

An Annotated Bibliography:

Multicultural Health: Setting the Stage for Innovative and Creative Approaches



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Prepared for The California Endowment - July 1999

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Dear Colleague:

Multicultural health is a vital component of The California Endowment's mission to improve the health of all Californians and plays an increasingly important role as California strives to meet the needs of its changing population. The California Endowment believes that only by addressing health in the context of culture, can we enhance the quality of care, reduce disparities among residents, cut costs associated with delayed care and use of emergency services, assist health providers to develop more effective policies and enhance cultural competency and diversity in the health work force.

It is with these thoughts in mind that The California Endowment presents this annotated bibliography - ***Multicultural Health: Setting the Stage for Innovative and Creative Approaches***.

This piece gives us a glimpse into the unique health needs of underserved populations – and demonstrates the ways that race, class, gender, disability, sexual orientation and economics affect a community's ability to receive quality health care. It is meant to serve as a reference point – a compass to direct those who are interested in learning about how to improve health care for California's diverse residents.

As you will see, this bibliography is not comprehensive, rather it helps us to understand the work we have yet to accomplish. The California Endowment is committed to the field of multicultural health. It is our hope that this report illustrates the need for greater resources, research and education to be directed toward the field of multicultural health.

Sincerely,

E. Lewis Reid
President and Chief Executive Officer

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Introduction

Setting the Stage for Innovative and Creative Approaches to Multicultural Health

In Sonoma County, California, a farm worker waiting to hear about his INS application to adjust his status to permanent residency, cut his hand badly on the job. He was so afraid of jeopardizing his pending application that he refused to go to the hospital or clinic to get medical care. Instead, he used peroxide and stitched his hand himself, risking infection and permanent damage.

A 51-year old Korean immigrant with a conditional green card who lives in L.A. County with her husband can no longer work because she is very ill. She would like to apply for Medicaid because of her medical problems, but she is afraid to do so. She believes that getting Medicaid right now will jeopardize her ability to remove the condition from her green card. She is currently not seeking medical attention.

In East Los Angeles, California a forty-year-old pregnant woman, married to a U.S. citizen, has decided not to apply for Medicaid benefits to get pre-natal care even though she is eligible. She believes that if she receives Medicaid her application for adjustment for permanent residency will be denied, and she could be separated from her family. She has developed pregnancy-related diabetes. Without care and appropriate monitoring, the clinic where she was receiving care feels that both mother and child are at risk of major medical complications.¹

These vignettes illustrate the plight of many of California's populations who because of the intersection of class, ethnicity, immigration status, and public policy are falling through the cracks of what is believed to be one of the most progressive health care systems in the nation. They illustrate the need to examine critically a host of issues related to achieving health and social justice for the state's diverse communities. As a state that is rapidly becoming a bell-weather of demographic and socioeconomic change for the country, California will soon be comprised of a majority of people with ancestral and cultural roots in Asia, Latin America, and

¹ Vignettes excerpted from cases described in Schlosberg, C. and Wiley, D. "The Impact of INS Public Care Determinations on Immigrant Access to Health Care." National Immigration Law Center, May 22, 1998.

Africa. This demographic reality will continue to impact many aspects of socioeconomic and political life, and the arenas of health policy, services, and intervention programs are no exception. Cultural, ethnic and linguistic diversity present many opportunities for enriching contemporary health and social service systems as well as many challenges. Diverse communities have strong legacies of indigenous healing traditions and cultural strengths that can be a source of innovation and creativity for stimulating and preserving health. However, many of these communities are socially and economically disenfranchised and experience serious, longstanding deficiencies in health status. Generally rooted in social inequality, these problems are intensified by the lack of access to culturally appropriate health care. They illustrate the urgency of developing and supporting more culturally flexible, sustainable, and responsive health service delivery and social institutions to alleviate poor health, stressful life conditions and early mortality experienced by ethnic minorities and other marginalized populations.

This annotated bibliography provides a focused literature survey to increase knowledge in the area of multicultural health as a part of the process of creating culturally appropriate health intervention programs, policy, and social services. The multicultural health framework used to build the bibliography reflects concepts embraced by The California Endowment; these concepts emphasize the importance of respecting and valuing diversity and assume a stance of cultural humility when approaching groups from other cultural backgrounds. The term multicultural is defined broadly and includes populations that differ from the dominant North American culture in terms of race, ethnicity, language, sexual orientation, and disability status. However this framework does not assume that cultural groups are homogeneous in terms of their socio-economic position or experience with health care programs. Moreover, special attention is paid to the importance of multiple identities within cultural groups such as gay, lesbian, bisexual, and transgender communities who are from different racial and ethnic backgrounds.

This bibliography encompasses several critical areas for understanding and addressing disparities in the health status and social experiences of diverse cultural groups within North American society. These areas include the relationship between socio-political forces and health status and behavior; the influence of cultural patterns, beliefs, and values on health; issues related to health care access and diversity in the workforce; mandates and models for achieving cultural competency; best practices in community-based interventions; and applied research and evaluation approaches for health care interventions. The intended audiences for the bibliography are health care practitioners, social service workers and policy advocates, as well as students and consumers representing all cultural backgrounds.

