additionally, some groups of Asian women have prevalence rates of stomach, liver, and cervical cancer above the national average [23]. Women immigrating to the United States from Asia develop an increased prevalence of breast cancer [33] compared with women still living in Asia.

Of subcultural groups who are Asian, there are approximately 4.8 million adult women [28]. Barriers to health care include cultural beliefs inconsistent with westernized health care and language barriers [28]. Breast, colorectal, and lung cancers are most commonly diagnosed among Asian women. Vietnamese women experience the highest rates of cervical cancer in the United States of all women [23]. Breast cancer risk among certain Asian

subgroups is relatively low, but Filipino and Japanese women are at increased risk for breast cancer [15]. Inadequate screening for cervical and breast cancer may contribute to these increased rates [28]. Additionally, Asian American women are 13 times more likely than white Americans to be infected with tuberculosis [26].

There are 120,500 native Hawaiian adult women in the United States [28]. Native Hawaiians tend, as a group, to have increased rates of obesity, high-fat and high-calorie diets, and tobacco use [28]. These women also have an increased incidence of diabetes [1,26]. Additionally, cancer incidence among Native Hawaiians is among the highest in the world [28]. The most common cancers in Native Hawaiian women are breast cancer followed by lung cancer, which has the highest mortality rate in the native Hawaiian population [28]. Native Hawaiian women have an unusually high death rate from breast cancer [1], and mammography screening is lower than in other ethnic groups [28].

There are 40,000 adult American Samoan women in the United States [23]. American Samoans have the highest poverty rates of all American ethnic groups [28]. Health risks include cancer, heart disease, stroke, unintentional injuries, increased incidence of cervical cancer, and increased incidence of tuberculosis and hepatitis B [16,26]. Barriers include health decisions influenced by beliefs concerning western medicine and the lack of western understanding of their health beliefs [28]. Breast, uterine, lung, stomach, and ovarian cancers are most common in this group [28]. Furthermore, cancers, when diagnosed, tend to occur at earlier ages and be at a more advanced stage compared with cancers diagnosed in white women [28].

#### *Alaskan native and American Indian women*

Overall, Alaskan native and American Indian women have a high risk of heart disease, cancer, unintentional injuries, diabetes, liver disease caused by cirrhosis [16], increased mortality from motor vehicle-related injuries [26], and an increased mortality from homicide [26]. Additionally, Alaskan native and American Indian women are more likely to smoke and have a higher incidence of diseases associated with smoking.

There are about 24,500 adult Alaskan native women [28]. Alaskan native women have the highest rates of smoking [1] and experience the highest rates of colon and rectal cancers in particular [23]. Alaskan native women also have the highest mortality rate of all cancers combined and for colorectal and lung cancers [28]. Barriers to health care include limited access to care [28].

There are 825,000 adult American Indian women in the United States [28]. American Indians disproportionately die from diabetes, liver disease and cirrhosis, and unintentional injuries [23]. Breast, lung, and colorectal cancers are commonly diagnosed [28]. Additionally, American Indian women experience higher rates of stomach and gallbladder cancers [28] and have a lower 5-year cancer survival rate than white women [28]. Barriers to care include limited access [28] and inadequate screening for diseases, such



as cervical and breast cancer [28]. American Indian women also have lower life expectancy rates compared with white women [28].

The highlighted health outcomes are not intended to be all-inclusive, but a framework to build on as the clinician integrates population-specific data into better tailored strategies for delivering clinical care. Information on minority women's health can be found in a number of federal sites and reports. The National Women's Health Information Center includes in their Women's Health Statistics information on minority women's health ([www.4woman.gov/HealthPro/statistics](http://www.4woman.gov/HealthPro/statistics) and [www.4woman.gov/minority/index.cfm](http://www.4woman.gov/minority/index.cfm)). The Institute of Medicine has published a number of data-driven reports focusing on gender differences in health, quality of care, and health disparities (<http://books.nap.edu/v3/makepage.phtml?val1 = subject&val2 = ms.>). Another resource is located at the Bureau of Primary Health Care's Office of Minority and Women's Health at [bphc.hrsa.gov/omwh/default.htm](http://bphc.hrsa.gov/omwh/default.htm). Additional information can be obtained from the Agency for Health Care Policy and Research at [www.ahrp.gov/research/minority.htm](http://www.ahrp.gov/research/minority.htm).

