UNIT I

The Foundations

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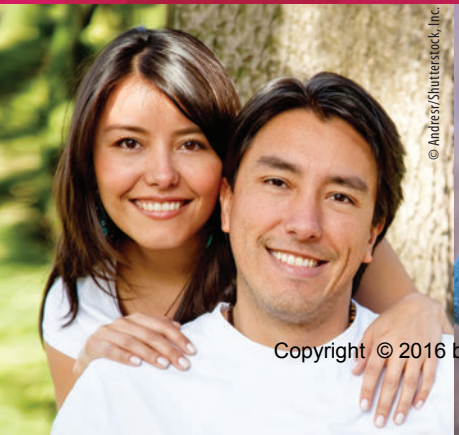
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CHAPTER 1

Introduction to Multicultural Health

We have become not a melting pot but a beautiful mosaic.
—Jimmy Carter

One day our descendants will think it incredible that we paid so much attention to things like the amount of melanin in our skin or the shape of our eyes or our gender instead of the unique identities of each of us as complex human beings.
—Author unknown

Key Concepts

Multicultural health
Cultural competence
Culture
Dominant culture
Race
Racism
Discrimination
Ethnicity
Cultural ethnocentricity
Cultural relativism
Cultural adaptation
Acculturation
Minority
Assimilation
Heritage consistency
Health disparity
Healthy People 2020
Hill-Burton Act
Ethics
Morality
Autonomy
Respect
Veracity
Fidelity
Beneficence
Nonmaleficence
Justice

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Learning Objectives

After reading this chapter, you should be able to:

1. Explain why cultural considerations are important in health care.
2. Describe the processes of acculturation and assimilation.
3. Define race, culture, ethnicity, ethnocentricity, and cultural relativism.
4. Explain what cultural adaptation is and why it is important in health care.
5. Explain what health disparities are and their related causes.
6. List the five elements of the determinants of health and describe how they relate to health disparities.
7. Explain key legislation related to health and minority rights.

Why do we need to study multicultural health? Why is culture important if we all have the same basic biological makeup? Isn't health all about science? Shouldn't people from different cultural backgrounds just adapt to the way we provide health care in the United States if they are in this country?

For decades, the role that culture plays in health was virtually ignored, but the links have now become more apparent. As a result, the focus on the need to educate health care professionals about the important role that culture plays in health has escalated. Health is influenced by factors such as genetics, the environment, and socioeconomic status, as well as by other cultural and social forces. Culture affects people's perception of health and illness, how they pursue and adhere to treatment, their health behaviors, beliefs about why people become ill, how symptoms and concerns about the problem are expressed, what is considered to be a health problem, and ways to maintain and restore health. Recognizing cultural similarities and differences is an essential component for delivering effective health care services. To provide quality care, health care professionals need to provide services within a cultural context, which is the focus of multicultural health.

Multicultural health is the phrase used to reflect the need to provide health care services in a sensitive, knowledgeable, and nonjudgmental manner with respect for people's health beliefs and practices when they are different from our own. It entails challenging our own assumptions, asking the right questions, and working with the patient and the community in a manner that respects the patient's lifestyle and approach to maintaining

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health and treating illness. Multicultural health integrates different approaches to care and incorporates the culture and belief system of the health care recipient while providing care within the legal, ethical, and medically sound practices of the practitioner's medical system.

Knowing the health practices and cultures of all groups is not possible, but becoming familiar with various groups' general health beliefs and preferences can be very beneficial and improve the effectiveness of health care services. In this text, generalizations about cultural groups are provided, but it is important to realize that many subcultures exist within those cultures, and people vary in the degree to which they identify with the beliefs and practices of their culture of origin. Awareness of general differences can help health care professionals provide services within a cultural context, but it is important to distinguish between stereotyping (the mistaken assumption that everyone in a given culture is alike) and generalizations (awareness of cultural norms) (Juckett, 2005). Generalizations can serve as a starting point but do not preclude factoring in individual characteristics such as education, nationality, faith, and level of cultural adaptation. Stereotypes and assumptions can be problematic and can lead to errors and ineffective care. Remember, every person is unique, but understanding the generalizations can be beneficial because it moves people in the direction of becoming culturally competent.

Cultural competence refers to an individual's or an agency's ability to work effectively with people from diverse backgrounds. *Culture* refers to a group's integrated patterns of behavior, and *competency* is the capacity to function effectively. Cultural competence occurs on a continuum, and this text is geared toward helping you progress along the cultural competence continuum.

Specific terms related to multicultural health, such as *race* and *acculturation*, need to be clarified, and this chapter begins by defining some of these terms. Following that is a discussion of the demographic landscape of the U.S. population and how it is changing, types and degrees of cultural adaptation, and health disparities and their causes. The chapter concludes with an analysis of the legislation related to health care that is designed to protect minorities.

Key Concepts and Terms

Some of the terminology related to multicultural health can be confusing because the differences can be subtle. This section clarifies the meaning of terms such as *culture, race, ethnicity, ethnocentricity,* and *cultural relativism*.

Culture

There are countless definitions of culture. The short explanation is that **culture** is everything that makes us who we are. E. B. Tylor (1924/1871), who is considered to be the founder of cultural anthropology, provided the classical definition of culture. Tylor stated in 1871, "Culture, or civilization, taken in its broad, ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (p. 1). Tylor's definition is still widely cited today. A modern definition of culture is the "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups" (Office of Minority Health, 2013).

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Culture is learned, changes over time, and is passed on from generation to generation. It is a very complex system, and many subcultures exist within each culture. For example, universities, businesses, neighborhoods, age groups, homosexuals, athletic teams, and musicians are subcultures of the dominant American culture. **Dominant culture** refers to the primary or predominant culture of a region and does not indicate superiority. People simultaneously belong to numerous subcultures because we can be students, fathers or mothers, and bowling enthusiasts at the same time.

Race and Ethnicity

Race refers to a person's physical characteristics and genetic or biological makeup, but race is not a scientific construct. Race is a social construct that was developed to categorize people, and it was based on the notion that some "races" are superior to others. Many professionals in the fields of biology, sociology, and anthropology have determined that race is a social construct and not a biological one because not one characteristic, trait, or gene distinguishes all the members of one so-called race from all the members of another so-called race. "There is more genetic variation within races than between them, and racial categories do not capture biological distinctiveness" (Williams, Lavizzo-Mourey, & Warren, 1994).

Why is race important if it does not really exist? Race is important because society makes it important. Race shapes social, cultural, political, ideological, and legal functions in society. Race is an institutionalized concept that has had devastating consequences. Race has been the basis for deaths from wars and murders and suffering caused by discrimination, violence, torture, and hate crimes. The ideology of race has been the root of suffering and death for centuries even though it has little scientific merit.

The 2010 U.S. Census questions related to ethnicity and race can be found in **Figure 1.1** and **Figure 1.2**. **Box 1.1** explains how these terms were defined in the 2010 census. The U.S. government declared that Hispanics and Latinos are an ethnicity and not a race.