Section I of the bibliography focuses on the dynamic interplay between political, economic, and social forces and health among multicultural populations. This section includes sub-sections on the relationship between race, social class, gender and health status; the role of social policy in influencing health disparities and health access; the relationship between racism and

bioethics; and the impact of environmental inequality on the health status of people of color. The unifying theme of these articles is the importance of socio-economic and political phenomena such as racism, poverty, institutionalized discrimination, segregation and anti-immigrant policies, in shaping the life chances and health opportunities of ethnic minorities and other marginalized populations. These factors affect housing quality, nutrition, employment, working conditions, education, stress, exposure to pollution and disease agents, and access to health care—all of which contribute to disparities in health status. Alleviating these systemic disparities ultimately requires advocating for social and economic justice as the cornerstone of any public health policy and community-based intervention program aimed at improving the health status of disadvantaged groups.

Section II of the bibliography explores the impact of cultural beliefs, values, and behavior on health. Several themes are highlighted, including the relationship between migration, acculturation and health status and behavior among immigrant groups in North American society such as Latinos and Asian Americans and Pacific Islanders. Cultural retention, bi-culturalism and cultural change have been shown to have important effects on concepts of health and disease, physical and mental health status, as well as on health behavior and health service utilization among diverse immigrant groups. An important aspect of the cultural legacy of these groups is their indigenous healing traditions which often remain a source of support and treatment, particularly for chronic diseases, alcohol and drug abuse, and mental health problems. The cultural context and ideology of sexual orientation across ethnic and racial groups is also explored in this section. Differences in gender roles, family structure, and cultural values all affect the expression of sexual identity and sexual behavior among various cultural groups and have implications for how they relate to health services. The cultural aspects of disability in North American society are also explored in this section by including studies that examine differences in the ways some cultural groups conceptualize disabilities and what strategies and networks they use to cope with these issues.

Section III examines the myriad of factors affecting access to health care services. The first topic explores the extensive literature documenting racial and socio-economic disparities in health care delivery. Racial minorities and low income groups systematically receive inadequate, inappropriate, or lower quality health care services for any number of medical problems including heart diseases, kidney diseases, eye problems, and cancer. These disparities have been attributed to racial bias, housing segregation, poverty, and insurance status. In addition to race and class bias, access to health care has been greatly affected by linguistic and cultural barriers. The lack of bicultural and bilingual health care personnel in the US has led to such problems as the under-utilization of health care services by many immigrant or ethnic minority communities; receiving inappropriate diagnoses and treatment by health care providers; and misunderstanding of health care protocols in clinical encounters. Cultural insensitivity and bias often characterize the interaction between health care service providers

and gay, lesbian, bisexual, and transgender people, as well as the disabled community. Stigmatizing attitudes and a poor knowledge of health care needs leads to the under utilization of health care services in both of these communities. Disabled people may be denied access to services due to the lack of proper equipment or technology to address specific health care needs. The inability of most therapists to use sign language is a case in point. The impact of managed care on poor and ethnic minority populations is explored in the final part of this section. The rapid transformation in health care delivery to managed care systems has also adversely impacted health care access for some population groups. The economic incentives implicit in managed care plans can make it difficult to effectively serve populations who need bicultural/bilingual providers or other specialized health care services.

Section IV examines the issue of diversity in the health care work force. Developing a multicultural workforce at all levels of public health and medicine is critical for addressing disparities in health and social status. Health care utilization, cultural sensitivity, cultural competence, and community participation are all enhanced by having a diverse workforce. The passage of Proposition 209 has severely challenged ongoing efforts to develop and train an adequate pool of multicultural physicians, nurses, public health practitioners, researchers, and community outreach workers in California. For example, in the wake of this initiative, minority applications to medical school declined 22% in California compared to 14% nationwide. The effect of anti-affirmative action legislation and welfare reform is reviewed in this section along with promising models and training programs that seek to increase diversity in the health care workforce.

The issue of cultural competency constitutes the core of Section V. The section examines official mandates describing principles, standards, and definitions of cultural competency for health care organizations. These principles encompass the need for effective, culturally relevant services based on the use of bi-lingual, bi-cultural staff, as well as community outreach, assessment, and participation in health service delivery. Studies in this section also review theories and innovative models for developing cultural competence in health care delivery.

The literature reviewed in Section VI focuses on community based interventions for public health and social change. Key principles for achieving social justice and promoting health and social change include ensuring the participation of community members not only as recipients of services, but also as leaders and architects of social change; using approaches that respect and affirm cultural heritage and social ties; and implementing multi-level strategies that emphasize transforming environmental and community-level problems (e.g. unemployment, pollution, housing problems), as well as individual health behavior.

The final section of the bibliography examines promising research approaches that are especially relevant for addressing multicultural health issues. A critical area of concern in implementing programs for cultural competency is evaluating their effectiveness. Several studies explore evaluation principles that can be used to plan and assess efforts to increase cultural sensitivity in health care delivery and training. Another aspect of this section includes applied research that seeks to promote awareness and social action regarding health problems in community settings.