As important as federal data are, there are health care trends that are regionally, state-based, or locally focused. With the advent of the Internet, access to data has become easier for physicians. State-based data are available through links at the Centers for Disease Control and Prevention website ([cdc.gov](http://cdc.gov)). It may, in some cases, be easier to develop a working relationship with a local health department to receive updates on trends and changes outside of the usual reportable infectious diseases. Two other sources exist. First, community groups are interested in obtaining health education. This venue provides physicians with input on health concerns from a community perspective. Second, patients can share their concerns, ideas, and perception of health trends. All that needs to occur is a mechanism and process to get this information.

### **How best to process the data?**

The area that most cross-cultural education educators find frustrating is the misapplication of culturally specific facts. The books of lists that highlight cultural data about a specific population do not have a "pop-up" that reminds the reader that the data may or may not apply to the individual at hand. The impact of acculturation may make health data irrelevant. For example, when counseling a Latina about nutrition, if the clinician makes recommendations about changing her diet away from rice and beans rather than asking her what she eats, the patient who does not eat food associated with her ethnicity will likely disregard the point of healthier eating. It is essential to be mindful of avoiding stereotyping and misapplying information: to ask, rather than to assume. The clinician needs to use the same skills of inquiry that he or she uses when exploring a chief complaint. Ethnic knowledge, such as that Asian women have cancer as the leading cause of death (stomach, liver, cervical, and breast), may require more rigorous

exploration of complaints of indigestion or fatigue and for the physician to be even more vigilant regarding routine gynecologic examinations. The patient's symptoms may be caused by reflux or stress, but they may be early malignancy. Physicians need to inquire about illness common to all patients and unique to the patient at hand using information about health statistics, ethnicity, and lifestyle and environment.

Cross-cultural efficacy implies that both the physician and the patient have cultural influences. The physician has, at least, the culture of medicine and the indoctrination of what is the best choice in health care issues. Physicians have views on what is valued even when cultural influences may seem invisible. Culture is a framework to interpret, understand, and give meaning to the world. From that are generated traditions, values, and beliefs. To optimize the interaction, physician and patient need to increase their awareness, knowledge, and skills to reach consensus about what can be achieved that is in the best health interest and works with, not against, the cultural context of the patient [34]. Strategies for implementing effective cross cultural efficacy among minority women including the acquisition of appropriate data, health care delivery dynamics, institutional challenges, tools for improvement, and mechanisms for advocacy are outlined in Table 1.

### **The dynamics of the medical encounter**

Traditional medical culture prefers one-on-one, patient-physician interaction where the patient is verbal in English, is amenable to directions and advice, and is fully autonomous and independent when agreeing to a course of action. It is one that prefers action over inaction [35].

Many cultures traditionally bring more than one person into the examination room, literally or figuratively speaking. It is not an atypical response to have a woman say "I need to talk to my spouse or family about this." It is often difficult for clinicians when a serious medical decision seems to be deferred because of the patient's inability to decide for herself. The differential diagnosis of interpretation of behavior through the cultural lens may be that she is a dependent personality, that she is indecisive, or it may be that her culture dictates that she may only see her needs in the context of the family's. If the latter is the case, then the information must be delivered to the family to best decide on how to proceed. This worldview of group over the individual is difficult to appreciate because it runs countercurrent to how medical care is delivered, especially in busy clinical settings.