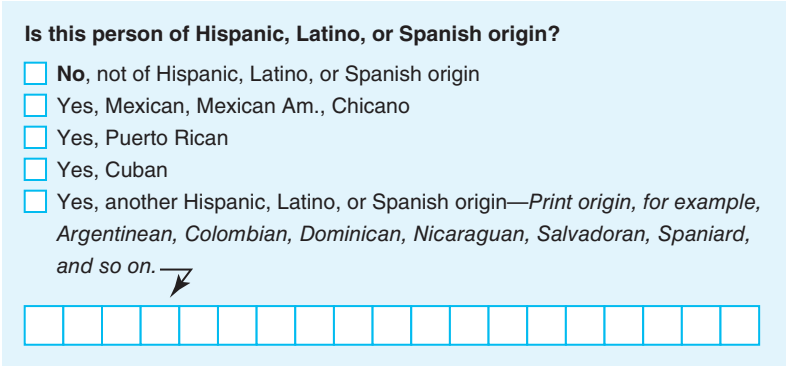

FIGURE 1.1

U.S. Census origin question, 2010.

Source: Population Reference Bureau (2013).

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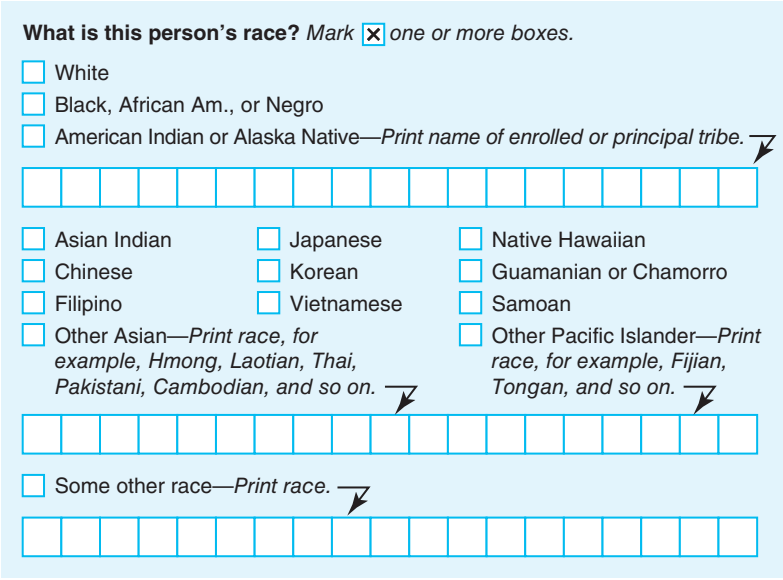

FIGURE 1.2

U.S. Census race question, 2010.

Source: Population Reference Bureau (2013).

It is important to note that there is great variation within each of the racial and ethnic categories. For example, American Indians are grouped together even though there are variations between the tribes. It is essential to be aware of the differences that occur within these groups and not to stereotype people. Stereotyping people by their race and ethnicity is racism. **Racism** is the belief that some races are superior to others by nature. **Discrimination** occurs when people act on that belief and treat people differently as a result. Discrimination can occur because of beliefs related to factors such as race, sexual orientation, dialect, religion, or gender.

Ethnicity is the socially defined characteristic of a group of people who share common cultural factors such as race, history, national origin, religious belief, or language. So how is ethnicity different from race? Race is primarily based on physical characteristics, whereas ethnicity is based on social and cultural identities. For example, consider these terms in relation to a person born in Korea to Korean parents but adopted by a French family in France as an infant. Ethnically, the person may feel French: she or he eats French food, speaks French, celebrates French holidays, and learns French history and culture. This person knows nothing about Korean history and culture, but in the United States she or he would likely be treated racially as Asian. Let's consider another example. The physical characteristics of Caucasians (a race) are typically light skin and eyes, narrow noses, thin lips, and straight or wavy hair. A person whose appearance matches these characteristics is said to be a Caucasian. However, there are many ethnicities within the Caucasian race such as Dutch, Irish, Greek, German, French, and so on. What differentiates these Caucasian ethnic groups from one another is their country of origin, language, cultural heritage and traditions, beliefs, and rituals.

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BOX 1.1 Definition of Race Categories Used in the 2010 Census

"White" refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicated their race(s) as "White" or reported entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.

"Black or African American" refers to a person having origins in any of the black racial groups of Africa. It includes people who indicated their race(s) as "Black, African Am., or Negro" or reported entries such as African American, Kenyan, Nigerian, or Haitian.

"American Indian or Alaska Native" refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. This category includes people who indicated their race(s) as "American Indian or Alaska Native" or reported their enrolled or principal tribe, such as Navajo, Blackfeet, Inupiat, Yup'ik, or Central American Indian groups or South American Indian groups.

"Asian" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes people who indicated their race(s) as "Asian" or reported entries such as "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian" or provided other detailed Asian responses.

"Native Hawaiian or Other Pacific Islander" refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicated their race(s) as "Pacific Islander" or reported entries such as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," and "Other Pacific Islander" or provided other detailed Pacific Islander responses.

"Some Other Race" includes all other responses not included in the White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander race categories described above. Respondents reporting entries such as multiracial, mixed, interracial, or a Hispanic or Latino group (for example, Mexican, Puerto Rican, Cuban, or Spanish) in response to the race question are included in this category.

Source: Humes, Jones, & Ramirez (2011).

How is ethnicity different from culture? One can belong to a culture without having ancestral roots to that culture. For example, a person can belong to the hip-hop culture, but he or she is not born into the culture. With ethnicity, the culture is a part of the ethnic background, so culture is embedded within the ethnic group. Ethnic groups have shared beliefs, values, norms, and practices that are learned and shared. These patterned behaviors are passed down from one generation to another and are thus preserved.

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Cultural Ethnocentricity and Cultural Relativism

Cultural ethnocentricity refers to a person's belief that his or her culture is superior to another one. This can cause problems in the health care field. If a professional believes that his or her way is the better way to prevent or treat a health problem, the health care worker may disrespect or ignore the patient's cultural beliefs and values. The health care professional may not take into consideration that the listener may have different views than the provider. This can lead to ineffective communication and treatment and leave the listener feeling unimportant, frustrated, disrespected, or confused about how to prevent or treat the health issue, and he or she might view the professional as uneducated, uncooperative, unapproachable, or closed-minded.

To be effective, one needs to see and appreciate the value of different cultures; this is referred to as **cultural relativism**. The phrase developed in the field of anthropology to refute the idea of cultural ethnocentricity. It posits that all cultures are of equal value and need to be studied from a neutral point of view. It rejects value judgments on cultures and holds the belief that no culture is superior to any other. Cultural relativism takes an objective view of cultures and incorporates the idea that a society's moral code defines whether something is right (or wrong) for members of that society.

What Do You Think?

Cultural imposition occurs when one cultural group, usually the majority group, forces their culture view on another culture or subculture. Can you provide examples of cultural imposition? Do you think it is ethical? Why or why not?

Diversity Within the United States

A great strength of the United States is the diversity of the people. Historically, waves of immigrants have come to the United States to live in the land of opportunity and pursue a better quality of life. Immigrants brought their traditions, languages, and cultures with them, creating a country that developed a very diverse landscape. Of course, some peoples, such as Native Americans, were already on the land, and others, such as African Americans, were forced to come to the United States. An unfortunate outcome was that despite its great advantages, this diversity contributed to racial and cultural clashes as well as to imbalances in equality and opportunities that continue today. These positive and adverse consequences of diversity must be considered in our health care approaches, particularly because the demographics are continuing to change and the inequalities persist. The delivery of health care to individuals, families, and communities must meet the needs of the wide variety of people who reside in and visit the United States.

The percentage of the U.S. population characterized as white is decreasing (see **Table 1.1**). This is an important consideration for health care providers because ethnic minorities experience poorer health status, which is usually due to economic disparities.