In sum, this annotated bibliography brings together selected references, including articles and books, in order to explore key themes regarding the large and dynamic arena of multicultural health. Hopefully, these resources will be useful in giving voice to some of the experiences of those who have been invisible or marginalized within our society and its health care institutions. This is a beginning step in the ongoing struggle to achieve health equity, and ultimately social justice, for all communities in California.

I. Social Determinants of Health

A. Impact of Race, Class and Gender on Health Status and Behavior

B. Impact of Health Policy and Politics on Health

C. Bioethics

D. Environmental Factors and Multicultural Health

A. *Impact of Race, Class and Gender on Health Status and Behavior*

Bound J., Schoenbaum M. and Waidmann T. (1996). "Race differences in labor force attachment and disability status." *The Gerontologist* 36: 311-321.

This is a study of 8,637 Black and White respondents (ages 50-62) who completed the national Health and Retirement Survey to assess "what the labor force participation rate of Black and White men and women would be if their health status were the same as that of their White counterparts." Respondents answered questions regarding their sociodemographic characteristics, their occupations, their general health status, their specific functional status, and their application for government assistance for disability-related supplemental income.

Previous studies found that Black men and women are more likely to label themselves unable to work; that Black men participate in the labor force to a lesser extent than White men, and that this gap in participation widens with increasing age; and that Black women participate in the workforce to a greater extent than White women, a difference that narrows with increasing age. In this study, authors found: 1) Black men and women are much more likely to apply for Social Security Disability Insurance and Supplemental Security Income, and that virtually all of this difference can be accounted for by differences in health and disability status between Blacks and Whites. 2) Much of the difference in timing of earlier labor force exit for Black men versus White men is accounted for by differences in health and disability status. 3) In their model, health differences accounted for all of the 2:1 difference in Black men out of the work force compared with White men. 4) If Black women had been as healthy and able to work as White women, their labor force participation would have actually been higher than that of White women.

Brunner E. (1997). "Stress and the biology of inequality." *British Medical Journal* 314: 1472-1476.

This is a brief but intriguing review of the literature documenting the neuroendocrine and biochemical effects of stress and suboptimal social relations. Examples include the following: the release of cortisol (a stress hormone) in response to stress has been shown to suppress immune function; high density lipoproteins (protective against cardiovascular disease) have been shown to rise with socioeconomic status in both genders; low perceived control is associated with high concentrations of a biochemical marker for cardiovascular disease.

The author asserts, "The biological perspective does not detract from the primary importance of social organization in generating health inequities, but it can provide an approach to determining the specific aspects of the psychosocial environment that influence health." This article is included for reasons of completeness, as the most direct example of "how we literally incorporate, biologically, social relations into our bodies..."

David, R. and Collins J. (1991). "Bad outcomes in black babies: Race or racism?" *Ethnicity and Disease 1: 236-244.*

The gap between Black and White infant death rates in the United States has grown over the last three decades. Epidemiologic and medical studies by investigators seeking to understand and reverse this adverse trend have been unsuccessful. Researchers have looked in vain for the combination of social and environmental risk factors that are more common among Blacks and would therefore explain this group's poor reproductive outcomes. The implicit alternate hypothesis is genetic differences between Blacks and Whites. In fact, there is more of a gap between Black and White mothers of higher socioeconomic position than between overall Black and White rates without socioeconomic stratification. An alternative to the genetic theory explains these results, however, on the basis of social factors that, because of the presence of widespread discrimination in the society under study, apply only to Blacks. Such factors are the effects of racism, not race per se. Several lines of research are needed to investigate the effects of racism on perinatal outcomes, including studies on psychophysiological reactions to racial discrimination and on ethnic group differences in coping mechanisms, social supports, and physical environment. Analysis of trends over the past 37 years indicates that improvements in White (and total U.S.) infant mortality rates cannot be anticipated until the racial gap is closed.

Hahn R., Eaker E., Barker N., Teutsch S., Sosniak W. and Krieger N. (1996). "Poverty and death in the United States." *International Journal of Health Services 26: 673-90.*

The authors conducted a survival analysis to determine the effect of poverty on mortality in a national sample of Blacks and Whites, 25 years of age (the first National Health and Nutrition Examination (NHANES-1 and NHANES-1 Epidemiologic Follow up Study). They determined the proportion of mortality associated with poverty during 1971-1984 and 1991 by calculating population attributable risk and assessed by major known risk factors (e.g., smoking, cholesterol levels, and physical inactivity). In 1973, 6.0 percent of U.S. mortality among Black and White persons 25 to 74 years of age was attributable to poverty; in 1991, the proportion was 5.9 percent. In 1991, rates of mortality attributable to poverty were lowest for White women, 2.2 times as high for White men, 8.6 times as high for Black men, and 3.6 times as high for women. Adjustment for all these potential confounders combined had little effect on the hazard ratio among men, but reduced the effect of mortality among women by 42 percent. The proportion of mortality attributable to poverty among U.S. Black and White adults has changed minimally in recent decades. The effect of poverty on mortality must largely be explained by conditions other than commonly recognized risk factors.

Hart K., Kunitz S., Sell R. and Mukamel D. (1998). "Metropolitan governance, residential segregation, and mortality among African Americans." *American Journal of Public Health* **88**: 434-8.