Even when the clinician and the patient share the same language, semantics may vary greatly. For example, if a woman is asked if she lives with family, she may reply that she does not. This is likely to be recorded by a house-officer that she lives alone. This may be inaccurate if "living with family" is interpreted by her as living with her extended family (her parents, her in-laws, cousins, and so forth). These semantic difficulties become especially important when the clinician and patient do not share the same

Table 1  
Strategy for cross-cultural efficacy with minority women

Strategy	Examples
Develop conduits for data and input	Identify websites that highlight health care disparities for minority women important nationally, regionally, and locally. Evaluate CDC websites for illnesses endemic to patients country origin Contact local health department on health trends and immigration patterns Explore trends observed in the clinical setting Request data from MCOs to tailor care better Participate in local or regional conferences on health trends Present to community groups on health education to have a forum on health issues of concern to patients
Awareness health care delivery dynamics:physician-patient and family	Interaction may not be one-on-one. Investigate influences on health care practices and support structures Role of cultural assessment (“What traditions or practices are used in your family when sick or to stay well?”)
Institutional health care challenges	Identify how your organization or practice performs quality assurance and patient satisfaction. Inquire how multicultural issues are address and advocate for their inclusion Perform surveys of patients on their experience in your office or hospital
Develop tools for improvement	Identify needed resources, faculty development, or training Use the Internet, regional or national meetings, and specialty associations as resources
Develop practical systems for advocacy	Subscribe to e-mail updates on health policy changes for patient Increase involvement in community, city, and regional outreach

*Abbreviations:* CDC, Centers for Disease Control and Prevention; MCO, managed care organization.

language and a translator is used. The translator may provide a literal translation that fails to communicate the message, especially when idioms and jargon are used. Conversely, the translator may provide interpretation of the clinician’s words by filling in with his or her own perceptions of what is being said and the clinician will not have a way to validate the message [36–38].

Integrity of communication is a cardinal feature of culturally responsive care. Translators provide limitations as described previously and may not even be available, especially with hospitals having little resources for what often gets viewed as a luxury service. Delineation of the role of translators and their use in the clinical setting is beyond the scope of this article; however,

some basic principles should be applied [37]. Given these limitations, clinicians can use several strategies to address the language gap. When translators are not available, clinicians should educate patients to recruit a bilingual health advocate to join them for their office visit. Some physicians have taken language courses to understand better the nature of the translation that occurs. At the very least, physicians should avoid using children as translators especially for gynecologic complaints or domestic violence issues.

Beyond language, there exists culture-based variation in goal-setting. For example, if a woman responds that her diabetes is under control, but the office glucometer reading is 400 mg/dL, another culture-based differential diagnosis of interpretation may be playing a role. Many cultures view success as harmony with nature rather than control of nature. Medicine is based on science, quantification, and discrete control of numbers. If the patient mentioned previously is able to be functional in her daily responsibilities, then her perception is that her diabetes is under control and she is in harmony with her world. It does not translate, however, into strict glycemic control. Decoding cultural influence provides the physician an inroad to negotiating between functional status and long-term health risks and is ultimately less frustrating.

Too often, clinicians are uncomfortable about inquiring about ethnicity or cultural influence. The risk of alienating the patient or appearing uninformed may perpetuate the barrier in the encounter. Incorporation of ethnicity into history-taking is not a difficult undertaking. If the physician informs the patient that some illnesses are associated with some ethnicities, he or she sets the stage for questions pertaining to the family history. The physician can then ask about illnesses that are passed down in her family. It may also be the easiest time to talk about how family members receive their care and about complementary health care practices. By providing examples of the use of alternative health practices, such as acupuncture, herbal medicines, and non-Western healers, a physician transmits his or her openness to hear about and learn about all health practices that the patient uses. This questioning can be reinforced during the history component of medications used. Asking the patient if she uses any prescription, over-the-counter, and alternative medicines reinforces the message of inclusiveness. The comprehensive examination provides a number of additional opportunities for cultural questions: during the health promotion questions (self-breast examinations, frequency of gynecologic evaluations, seat belt use); during the gynecologic questions (reproductive issues, sexual health); and within self-care, stress management (family dynamics, gender roles, support structure analysis.) Patients usually do not perceive their health care practices from a cultural lens, it is merely what they do or how they were raised to take care of themselves. They can provide a great deal of information if they understand how their actions relate to the physician's generated action plan. Patients teach physicians about illnesses by how these illnesses impact on their lives. The same clinical skills used to get information about diseases, can be used to

get information about the context of patients lives. Additional tools of inquiry are outlined in Box 1.