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TABLE 1.1 Population Data Related to Origin and Race, 2010

Hispanic or Latino origin and race	2000		2010		Change, 2000 to 2010	
	Number	Percentage of total population	Number	Percentage of total population	Number	Percent
HISPANIC OR LATINO ORIGIN AND RACE						
Total population	**281,421,906**	**100.0**	**308,745,538**	**100.0**	**27,323,632**	**9.7**
Hispanic or Latino	35,305,818	12.5	50,477,594	16.3	15,171,776	43.0
Not Hispanic or Latino	246,116,088	87.5	258,267,944	83.7	12,151,856	4.9
White alone	194,552,774	69.1	196,817,552	63.7	2,264,778	1.2
RACE						
Total population	**281,421,906**	**100.0**	**308,745,538**	**100.0**	**27,323,632**	**9.7**
One Race	274,595,678	97.6	299,736,465	97.1	25,140,787	9.2
White	211,460,626	75.1	223,553,265	72.4	12,092,639	5.7
Black or African American	34,658,190	12.3	38,929,319	12.6	4,271,129	12.3
American Indian and Alaska Native	2,475,956	0.9	2,932,248	0.9	456,292	18.4
Asian	10,242,998	3.6	14,674,252	4.8	4,431,254	43.3
Native Hawaiian and Other Pacific Islander	398,835	0.1	540,013	0.2	141,178	35.4
Some Other Race	15,359,073	5.5	19,107,368	6.2	3,748,295	24.4
Two or More Races[1]	6,826,228	2.4	9,009,073	2.9	2,182,845	32.0

[1] In Census 2000, an error in data processing resulted in an overstatement of the Two or More Races population by about 1 million people (about 15 percent) nationally, which almost entirely affected race combinations involving Some Other Race. Therefore, data users should assess observed changes in the Two or More Races population and race combinations involving Some Other Race between Census 2000 and the 2010 Census with caution. Changes in specific race combinations not involving Some Other Race, such as White *and* Black or African American or White *and* Asian, generally should be more comparable.

Source: U.S. Census Bureau (2011, March). Sources: U.S. Census Bureau, *Census 2000 Redistricting Data (Public Law 94-171) Summary File*, Tables PL1 and PL2; and *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Tables P1 and P2.

Source: U.S. Census Bureau (2011).

Cultural Adaptation

With this changing landscape in the United States, professionals are encouraged to consider the degree of cultural adaptation that the person has experienced. **Cultural adaptation** refers to the degree to which a person or community has adapted to the dominant culture or retained their traditional practices. Generally, a first-generation individual will identify more with his or her culture of origin than a third-generation person. Therefore, when working with the first-generation person, the health care professional needs to be more sensitive to issues such as language barriers, distrust, lack of understanding of the American medical system, and the person's ties to his or her traditional beliefs.

Acculturation relates to the degree of adaptation that has taken place; a process in which members of one cultural group adopt the beliefs and behaviors of another group. Essentially, members of the **minority** cultural group take up many of the dominant culture's traits. Because of the great variety of peoples who have immigrated to the United States, the country is often said to be a melting pot. However, given the tendencies of cultural groups to locate together and maintain some familiar practices in a foreign land, the country also has been described as more like a salad bowl. Both of these analogies reflect the process of cultural interaction.

Except for the indigenous population, everyone in the United States is or is descended from immigrants and refugees. For instance, the Pilgrims of Plymouth Rock were refugees from religious persecution. Each group of people who traveled to America built on the strengths of their own culture while adapting to a new social and economic environment through acculturation. Acculturation can include adopting customs from one culture to another or direct change of customs as one culture dominates the other. Each of the cultures discussed in the text has adapted as new populations arrive, territory is acquired or conquered, or popular or useful practices and beliefs are invented and spread throughout the overall population. Some interactions between cultures generate discriminatory responses, individual stress, and family conflict, whereas others create an appreciation for variation as customs or practices are welcomed into other cultures. Whether melting or mixing, the interrelationship of cultures in the United States in constantly changing. The process continues as new people arrive in the country.

People can experience different levels of acculturation as illustrated in Berry and colleagues' acculturation framework (see **Figure 1.3**). The acculturation framework identifies four levels of integration:

1. An **assimilated** individual demonstrates high-dominant and low-ethnic society immersion. This entails moving away from one's ethnic society and immersing fully in the dominant society (Stephenson, 2000). As a result, the minority group disappears through the loss of particular identifying physical or sociocultural characteristics. This usually occurs when people immigrate to a new geographic region and in their desire to be part of the mainstream give up most of their culture traits of origin and take on a new cultural identity defined by the dominant culture. Many people do not fully assimilate, however, and tend to keep some of their original cultural beliefs.
2. An integrated person has high-dominant and high-ethnic immersion. Integration entails immersion in both ethnic and dominant societies (Stephenson, 2000). An example of an

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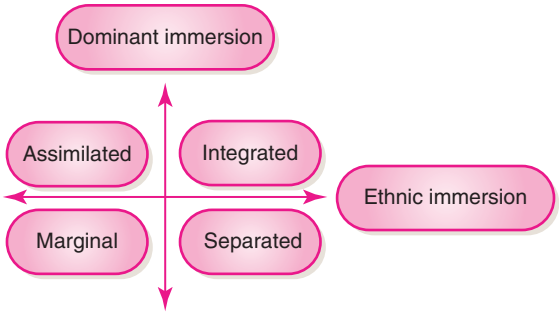

FIGURE 1.3
Acculturation framework.

integrated person is a Russian American who socializes with the dominant group but chooses to speak Russian at home and marries a person who is Russian.

3. Separated individuals have low-dominant and high-ethnic immersion. A separated individual withdraws from the dominant society and completely submerges into the ethnic society (Stephenson, 2000). An example is a person who lives in an ethnic community such as Little Italy or Chinatown.
4. A marginalized individual has low-dominant and low-ethnic immersion and does not identify with any particular culture or belief system.

Marginalized people tend to have the most psychological problems and the highest stress levels. These individuals often lack social support systems and are not accepted by the dominant society or their culture of origin. A person in the separated mode is accepted in his or her ethnic society but may not be accepted by the dominant culture, leaving the person feeling alienated. The integrated and assimilated modes are considered to be the most psychologically healthy adaptation styles, although some individuals benefit more from one than from the other. Western Europeans and individuals whose families have been in the United States for a number of generations (and are not discriminated against) are most likely to adopt an assimilated mode because they have many beliefs and attributes of the dominant society. Individuals who retain value structures from their country of origin and encounter discrimination benefit more from an integrated (bicultural) mode. To be bicultural one must be knowledgeable about both cultures and see the positive attributes of both of them.

The degree to which people identify with their culture of origin is sometimes referred to as **heritage consistency**. Some indicators that can help professionals assess the level of cultural adaptation are inquiring about how long the person has been in the country, how often the person returns to his or her culture of origin, what holidays the person celebrates, what language the person speaks at home, and how much knowledge the person has of his or her culture of origin.

Are people who have higher levels of cultural adaptation healthier? Despite increasing research on the relationships between acculturation and health, the answer to that

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question is not clear. Research on the influence of acculturation on health indicates contradictory results because the variables are complex. The answer also is dependent upon which health habits are incorporated into one's lifestyle and which are lost. For example, acculturation can have detrimental effects on one's dietary patterns if a person is from a culture where eating fruits and vegetables is common and the person incorporates the habit of eating at fast-food restaurants, which is common in the United States. On the other hand, if someone moves from a culture where smoking is common to a culture where it is frowned upon, the person may stop smoking and reduce his or her chances of serious illness.