This study tested the hypothesis that the degree the government is metropolitanized is associated with mortality rates of African Americans and with residential segregation, which has itself previously been shown to be positively associated with mortality among African Americans. One hundred fourteen U.S. standard statistical areas were examined. The primary dependent variable was the age-adjusted, race- and sex-specific all-cause mortality rate, averaged for 1990 and 1991. The two primary independent variables were residential segregation, as measured by the index of dissimilarity, and metropolitanization of government, as measured by the central city's elasticity score. Mortality rates for male and female Americans were lower in metropolitan statistical areas with more metropolitanized local governments and lower levels of residential segregation. Mortality for male and female Whites was not associated in either direction with residential segregation. White male mortality showed no association with level of metropolitanization, but lower White mortality rates were associated with less metropolitanization. This study suggests the need for further research into whether changes in areas not traditionally thought of as "health policy" improve the health of urban minorities.

Kaplan G., Pamuk E., Lynch J., Cohen R. and Balfour J. (1996). "Inequality in income and mortality in the United States: Analysis of mortality and potential pathways." *British Medical Journal* **312**: 999-1003.

The authors designed a study to examine the relation between health outcomes and the equality with which income is distributed in the United States. They examined the degree of income inequality, defined as the percentage of total household income received by the less well off 50 percent of households. Changes in inequality were calculated for the 50 states in 1980 and 1990. These measures were then examined in relation to all cause mortality adjusted for age for each state, age specific deaths, changes in mortalities, and other health outcomes and potential pathways for 1980, 1990, and 1989-91.

They found that states that had greater inequality in the distribution of income also had higher rates of unemployment and incarceration, more people receiving income assistance and food stamps, and larger numbers of medically uninsured people. These states also spent a smaller proportion of total spending on education and had poorer educational outcomes, ranging from poor reading and proficiency in mathematics to lower rates of completion of high school education. In addition, income inequality was a strong predictor of trends in mortality, measured as percentage change in age adjusted mortality between 1980 and 1990 ($r=-0.62$; $P<0.001$).

Authors conclude that variations between states in the inequality of the distribution of income are significantly associated with variations between a large number of health outcomes and social indicators and with mortality trends. These differences parallel relative investments in human and social capital. Economic policies such as taxation policy, benefits, and income transfers, that influence income and wealth inequality may have an important impact on the health of countries.

Kawachi L. and Kennedy B. (1997). "Health and social cohesion: Why care about income inequality?" *British Medical Journal* 314: 1037-1040.

There is growing evidence that income inequality (the growing disparity between the rich and poor) impacts negatively on mortality and morbidity. One theory to explain the impact of income inequality is an erosion in the social fabric of communities that results from increasing income inequity. Two dimensions of social cohesion that have been strongly correlated with income inequality and with overall mortality are the degree to which citizens distrust one another and the density of "associational life," or membership in church groups, sports groups, labor unions, et cetera. Authors posit that the greater concentration of the poor leads to segregated communities characterized by marked differences in investment in public education and other municipal services, for example. The "segregated nature of the resulting forms of social capital will tend to undermine social cohesion in the society at large." Disparities in mortality associated with regional differences in income inequality and social cohesion exemplify how we incorporate, biologically, our social relations. The authors suggest further study into how income inequality specifically impacts health, or, alternatively, that simply putting "a halt to the growth in income inequality" could lead to a decrease in variations of excess burdens of mortality and morbidity.

Krieger N. (1990). "Racial and gender discrimination: Risk factors for high blood pressure?" *Social Science and Medicine* 30: 1273-1281.

Phone interviews of 51 Black and 50 White women, ages 20-80, who lived in Alameda County in 1987 were administered to ascertain the extent and response to gender and racial discrimination and their relation to hypertension. A present or past diagnosis of hypertension status was self-reported. No relationship between reported gender discrimination and blood pressure existed among the White women. However, Black women who reported that they kept quiet about and accepted unfair treatment were over four times as likely to report having had a diagnosis of hypertension than those Black women who said they talked to others or acted against the discriminatory act. Black women who "least recounted racist or sexist incidents" were at greater risk for self-reported high blood pressure. These data suggest that the social experience of being Black in the United States "carries a risk for high blood pressure that can be modified by, but not reduced to, gender and class position."

Krieger N. (1996). "Inequality, diversity and health: Thoughts on "race/ethnicity" and gender." *Journal of the American Women's Association* 51: 133-136.

An excellent, insightful 'thought piece' that focuses dialogue on the language of how we describe and subsequently approach solutions to inequities in health status. Krieger illustrates how the politically neutral, euphemistic terms we use often obscure responsibility and divert attention 1) "away from the social and economic forces driving inadequate population distributions of health, and 2) away from the social and economic groups who benefit from social inequalities they produce and maintain." She juxtaposes the more widely used biomedical model ("emphasizes disease processes in humans construed chiefly as biological organisms") to the potentially more fruitful ecological model which asks, "how we literally incorporate, biologically, social relations (such as those of social class, race/ethnicity, and gender) into our bodies thereby focusing attention on who and what drives population patterns of health, disease and well-being." Krieger would expand the intellectual, research, and policy agendas to include honest and critical, specific, and directed inquiries into the effects on health of the discriminatory practices of social institutions, the effects of everyday experiences of discrimination on the health of individuals, and the "racially coded" attacks on social welfare programs.