Medical care delivery does not exclusively occur when the patient is sitting in the examination room. Attention to each step of the encounter, from calling to make the appointment to interacting with the front desk staff to leaving the office, needs attention when delivering culturally appropriate care. Without formal staff training, staff and systems may generate barriers to care. Something as simple as bilingual signage can significantly improve a patient's ability to maneuver through the system and build trust that her needs are respected. Beyond the outpatient clinical setting, hospital access and limitation of other health care resources, such as transportation and limited flexibility in hours available, also play a role. For example, patients can be aided by having clerical staff be knowledgeable about bus routes to get patients to the appointment. The physician can impact these system-wide issues by asking questions and encouraging quality assessment of these areas.

### **Tools for assessment, training, and development**

Physicians can extend the usage of quality assessment tools to evaluate the degree of effectiveness in culturally responsive care delivered. Anecdotal information is as limited in its use for making improvements in care as it is limited in clinical decision-making. Evidence-based data including patient satisfaction and quantitative measure of health screening coupled with qualitative data from focus groups of patients can generate a well-rounded evaluation report. These tools do not have to be created independently by the

#### **Box 1. Incorporating inquiry of cultural information into medical history**

- Ask her what ethnic background she is and discuss the role of ethnicity and increased risk for diseases.
- Ask if she is aware of any illnesses that run in her family or that she is concerned about.
- Ask about health practices but do not uniformly expect patient insight into the reasons behind these practices.
- Example: Chinese American women may know that a “smart doctor” is one who does not ask a lot of questions, but can tell what is wrong and prescribe a treatment plan. She may not know why or how she knows this, other than that is what her grandmother taught her.
- Ask about what people in her family use when ill.
- Supply complementary and alternative options to indicate that their choice is not limited to Western medical options.

practitioner. Most health care organizations including managed care groups have tools available to assess satisfaction and levels of care delivery. Linking with individuals within these entities to focus on population-specific issues for women can enhance care delivery for both the health care group and patients.

There exist numerous excellent resources in cross-cultural care. The Office of Minority Health spearheaded national standards for culturally and linguistically appropriate services in health care in *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda* available at [www.omhrc.gov/CLAS](http://www.omhrc.gov/CLAS). Most recently a compendium of resources has been made available at the California Endowment website ([www.calendow.org](http://www.calendow.org)) [39].

Standards and data are useful guides in knowledge-based domains, but skills need faculty development and staff training opportunities. There exists a large number of training opportunities available to clinicians. Some are offered by managed care organizations, some are in the private sectors. Consultancy can also be available from networked clinician and faculty educator groups, such as the Northeast Consortium for Cross Cultural Education and Medical Practice.

### **Tools for advocacy**

Physicians have an opportunity to engage in public debates about how best to help patients with their health. With the rise of managed care organizations and the shift to moving large groups of patients with limited health care access to the underattended “safety net,” the need for clinicians’ input has never been so important. Advocacy can be as invisible as filling out forms for health services during the office visit or as vocal as testifying at regional or national governmental forums. Governmental officials need input from resources and physicians often underuse this option. At the least, physicians can remain aware of health care policy trends by getting information from such sites as the Kaiser Health Watch (<http://www.kff.org/sections.cgi?section = women>) or Congress.org ([www.congress.org](http://www.congress.org)).

### **Summary**

As patient practices continue to diversify, clinical skills need to extend beyond disease manifestation and treatment modalities into awareness of health statistics that highlight disparities, training, cross-cultural health care delivery at the individual and system-based levels, and skills of health care advocacy. Excellent care for multicultural women implies the ability to assess the health issues applicable to all women as well as the issues specific to the women in the clinician’s office. It implies enabling the patient to share with her individual and cultural influences. Incorporating both of these influences at the same time and integrating them into her context of care can result in developing the best fit for health care goals, eliminating disparities and

improving health outcomes in terms of quantity and quality of lives for all women.

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