Acculturation from traditional, nonindustrialized cultures to a modern westernized culture generally has been associated with higher rates of disease. An example of this is the rate of cardiovascular disease among Japanese males in the United States. Increasing levels of acculturation also have been associated with higher rates of specific mental disorders and with substance abuse, suggesting that these disorders result from acculturation. Increasing levels of acculturation are correlated with advancing socioeconomic status, and higher socioeconomic status is correlated with lower rates of disease and disorders. However, in some instances higher acculturation is correlated with higher rates of disease and disorders. What constitutes healthy acculturation, as contrasted with unhealthy acculturation, for which health outcomes, for whom, and under what conditions? Scientific answers to these questions may help empower diverse communities by promoting health and wellness in the presence of acculturation (González Castro, 2007).

Health Disparities

Health disparities "are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes" (Centers for Disease Control and Prevention, Division of Community Health, 2013, p. 4). Health disparities occur among groups who have persistently experienced historic trauma, social disadvantage, or discrimination. They are widespread in the United States as demonstrated by the fact that many minority groups in the United States have a higher incidence of chronic diseases, higher mortality, and poorer health outcomes when compared to Whites. Numerous other disparities exist such as the health of rural residents being poorer than urban residents and people with disabilities reporting poorer health when compared to those without disabilities.

Eliminating health disparities is an important goal for our nation and is one of the four overarching goals of ***Healthy People 2020***. These four goals are:

1. "Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
2. Achieve health equity, eliminate disparities, and improve the health of all groups.
3. Create social and physical environments that promote good health for all.
4. Promote quality of life, healthy development, and healthy behaviors across all life stages" (U.S. Department of Health and Human Services [USHHS], 2014).

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Some examples of health disparities follow, but numerous other statistics illuminate these differences as well.

- African Americans can expect to live 6 to 10 fewer years than whites and face higher rates of illness and mortality (Mead et al., 2008, p. 20).
- The prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States (USHHS, 2009).
- Hispanic and Vietnamese women are twice as likely as white women to face cervical cancer (USHHS, 2009).
- African Americans experience rates of infant mortality that are 2.5 times higher than for whites (Mead et al., 2008, p. 20).
- Asian and Pacific Islanders make up less than 5% of the total population in the United States but account for more than 50% of Americans living with chronic hepatitis B (Centers for Disease Control and Prevention [CDC], 2014).
- A nationally representative study of adolescents in grades 7 to 12 found that lesbian, gay, and bisexual youth were more than twice as likely to have attempted suicide as their heterosexual peers (Russell & Joyner, 2001).
- Rural residents are more likely to be obese than urban residents, 27.4% versus 23.9% (Rural Health Research & Policies Centers, 2008).
- People with disabilities have the highest proportion of current smokers (29%), followed by American Indian/Alaska Natives (23%), blacks (22%), Hispanics (16%), and Asians (9%); (Drum, McClain, Horner-Johnson, & Taitano, 2011).

Did You Know?

… that April is National Minority Health month? The purpose is to raise awareness of health disparities. Public health agencies across the national engage in activities to raise awareness about the health disparities that exist around issues such as alcohol and drug use and infectious diseases.

Causes of Health Disparities

Health disparities exist due to both voluntary and involuntary factors. Voluntary factors related to health behaviors, such as smoking and diet, can be avoided. Factors such as genetics, living and working in unhealthy conditions, limited or no access to health care, and language barriers are often viewed as involuntary factors because they are not within that person's control.

Most experts agree that the causes of health disparities are multiple and complex; no single factor explains why disparities exist across such a wide range of health measures. Access to health care and the quality of health care are important factors, but they do not explain why some groups experience greater risks for poor health in the first place (Alliance for Health Reform, 2010).

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Socioeconomic status (SES) is one of the most important predictors of health. Socioeconomic status is typically measured by educational attainment, income, wealth, occupation, or a combination of these factors. In general, the higher one's SES, the better one's health (Alliance for Health Reform, 2010). Socioeconomic status is thought to affect health in many ways, such as by increasing access to health-enhancing resources, access to health care, and living in healthier neighborhoods.

SES is related to health disparities, and racial and ethnic minorities are disproportionately found in lower socioeconomic levels. An important exception is the "Hispanic Epidemiologic Paradox." This refers to the fact that new Hispanic immigrants are found to have generally better health than U.S.-born individuals of the same SES (Alliance for Health Reform, 2010).

Another way to frame the causes of health disparities is via the factors affecting health that were identified in the 1974 Lalonde report, "A New Perspective on the Health of Canadians." This report probably was the first acknowledgment by a major industrialized country that health is determined by more than biological factors. The report led to the development of the "health field" concept, which identified four health fields that were interdependently responsible for individual health:

1. *Environment.* All matters related to health external to the human body and over which the individual has little or no control. Includes the physical and social environment.
2. *Human biology.* All aspects of health, physical and mental, developed within the human body as a result of organic makeup.
3. *Lifestyle.* The aggregation of personal decisions over which the individual has control. Self-imposed risks created by unhealthy lifestyle choices can be said to contribute to, or cause, illness or death.
4. *Health care organization.* The quantity, quality, arrangement, nature, and relationships of people and resources in the provision of health care.

These four domains were later refined to include five intersecting domains:

1. environmental exposures,
2. genetics,
3. behavior (lifestyle) choices,
4. social circumstances, and
5. medical care (Institute of Medicine [IOM], 2001).

All five domains are integrated and affected by one another. For example, people who have more education usually have higher incomes (social circumstances), are more likely to live in neighborhoods with fewer environmental health risks (environmental exposures), and have money to purchase healthier foods (lifestyle). Let's look at each of these domains in more detail.

Environmental Exposures

Environmental conditions are believed to play an important role in producing and maintaining health disparities. The environment influences our health in many ways, including through exposures to physical, chemical, and biological risk factors and through related changes in our behavior in response to those factors. In general, whites and minorities do not have the same exposure to environmental health threats because they live in different neighborhoods. Residential segregation still exists.

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Residential segregation between white and black populations continues to be very high in U.S. metropolitan areas. Residential segregation of Hispanics/Latinos is not yet as high as that of African Americans, but it has been increasing over the past few decades; black segregation has modestly decreased (Iceland, Weinberg, & Steinmetz, 2002).

Growing evidence suggests that segregation is a key determinant of racial inequalities for a broad range of societal outcomes, including health disparities (Acevedo-Garcia, Osypuk, McArdle, & Williams, 2008). Segregation affects health outcomes in a multitude of ways. It limits the socioeconomic advancement of minorities through educational quality and employment, and lowers the returns of home ownership due to lower school quality, fewer job opportunities, and lower property values in disadvantaged neighborhoods. Segregation also leads to segregation in health care settings, which in turn is associated with disparities in the quality of treatment (Acevedo-Garcia et al., 2008).