Krieger N. and Fee E. (1994). "Man-Made medicine and women's health: the biopolitics of sex gender, and race ethnicity." *International Journal of Health Services* 24: 265-283.

National vital statistics in the United States present data in terms of race, sex, and age, treated as biological variables. Some races are clearly of more interest than others: data are usually available for Whites and Blacks, and increasingly for Hispanics, but seldom for Native Americans or Asians and Pacific Islanders. These data indicate that White men and women generally have the best health and that men and women, within each racial/ethnic group, have different patterns of disease.

Obviously, the health status of men and women differs for conditions related to reproduction, but it differs for many nonreproductive conditions as well. In national health data, patterns of disease by race and sex are emphasized while social class differences are ignored. This article discusses how race and sex became such all-important, self-evident categories in 19th and 20th century biomedical thought and practice. It examines the consequences of these categories for knowledge about health and for the provision of health care. It then presents alternative approaches to understanding the relationship between race/ethnicity, gender, and health, with reference to the neglected category of social class.

Krieger N., Rowley D., Herman A., Avery B. and Phillips M. (1993). "Racism, sexism, and social class: Implications for studies on health, disease, and well-being." *American Journal of Preventive Medicine* 9 (6 Suppl.): 82-122.

Though written as a discussion of birth outcomes, this is perhaps the most comprehensive journal article (495 references) on the topic of how racism, sexism and social class contribute to disparate patterns of disease. The authors first present theoretical constructs and approaches in studying disparities in health status by race, gender, and class. They then consider the evidence of the impacts of racism, sexism, and classism on health status and health care delivery. They describe the "new research" which explores how "social relations are determinants of population patterns of disease through four principle pathways: 1) by shaping exposure and susceptibility to risk factors, events and processes; 2) by shaping exposure and susceptibility to protective factors, events and processes; 3) by shaping access to, and type of, health care received; and 4) by shaping health research and health policy." Recommendations are discussed for future research specifically in the area of birth outcomes.

Laveist T, 1993. "Segregation, poverty, and empowerment: Health consequences for African Americans." *Milbank Quarterly* 71: 41-64.

In spite of strong achievements in improving the chances of survival for infants born in the United States, there has been little success in reducing the national Black-White differential in infant mortality. The Black infant mortality rate has been reported consistently to be double the White rate. However, when this mortality disparity is examined within smaller geographic units, a more complex relationship between race and infant mortality emerges. There is, indeed, substantial geographic variation in the degree of Black to White relative disadvantage.

Three factors distinguished cities in this analysis: segregation, poverty, and Black political empowerment. Because these are malleable social factors, policy and other interventions have the potential to be effective.

Pappas G, Queen S, Hadden W. and Fisher G. (1993). "The increasing disparity in mortality between socioeconomic groups in the United States, 1960 and 1986." *New England Journal of Medicine* 329: 103-109.

This classic article is one of the most often-referenced in studies and discussions on the social determinants of health in the U.S. Results from national data sets show that the well-documented inverse relationship between socioeconomic status and mortality has persisted from 1960 (of course, before that as well) to 1986, and actually was stronger in 1986. That is, the disparity between those with low levels of education and those with higher levels of education increased over these 26 years by 30 percent for Black women and 23 percent for White women. Inequality in mortality rates according to educational level doubled for Black men and White men during this period, similar trends existed for income.

Shoemaker W., James C., King L., Hardin E. and Ordog G. (1993). "Urban violence in Los Angeles in the aftermath of the riots. A perspective from health care professionals, with implications for social reconstruction." *Journal of the American Medical Association* 270: 2833-2837.

A hard hitting, eloquently written commentary on the impact of what the authors depict as misguided public policy on the magnitude of the violence epidemic, with particular attention to the Los Angeles area. Approaching "violence as a response to social injustice," the authors review the contributions of inadequate educational and economic opportunities, and the ineffective and "redundantly expensive" law and order approach to violence. They include valuable cost analyses of each of these three public policy arenas. They posit a broader advocacy role for health professionals in this multidimensional threat to the public's health: "Given the dominant role of the medical profession in social and civic life, it is now appropriate for the medical profession to enter the debate on health improvement, violence deterrence, and the general field of social construction." This is a good case study of how our dysfunctional social relations on a societal level and in various public policy arenas, have contributed to the "hostility, anguish, and alienation" that fuel the violence epidemic.

Waitzman N. and Smith K. (1994). "The effects of occupational class transitions on hypertension: Racial disparities among working age men." *American Journal of Public Health* 84: 945-950.

A nationally representative sample of White (N=1799) and Black (N=183) men, ages 25-55, were followed for at least 7 years to assess the association between occupational class transitions and blood pressure changes. After controlling for obesity, alcohol intake, urban residence, measure of poverty, baseline ages, and the time between baseline and follow-up exams, Whites and Blacks who stayed in the "lower" occupational classes developed uncontrolled hypertension more frequently than did Whites remaining in the "highest" occupational class. Blacks had more than twice the risk of Whites of developing uncontrolled hypertension as Whites in the same class. Both Blacks and Whites who moved down in their occupational classes had a higher rate of uncontrolled hypertension, although the risk was much higher for Blacks. Authors conclude the "reduced prospects for vocational training and occupational mobility may play a significant role in the incidence of hypertension and may be an important factor in racial differences in hypertension and, by extension, in the incidence of heart disease." This study suggests that the societal relations/dimensions of class and race are independent and interactional facts in the manifestation of biologic disease.

Wallace R. (1990). "Urban desertification, public health and public order: 'Planned shrinkage', violent death, substance abuse, and AIDS in the Bronx." *Social Science and Medicine* 31: 801-813.

The author presents a refreshingly creative and fascinating, albeit complex theoretical and analytical framework for the differential distribution and spread of some of the most vexing public health challenges of our time. The author uses regression analyses, maps of geographic distribution of disease over time, measures of withdrawal of municipal services, and maps of resident 'flight' from areas of urban decay (including measures of pupil transfers from community school districts). A summary of this important article is best presented in the author's own words: "Empirical and theoretical analyses strongly imply...sharply rising levels of violent death, intensification of deviant behaviors implicated in the spread of AIDS, and the pattern of the AIDS outbreak itself, have been gravely affected, and even strongly determined by the outcomes of a program of 'planned shrinkage' directed against African American and Hispanic communities, and implemented through a systematic and continuing denial of municipal services...essential for maintaining urban levels of population density and ensuring community stability...[These] results strengthen the obvious inference that the origins of public health and public order are much the same and deeply embedded in the security and stability of personal, domestic and community social networks and other institutions...With destruction of housing and community there is concomitant intensification of a nexus of deviant behaviors including (but not limited to) homicide, suicide, and substance abuse that expresses itself, among other ways, in the patterns of the AIDS outbreak."

Wallace R. and Wallace D. (1997). "Community marginalisation and the diffusion of disease and disorder in the United States." *British Medical Journal* 314: 1341-145.

This is a critically important article for understanding variations in the distribution of disease. The authors debunk the "cultural assumption" that widespread benign neglect and disinvestment in poor communities result in containment of disease. They present a review of the sociogeographic theory of disease spread and distribution. They present a highly accurate model (over 90 percent accurate) of predicting the geographic distribution and temporal spread of AIDS, violent crime, and tuberculosis in New York City. They demonstrate how this spread begins in the marginalized inner cities, travels along national travel routes to smaller cities, and then from the central portions of these smaller cities to the suburbs, the latter predictably following daily commute routes.

They further argue that public health is driven by factors operant most cogently at the neighborhood level, hence the profound effect of selective, national and regional disinvestment and benign neglect of these poor neighborhoods. "As a neighborhood disintegrates under the assaults of public policies of planned shrinkages and benign neglect,...weak ties begin to fray...Youth behavior such as doing well in school, getting a regular job, avoiding substance

abuse, and maintaining stable relationships become more difficult and the neighborhood structures that value such attainments dissolve. Negative acts such as violent behavior, multiple sexual conquests, and drug taking are messages that can be more easily 'heard' in a dissolving community than positive acts...Public policies and economic practices which increase marginalisation act to damage the 'weak ties' of the community social networks which bind central city neighborhoods into functioning units. Spreading disease and disorder can be interpreted as indices of the resulting disintegration, which is driven by policy." The authors put forth the notion that even in our 'flight' from the central cities, we cannot escape our interconnectedness and interdependence. With specific examples, this article represents a profoundly powerful example of how our social relations come to be incorporated biologically into our beings, and how our social relations impact the observed disparate distribution of disease.

Zierler S. and Krieger N. (1997). "Reframing women's risk: Social inequalities and HIV infection." *Annual Review of Public Health 18*: 401-36.

Social inequalities lie at the heart of risk of HIV infection among in the United States. As of December 1995, 71,818 U.S. women had AIDS-defining diagnoses. These women have been disproportionately African-American, and Latina. Their neighborhoods have been burdened by poverty, racism, crack cocaine, heroin, and violence. To explain which women are at risk and why, this article reviews the epidemiology of AIDS among women in light of four conceptual frameworks linking social justice: feminism, social production of disease/political health, ecosocial, and human rights. The article applies these theories to describe sociopolitical contexts for AIDS' emergence and spread in the United States, and reviews evidence linking inequalities of race/ethnicity, gender, and sexuality, as well as strategies of resistance to these inequalities, to the distribution of HIV among women.

B. Impact of Health Policy and Politics on Health

Aaronson S. and Hartmann H. (1996). "Reform, not rhetoric: A critique of welfare policy and charting of new directions." *American Journal of Orthopsychiatry 66*: 583-598.

This article reviews elements of welfare reform policy, together with common misconceptions about welfare recipients upon which many of these policies are built. They offer alternative policy options to those described as "punitive," including the improvement of "enforcement of equal opportunity laws and programs that reduce workplace discrimination." Women, particularly women of color, face significant discrimination in the workforce. They are segregated into low wage occupations that provide low benefits. As such, the authors' recommendations include enforcing pay-equity programs with respect to gender. They end their prescriptions with a call for social scientists to facilitate and "reconnect" their research to

policy implications: "...social scientists must work to increase the role of research in policy formation by making sure their work is accessible to policy makers. One particular challenge researchers face now is to monitor the ongoing changes in welfare policy in the states to assess their effect on women and children. Such research could be instrumental in decreasing the amount of rhetoric in the welfare reform debate, and opening the way for the creation of policies based on the real lives of poor women and children."