Minorities tend to live in poorer areas (see **Figure 1.4**), and these disadvantaged neighborhoods are exposed to greater health hazards, including tobacco and alcohol advertisements,

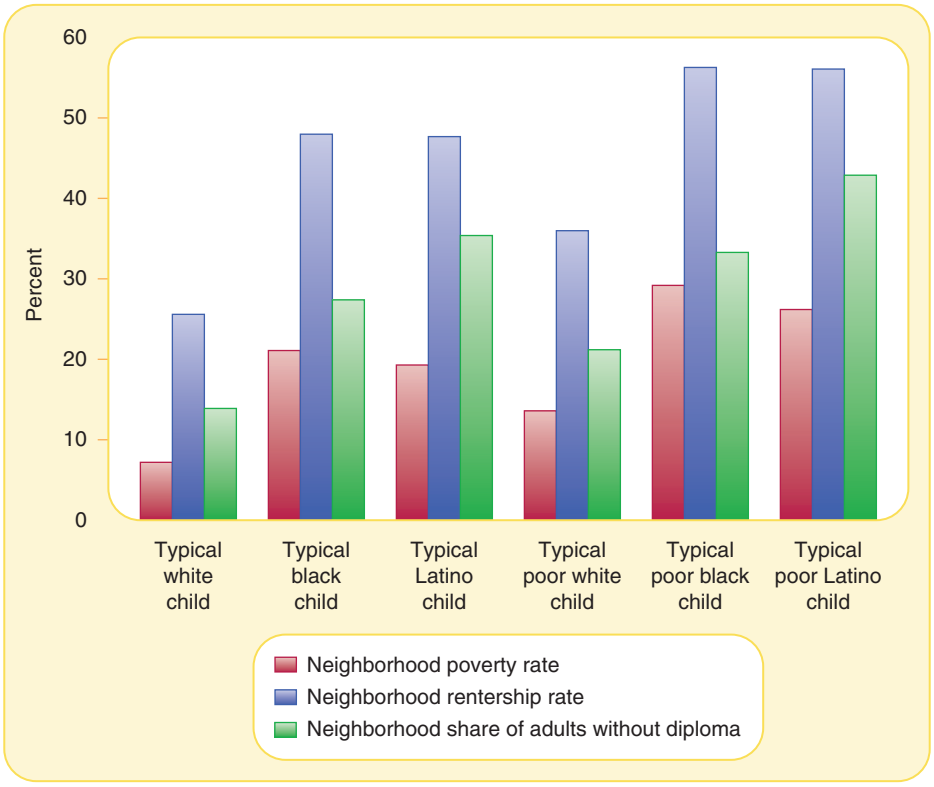

FIGURE 1.4

Racial and ethnic neighborhood disparities.

Source: Acevedo-Garcia et al. (2008).

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toxic waste incinerators, and air pollution. Tiny particles of air pollution contain more hazardous ingredients in non-white and low-income communities than in affluent white ones (Katz, 2012). The greater the concentration of Hispanics, Asians, African Americans, or poor residents in an area, the more likely it is that potentially dangerous compounds such as vanadium, nitrates, and zinc are in the mix of fine particles they breathe. In a study conducted in 2012, the group with the highest exposure to the largest number of these ingredients was Latinos, while whites generally had the lowest exposure. Economic stress within a community may exacerbate tensions between social groups, magnify workplace stressors, induce maladaptive coping behaviors such as smoking and alcohol use, and translate into individual stress, all of which makes individuals more vulnerable to illness (e.g., depression, high blood pressure). Factors associated with living in poor neighborhoods—crime, noise, traffic, litter, crowding, and physical deterioration—also can cause stress.

Some health issues related to where one lives include the following (Cooper, 2014):

- Two to three times as many fast food outlets are located in segregated black neighborhoods than in white neighborhoods of comparable socioeconomic status, contributing to higher black consumption of fatty, salty meals and in turn widening racial disparities in obesity and diabetes.
- Black neighborhoods contain two to three times fewer supermarkets than comparable white neighborhoods, creating the kind of "food deserts" that make it difficult for residents who depend on public transportation to purchase the fresh fruits and vegetables that make for a healthy diet.
- Fewer African-Americans have ready access to places to work off excess weight that can gradually cause death. A study limited to New York, Maryland and North Carolina found that black neighborhoods were three times more likely to lack recreational facilities where residents could exercise and relieve stress.
- Because of "the deliberate placement of polluting factories and toxic waste dumps in minority neighborhoods," exposure to air pollutants and toxins is five to twenty times higher than in white neighborhoods with the same income levels.
- Regardless of their socioeconomic status, African-Americans who live in segregated communities receive unequal medical care because hospitals serving them have less technology, such as imaging equipment, and fewer specialists, like those in heart surgery and cancer.

Genetics

Genetics have been linked to many diseases, including diabetes, cancer, sickle-cell anemia, obesity, cystic fibrosis, hemophilia, Tay-Sachs disease, schizophrenia, and Down syndrome. Currently, about 4,000 genetic disorders are known. Some genetic disorders are a result of a single mutated gene, and other disorders are complex, multifactorial or polygenic mutations. (*Multifactorial* means that the disease or disorder is likely to be associated with the effects of multiple genes in combination with lifestyle and environmental factors.) Examples of

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multifactorial disorders are cancer, heart disease, and diabetes. Although numerous studies have linked genetics to health, social and cultural factors play a role as well. For example, smoking may trigger a genetic predisposition to lung cancer, but that gene may not have been expressed if the person did not smoke.

There are concerns about relating genetics and health disparities because race is not truly biologically determined, so the relationship between genetics and race is not clear cut. There are more genetic differences within races than among them, and racial categories do not capture biological distinctiveness. Another problem with linking genetics to race is that many people have a mixed gene pool due to interracial marriages and partnerships. Also, it is difficult at times to determine which diseases are related to genetics and which are related to other factors, such as lifestyle and the environment.

Sometimes disease is caused by a combination of factors. For example, African Americans have been shown to have higher rates of hypertension than whites, but is that difference due to genetics? African Americans tend to consume less potassium than whites and have stress related to discrimination, which could be the cause of their higher rates of hypertension. Health disparities also can be related to the level of exposure to environmental hazards, such as toxins and carcinogens, that some racial groups are exposed to more than others. Therefore, it is difficult to link health disparities to genetics alone because a variety of factors may be involved. Genetics does play a role in health however, and some clear links have been made, such as people with lighter skin tones being more prone to skin cancer.

Lifestyle

Behavior patterns are factors that the individual has more control over. Many of the diseases of the 21st century are caused by personally modifiable factors, such as smoking, poor diet, and physical inactivity. So how does lifestyle relate to ethnicity? Studies reveal that differences in health behaviors exist among racial and ethnic groups. For example, the national Youth Risk Behavior Survey (YRBS) monitors priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. The national YRBS is conducted every 2 years during the spring semester and provides data representative of 9th through 12th grade students in public and private schools throughout the United States. Data shows racial and ethnic differences in behaviors such as alcohol consumption, use of sunscreen, physical activity levels, substance use, and being injured in a fight.

Social Circumstances

Social circumstances include factors such as SES, education level, stress, discrimination, marriage and partnerships, and family roles. SES is made up of a combination of variables including occupation, education, income, wealth, place of residence, and poverty. These variables do not have a direct effect on health, but they do have an indirect effect. For example, low SES does not cause disease, but poor nutrition, limited access to health care, and substandard housing certainly do, and these are just a few of the many indirect effects. Discrimination does not cause poor health directly either, but it can lead to depression and high blood pressure.

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One variable of social circumstances, poverty, can be measured in many ways. One approach is to measure the number of people who are recipients of federal aid programs, such as food stamps, public housing, and Head Start. Another method is through labor statistics, but the most common way is through the federal government's measure of poverty based on income. The federal government's definition of poverty is based on a threshold defined by income, and it is updated annually. So how is poverty related to ethnicity?