Calavita K. (1996). "The new politics of immigration—balanced budget conservatism and the symbolism of proposition 187." *Social Problems* 43: 284-305.

This paper focuses on the politics of the new immigration restrictionism as manifest in Proposition 187, passed by California voters in 1994. The author first shows that restrictionist sentiments and immigrant scapegoating have a long history in U.S. immigration politics, through reviewing three periods of early nativism: 1870s to the 1890s; 1900 to World War I; and World War I and its aftermath. She makes two principal arguments: First, that the new nativism embodied in Proposition 187—which would bar undocumented immigrants in California from receiving social services, including public schooling—corresponds to specific features of the late twentieth-century political/economic landscape. In particular, she links the focus on the alleged tax burden of immigrants and their costly use of social services to ongoing economic transformation, the retrenchment of the welfare state, and what Plotkin and Scheuerman (1994) call "balanced-budget conservatism." Second, following Edelman (1977) she shows that Proposition 187 is symbolic in that it derives from and evokes beliefs about immigrants' responsibility and blame for the current economic and fiscal crisis. In addition, she suggests that Proposition 187 may represent a new kind of symbolic politics in which alienated voters use their ballot symbolically to express anger and "send a message."

Fenton J., Catalano R. and Hargreaves W. (1996). "Effect of Proposition 187 on mental health services use in California: A case study." *Health Affairs* 15: 183-190.

In this DataWatch the authors examine whether the passage of California's Proposition 187 affected the use of mental health services in San Francisco County. Using time-series analyses, they identified a 26 percent decrease in the initiation of outpatient mental health services by younger Hispanics at selected services sites after the passage of Proposition 187 in November 1994. Further analyses suggests that decreased use of outpatient mental health services by young Hispanics was associated with their subsequent increased use of crisis services. Other studies of Proposition 187's effect on mental health service use in California are needed to corroborate the findings of this case study.

Gans H. (1990). "Deconstructing the underclass: The term's dangers as a planning concept." *Journal of the American Planning Association* 56: 271-277.

Urban planning has become hospitable to concepts and terms from other disciplines and professions. At times, planners also use the buzzwords that show up in the public discourse of these disciplines and professions as well as in the news media, official reports, and other material targeted at elite and college-educated Americans.

One of the concepts planners, along with other public and social policy makers, have begun to pay attention to most recently is the underclass. While this word can be used as a graphic technical term for the growing number of persistently poor and jobless North Americans, it is also a value-laden, increasingly pejorative term that seems to be becoming the newest buzzword for the undeserving poor. Consequently, the term 'underclass' needs badly to be taken apart analytically and critically. Although the term itself is less dangerous than the attitudes underlying it, its general usage, and the effects of that usage, make it into one of those words that ultimately become sticks and stones. This article describes ten major dangers of the term, not just for the poor but also for planners and social policy makers.

Garcia R. (1995). "Critical race theory and proposition 187: The racial politics of immigration law." *Chicano-Latino Law Review* 17: 118-154.

With the end of legally sanctioned race discrimination in the 1960s, immigration rhetoric has lost some of its overt racist overtones. However, in the 1990s, many politicians and lawmakers have emphasized the difference between "legal" and "illegal" immigration. Despite this rhetorical concern for law and order, immigration law and policy continue to be at least partially motivated by a drive for racial and cultural homogeneity. Focusing on Proposition 187, this comment uses Critical Race Theory to explore the racial underpinnings of immigration law and how purportedly race-neutral laws perpetuate racial and ethnic subordination.

Ladenheim K. (1997). "Health insurance of foreign-born U.S. residents—The implications of the new welfare reform law." *American Journal of Public Health* 87: 12-13.

Ladenheim comments on a recent study that shows that foreign-born U.S. residents are less likely to be insured than those born in the United States, with differences in rates of coverage persisting for 15 years post-immigration. This author considers the possibility that this finding might not be due simply to adaptation or maturation effects, but rather to the notion that there is a different cohort of less skilled, less educated immigrants in more progressively recent years. The author raises the following concerns in light of welfare reform: 1) the federal government's handing over of the provision and financing of health care to the state and county government simply shifts the responsibility to already overburdened systems. "Welfare reform is an exercise in federal hand washing that abrogates federal constitutional responsibility for the consequences of immigration policy for lower levels of government;" 2) elderly

immigrants, who could previously obtain Medicaid coverage through SSI will have to rely increasingly on family support; and 3) “hampering access to adult education and language programs, the new law also will slow the integration of current immigrants into the workforce and thus limit their ability to obtain coverage.”

Menefee L. (1996). “Are Black Americans entitled to equal health care? A new research paradigm.” *Ethnicity and Disease 6*: 56-68.