Poverty is higher among certain racial and ethnic groups (see **Figure 1.5**) and is a contributing factor to health disparities because poverty affects many factors, including where people live and their access to health care. What may not be surprising is that low SES groups more often act in ways that harm their health than do high SES groups. It is perplexing that some of these unhealthy behaviors are adopted despite the monetary and health costs. For example, smoking cigarettes and alcohol consumption require that the person spend money on these items. Pampel, Krueger, and Denney (2010) noted some important facts

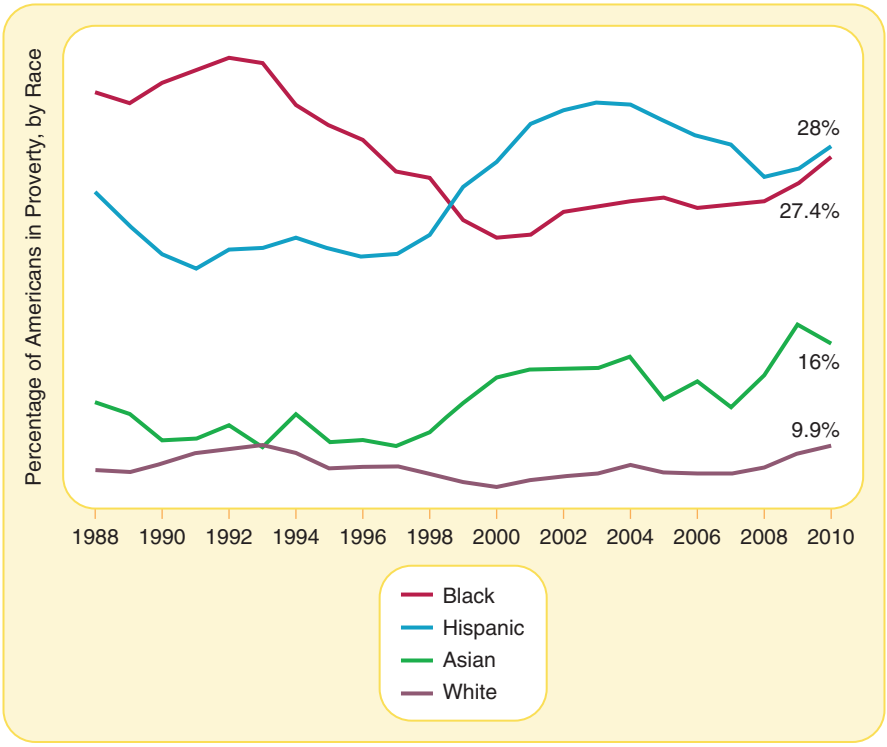

FIGURE 1.5

Poverty rates by race.

Source: Data from U.S. Census Bureau (2011).

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related to socioeconomic factors in health behaviors. One example is access to health aids. Adopting many healthy behaviors does not require money, but having more money to pay for tobacco cessation aids, joining fitness clubs and weight loss programs, and buying more expensive fruits, vegetables, and lean meats can help people achieve better health.

Medical Care

The shortfalls for minorities in the health care system in the United States can be categorized into three general areas: (1) lack of access to care, (2) lower quality of care, and (3) limited providers with the same ethnic background.

Lack of Access to Medical Care

Research has shown that without access to timely and effective preventive care, people may be at risk for potentially avoidable conditions, such as asthma, diabetes, and immunizable conditions (National Center for Health Statistics, 2006). Access to health care is also important for prompt treatment and follow-up to illness and injury.

Access to health care is a problem for many Americans due to lack of health care insurance. According to the National Health Interview Survey (NHIS), in 2012, 45.5 million persons of all ages (14.7%) were uninsured at the time of interview (Cohen & Martinez, 2013). Access to health care is particularly problematic for minorities because they have higher rates of being uninsured than whites. Based on data from the 2012 NHIS, Hispanics were more likely than non-Hispanic whites, non-Hispanic blacks, and non-Hispanic Asians to be uninsured at the time of interview, to have been uninsured for at least part of the past 12 months, and to have been uninsured for more than a year. More than one quarter of Hispanics were uninsured at the time of interview, and one third had been uninsured for at least part of the past year (Cohen & Martinez, 2013).

The Patient Protection and Affordable Care Act (ACA), passed in 2010, was designed to increase the quality and affordability of health insurance, hence lowering the rate of uninsured. The ACA went into effect on January 1, 2014, but it is too soon to know whether it will achieve this goal.

Lower Quality of Care

Despite improvements, differences persist in health care quality among racial and ethnic minority groups. People in low-income families also experience poorer quality care. Disparities in quality of care are common. For example,

- Blacks and American Indians and Alaska Natives received worse care than whites for about 40% of measures.
- Asians received worse care than whites for about 20% of measures.
- Hispanics received worse care than non-Hispanic whites for about 60% of core measures.
- Poor people received worse care than high-income people for about 80% of core measures. (Agency for Healthcare Research and Quality, 2011a)

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Disparities in access are also common, especially among Hispanics and poor people:

- Blacks had worse access to care than whites for one third of core measures.
- Asians and American Indians and Alaska Natives had worse access to care than whites for 1 of 5 core measures.
- Hispanics had worse access to care than non-Hispanic whites for 5 of 6 core measures.
- Poor people had worse access to care than high-income people for all 6 core measures. (Agency for Healthcare Research and Quality, 2011a.)

Examples of core measures include adults 40 and over with diabetes who received their exams, adults over age 50 who received a colonoscopy, and children ages 19 to 35 months who received their vaccines.

Limited Providers With the Same Ethnic Background

Ethnic minorities are poorly represented among physicians and other health care professionals. For almost all of the following list of health care occupations, Euro-Mediterraneans and Asians are overrepresented while blacks and Hispanics are underrepresented: physicians and surgeons, registered nurses, licensed practical and licensed vocational nurses, dentists, dental hygienists, dental assistants, pharmacists, occupational therapists, physical therapists, and speech-language pathologists (Agency for Healthcare Research and Quality, 2011b). Two exceptions were noted. Blacks are overrepresented among licensed practical and licensed vocational nurses, and Hispanics are overrepresented among dental assistants. Of the health care occupations tracked, these two require the least amount of education and have the lowest median annual wages (Agency for Healthcare Research and Quality, 2011b). More specifically, although African Americans, Hispanics, and Native Americans make up over a quarter of the nation's population, in 2007 African Americans accounted for only 3.5%, Hispanics 5%, and Native Americans/Native Alaskans 0.2% of physicians (American College of Physicians, 2010). Similar workforce disparities are found among some Asian subgroups, such as Samoans and Cambodians (American College of Physicians, 2010).

As a result, minority patients are frequently treated by professionals from a different racial or ethnic background. Many programs, funding agencies, and research studies suggest that more diversity is needed among health care professionals to improve quality of care and reduce health disparities. But is there evidence that racial concordance (patients being treated by people in the same ethnic group) accomplishes these goals?

A comprehensive review of research published between 1980 and 2008 was conducted by Meghani et al. (2009). Twenty-seven studies having at least one research question examining the effect of patient–provider race-concordance on minority patients' health outcomes and pertained to minorities in the United States were included in this review. Of the 27 studies, patient–provider race-concordance was associated with positive health outcomes for minorities in only 9 studies (33%); 8 studies (30%) found no association of race-concordance with the outcomes studied; and 10 studies (37%) presented mixed findings. The authors concluded that having a provider of same race did *not* improve "receipt of services" for minorities.

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Legal Protections for Ethnic Minorities

Many laws have been passed to help reduce discrimination, including in the health care arena. The Civil Rights Act of 1964 was passed by Congress and signed into law by President Lyndon Baines Johnson. Title VI of the Civil Rights Act prohibits federally funded programs or activities from discriminating on the basis of race, color, or national origin. Federal agencies are responsible for enforcement of this law. In areas involving discrimination in health care, the Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS), is responsible for enforcement. Title VI of the act is the operative section that informs nondiscrimination in health care. It has three key elements:

1. It established a national priority against discrimination in the use of federal funds.
2. It authorized federal agencies to establish standards of nondiscrimination.
3. It provided for enforcement by withholding funds or by any other means authorized by law.

Since the Civil Rights Act of 1964 was passed, numerous other statutes and regulations have been created to address discrimination against ethnic minorities in health care, including the **Hill-Burton Act**. The Hill-Burton Act has been amended a number of times since its inception. The amendment entitled "Community Service Assurance under Title IV of the U.S. Public Health Service Act" requires facilities to provide services to persons living within the service area without discrimination based on race, national origin, color, creed, or any other reason not related to the person's need for services. The subsequent HHS regulations set forth the requirements with which a Hill-Burton facility must comply (USHHS, Office for Civil Rights, 2006):

- A person residing in the Hill-Burton facility's service area has the right to medical treatment at the facility without regard to race, color, national origin, or creed.
- A Hill-Burton facility must post notices informing the public of its community service obligations in English and Spanish. If 10% or more of the households in the service area usually speak a language other than English or Spanish, the facility must translate the notice into that language and post it as well.
- A Hill-Burton facility may not deny emergency services to any person residing in the facility's service area on the grounds that the person is unable to pay for those services.
- A Hill-Burton facility may not adopt patient admission policies that have the effect of excluding persons on grounds of race, color, national origin, creed, or any other ground unrelated to the patient's need for the service or the availability of the needed service.

Title VI and HHS services regulations require recipients of federal financial assistance from HHS to take reasonable steps to provide meaningful access to limited English proficiency (LEP) persons. Federal financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance. Recipients of HHS assistance may include hospitals, nursing homes, home health agencies, managed care organizations, universities,

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and other entities with health or social service research programs. It also may include state Medicaid agencies; state, county, and local welfare agencies; programs for families, youth, and children; Head Start programs; public and private contractors, subcontractors, and vendors; and physicians and other providers who receive federal financial assistance from HHS (USHHS, Office for Civil Rights, n.d.).

Recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. The obligation to provide meaningful access is fact dependent and starts with an individualized assessment that balances four factors: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come into contact with the program; (3) the nature and importance of the program, activity, or service provided by the recipient to its beneficiaries; and (4) the resources available to the grantee/recipient and the costs of interpretation/translation services. There is no "one size fits all" solution for Title VI compliance with respect to LEP persons, and what constitutes "reasonable steps" for large providers may not be reasonable where small providers are concerned (USHHS, Office for Civil Rights, n.d.).

If, after completing the four-factor analysis, a recipient determines that it should provide language assistance services, a recipient may develop an implementation plan to address the identified needs of the LEP populations it serves. Recipients have considerable flexibility in developing this plan. The guidance provides five steps that may be helpful in designing such a plan: (1) identifying LEP individuals who need language assistance; (2) language assistance measures (such as how staff can obtain services or respond to LEP callers); (3) training staff; (4) providing notice to LEP persons (such as posting signs); and (5) monitoring and updating the LEP plan (USHHS, Office for Civil Rights, n.d.).

Culturally and Linguistically Appropriate Services (CLAS)

In compliance with Title VI and the LEP regulations, the HHS Office of Minority Health (OMH) has developed "National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)." In promulgating these standards, OMH provided its rationale for preparing the standards and recommendations for their use. The CLAS standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these standards is expected to help advance better health and health care in the United States. The CLAS standards are listed in **Table 1.2**.

It is worth noting that both federal and state governments have begun addressing the need for cultural competence through various standards and legislation. States are requiring cultural competence education in medical and nursing schools, and legislation in many states includes requiring cultural competence training for health care providers to receive licensure or relicensure. **Figure 1.6** highlights the states that are proposing to implement cultural competence training.

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TABLE 1.2 National CLAS Standards

Principal Standard
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
Governance, Leadership and Workforce
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
Communication and Language Assistance
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
Engagement, Continuous Improvement, and Accountability
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: USHHS, Office of Minority Health (n.d.).

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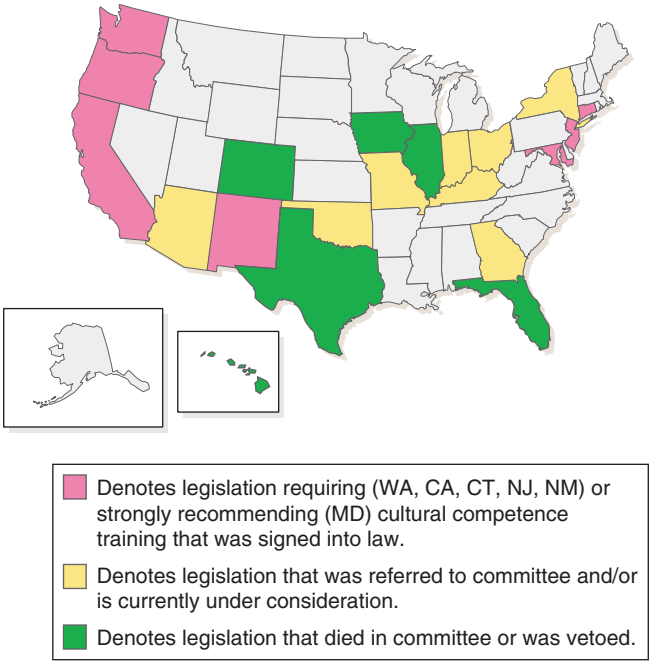

FIGURE 1.6
Map of states with cultural competence legislation.

Personal Health Decisions

Perhaps the area where law and cultural health issues intersect the most is in the area of personal health care decisions. How an individual approaches health care decisions is informed by his or her personal experiences as well as family, religious, and cultural influences. Different cultures approach how to undergo treatment, when to treat, and when to stop treatment differently. Even more important, who will make such decisions for a patient may differ from culture to culture.

Therefore, it is important to understand the legal construct that affects health care decisions. The laws of all the states reflect an individual's constitutional right to privacy and to make personal decisions free from outside influence. Consequently, the right to make health care decisions is personal to the patient involved, and no one else has the right to interfere. In cultures where family input is sought for such decisions, or a surrogate decision maker is used, this legal principle could create decision-making conflicts. A competent individual can appoint someone else to make decisions for him or her, thus removing the conflict.

The more problematic situation is when the patient is unable to make his or her wishes known because of the patient's medical condition. In that situation, it is important to have

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documents prepared in advance that name who will make decisions for the person and what decisions are to be made that are consistent with the person's cultural beliefs. Health care powers of attorney are documents that appoint who will make decisions for the person if he or she is unable to decide. A living will documents what decisions and desires a person has about his or her care and end-of-life decisions, and it can, and should, include instructions respecting the person's cultural beliefs. Many states have combined these two documents into one advance health care document that covers all the various decisions. Whatever format is utilized in a particular state, the importance of having these documents remains.

Ethical Considerations

Ethics point to standards or codes of behavior expected by the group to which the individual belongs. Ethics are different from morals in that **morality** refers to personal character and what the individual believes is right or wrong conduct. For example, a nurse's moral code may consider murder to be wrong, but the nurse has an ethical obligation to provide services for a murderer if the murderer is a patient in the medical facility.

The legal system is a set of rules and regulations that are binding on the members of a society and that set out what behavior is acceptable. They are subject to review and change as the society changes. The relationship between law and ethics significantly affects health care decisions and cultural influences. The ethical principles with the most impact on cultural issues in health care are autonomy, nonmaleficence, beneficence, and justice.

Autonomy is the ethical principle that embodies the right of self-determination. It is the right to choose what happens to one's self and decision making. It is embodied in the concept of informed consent in health care, which is the right to be informed about recommended treatment prior to consent. Autonomy requires that certain conditions exist, including understanding; an absence of controlling influences, which is traditionally understood as liberty; and agency, which is the ability to act intentionally (Beauchamp & Childress, 2001).

For this ethical principle to be achieved, the health care provider must respect and guard the patient's right to self-determination. This includes informing patients in a manner that considers both cultural and language barriers to understanding. The CLAS standards are an attempt to respect the ethical concept of autonomy. **Respect** takes into account individuals' rights to make determinations about their health and to live or die with the consequences. Respect for others does not allow cultural, gender, religious, or racial differences to interfere with that individual right. Respect is evident when the cultural heritage and practices of patients are considered in treatment even when the provider does not share that value.

In respect for autonomy, not only the right to choose is respected, but a right not to choose should be respected as well. Valuing a patient's right to defer decision making to another person, or not to be informed about the extent of his or her condition, is as essential to the principle of autonomy as ensuring that a patient who desires autonomy is fully informed about his or her treatment options.

Associated with respecting patient autonomy are two principles that should be followed by the caregiver: veracity and fidelity. **Veracity** involves being truthful and providing necessary

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information in an honest way. **Fidelity** entails keeping one's promises or commitments. It requires not promising what one cannot do or control. Both of these principles are necessary for patients to be truly informed about their care so they can make autonomous decisions.

Beneficence is the principle that requires doing good or removing harm. It is often intertwined with nonmaleficence, but it is a distinct ethical construct. Beneficence is at work when balancing the risk, benefit, harm, and effectiveness of treatment. When harm is found, positive actions are required to remove or limit it. This ethical principle was at work when segregated hospitals were outlawed by the Civil Rights Act.

Nonmaleficence is the principle that states that one should do no harm. Although simple in concept, it is often difficult in practice. In health care, actions can often cause harm, and very few treatment modalities are completely without risk of harm. Thus the practitioner must weigh the risks and benefits of any treatment.

However, it is the unknown harm that should be addressed in the cultural context. Practitioners should be aware that patients from cultures other than their own may perceive situations as harmful that are not readily apparent to them. For example, physical examination of a female by a male practitioner is considered to be unacceptable in some cultures and can lead to serious consequences for the female patient. Making arrangements for a female examiner would evidence the ethical concept of nonmaleficence.

Justice is the ethical principle that holds that people should be treated equally and fairly. Justice requires that people not be treated differently because of their culture or ethnic background. Justice is also at issue when the allocation and distribution of limited health resources are discussed. Ensuring that health resources are available to all without regard to race or ethnicity is the theory of distributive justice. It is this ethical principle that is breached when care is denied or withheld on racial or ethnic grounds.

The fair opportunity rule of justice states that no one should receive social benefits based on undeserved advantages or be denied benefits on the basis of disadvantages (Beauchamp & Childress, 2001). Although this may seem fairly straightforward, it becomes difficult to manage when applied to the variances of social inequalities. The rule states that discrimination is not ethically justifiable on the basis of social status or ethnicity.

Summary

One of the great attributes of the United States is its diverse landscape. Immigrants (voluntary and forced) who have come to the United States and natives of this country have experienced different levels of cultural adaptation to blend into the dominant society. Some have retained their strong cultural ties to create a society of rich and diverse cultures filled with various beliefs, traditions, languages, and societal norms. Understanding and respecting this diverse landscape is a goal for the nation, specifically for the health care industry. Health care providers need to be knowledgeable about and sensitive to cultural differences to provide effective care and education. Laws have been established to address inequalities.

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This chapter provides an understanding of the foundations of multicultural health and the key terms and concepts associated with it, such as culture, race, assimilation, and cultural relativism. You should now have a general appreciation of how culture affects health, the breadth and depth of health disparities and their related causes, as well as the legal protections provided to people in the United States.

Review

1. What is the focus of multicultural health, and why is it important?
2. Is race a biological or a social construct? Why is race important?
3. What is the difference between ethnicity and culture? What is the difference between race and ethnicity?
4. Explain cultural ethnocentricity and cultural relativism.
5. Explain the differences between the concepts of acculturation, assimilation, and bicultural.
6. Does the level of acculturation have a positive or negative effect on health? Explain.
7. Explain what health disparities are and their causes.
8. Describe the key intentions of the Civil Rights Act and the Hill-Burton Act.
9. Explain the ethical principles related to health care decision making and how they influence health care services.

Activity

Conduct research to identify a legal case related to health and culture. Write a paper explaining the situation, the court's decision and the reason behind the decision, and your reaction to the outcome.

Case Study

The book titled *The Spirit Catches You and You Fall Down*, by Anne Fadiman, tells the story of Lia Lee, a Hmong child with epilepsy, who lived in Merced, California. When 3-month-old Lia Lee arrived at the county hospital emergency room in Merced, a chain of events was set in motion from which Lia, her parents, and her doctors would never recover. Lia's parents, Foua and Nao Kao, were part of a large Hmong community in Merced, refugees from the "Quiet War" in Laos. Her parents and doctors both wanted the best for Lia, but their ideas about the causes of her illness and its treatment were very different.

The Hmong see illness and healing as spiritual matters that are linked to virtually everything in the universe, but the U.S. medical community marks a division between body and soul and concerns itself almost exclusively with the former. Lia's doctors attributed her seizures to the misfiring of her cerebral neurons; her parents called her illness "qaug dab peg"—the spirit catches you and you fall down—and ascribed it to the wandering of her soul. The doctors prescribed anticonvulsants; her parents preferred animal sacrifices. *The Spirit Catches You and You Fall Down* moves from hospital

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corridors to healing ceremonies, and from the hill country of Laos to the living rooms of Merced, uncovering in its path the complex sources and implications of two dramatically clashing worldviews.

Lia's doctors prescribed a complex regimen of medication designed to control her seizures. However, her parents believed that the epilepsy was a result of Lia "losing her soul" and did not give her the medication as indicated because of the complexity of the drug therapy and the adverse side effects. Instead, they did everything logical in terms of their Hmong beliefs to help her. They took her to a clan leader and shaman, sacrificed animals, and bought expensive amulets to guide her soul's return. Lia's doctors believed that her parents were endangering her life by not giving her the medication, so they called child protective services, and Lia was placed in foster care. Lia was a victim of a misunderstanding between these two cultures that were both intent on saving her. The results were disastrous: a close family was separated, and Hmong community faith in Western doctors was shaken.

Lia was surrounded by people who wanted the best for her and her health. Unfortunately, the involved parties disagreed on the best treatment because they understood her epilepsy differently. The separate cultures of Lia's caretakers had different concepts of health and illness.

This example illustrates how culture and health influence each other and at times clash. To help ensure good care for diverse patients, health care providers must address cultural issues and respect the cultural values of each patient.

There are several issues to consider about this case:

- How can health care providers prepare for situations like Lia's?
- Should child protective services have been contacted?
- Were Lia's parents irresponsible?
- How did the parents' belief system affect Lia's health care?
- Were the parents' decisions morally and legally wrong?

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