This paper analyzes the health, economic, and legal implications of most major health systems’ reform initiatives in the 20th century and, briefly, the 19th century. The paper suggests that models of analysis grounded in science deter the development of claims for racial equality in health care. Because race is a legal construct, the paper suggests that the 14th Amendment’s Equal Protection Clause is an analytical framework that better accommodates the complexity of the health system, is at the heart of our national laws and ethos, and has political rhetorical power to further the political and policy debate. Major components of the health care system, including professional training, hospital construction, and health care financing, are analyzed for racially discriminatory purpose or impact and the extent of government participation. Further research and analysis of the policy decisions that have constructed the current health care system as well as framing those analyses as claims for racial fairness will better develop the policy debate than more narrowly focused analytical models from biomedical science or epidemiology.

Shavers-Hornaday V., Lynch C., Burmeister L. and Torner J. (1997). “Why are African Americans under-represented in medical research? Impediments to participation.” *Ethnicity and Health 2*: 31-45.

In accordance with the NIH Revitalization Act of 1993, the National Institutes of Health and the Alcohol, Drug and Mental Administration require grant applicants and cooperative agreement participants to include minorities in human subject research. In an environment characterized by diminishing research dollars, this increased the pressure on investigators to determine factors that limit minority participation and to develop strategies to overcome these impediments. An extensive review of the literature was to identify the factors possibly responsible for the low levels of African Americans in medical research studies and to highlight areas for further research. The items examined included the relationship between African Americans and medical researchers and attitudes, and the perceptions and beliefs of potential participants and researchers as they relate to the low representation of African Americans in medical research.

The authors concluded that factors identified as possible impediments to African American participation included distrust of the medical/scientific community, poor access to primary medical care, failure of researchers to recruit African Americans actively, the alienation of

minority health professionals, lack of knowledge about clinical trials, and language and cultural barriers. Well-designed, relevant, ethical research in conjunction with an appreciation of the many barriers to participation are paramount to increasing African American presence in clinical research.

Sidel R. (1996). "The enemy within: A commentary on the demonization of difference." *American Journal of Orthopsychiatry* 66: 490-495.

A hard-hitting commentary on the ideological context in which welfare reform proceeded. Sidel speaks of the stigmatization of the poor as a necessary prerequisite for the aggressive blaming of the poor reflected in current welfare reform policy. "Poor mothers have been deemed unworthy, the 'undeserving poor'; nearly 15 million welfare recipients have been painted with one brush, have been relegated to that area in society that is beyond the pale. Systematic stereotyping and stigmatizing of 'welfare mothers' was necessary in order to dehumanize them in the eyes of other Americans before the...tenuous lifeline of [AFDC] and the other bare-bones programs would be shredded."

The author states that this stigmatization deflects attention away from 1) the concentration of wealth to the nation's wealthiest families (one-fifth of the U.S. population owned eighty-five percent of the nation's wealth, and this one-fifth saw their income increase over recent decades); and 2) from the decrease in incomes of the working and middle class. An "us versus them" mentality not only dehumanizes the poor, but also encourages "the middle and working classes to blame their losses on the poor and the powerless, particularly women and people of color, rather than on the rich and powerful." Sidel offers her insights as important for how we approach one another as a national community on this and other issues. "The problems the United States should be addressing as we move into the next century are widespread poverty amidst incredible affluence, massive hopelessness and alienation among those who feel themselves to be outside the headlines of society, and a deeply-felt despair among the poor and the working class that is increasingly expressed through violence."

Wellman D. and Yamashita R. (1996). *Color Blind: The Impact of the California Civil Rights Initiative on Healthcare Resources and Delivery*, Final Report for the Institute for Health and Socio-Economic Policy.

This 68-page document (including appendices and an extensive bibliography) is replete with demographic, health status, and health professions statistics on national and state levels. The discussion begins with a framework for understanding the many dimensions (societal, institutional; and individual levels) in which patients and providers interact to form the patient-provider encounter. With these dimensions identified, authors go on to detail the potential broad and detrimental impact of Proposition 209 on the health status and on health care delivery within the state.

Ignoring dramatic demographic shifts and the unequal distribution of disease, Proposition 209 would potentially prohibit the planning and implementation of public health programs targeted to specific communities and/or ethnic groups. Proposition 209 would almost certainly decrease the number of underrepresented students in health professions schools, and the targeted hiring of a representative health care workforce, further decreasing access to care for the underserved. Though written before the passage of Proposition 209, the projections are so detailed, well-reasoned and well-referenced, their almost prophetic nature makes them relevant for current dialogue. For instance, the authors' projections that there would be a dramatic decrease in the number of medical students from minority communities training at the University of California has quickly come to pass.

Westermeyer J, (1987). "Prevention of mental disorder among Hmong refugees in the U.S.: Lessons from the period 1976-1986." *Social Science and Medicine* 25: 941-947.

Scientifically valid, well-controlled studies on the prevention of mental disorders are sparse. Nonetheless, much quasi-experimental and descriptive work does exist. Published findings permit an evaluation of the mental health effects of policies, procedures, and programs designed for refugees. The federal government assigns legal status to refugees and is paramount in matters of refugee relocation and readjustment within its borders. In matters of social adjustment and prevention of mental disorder, agents of the federal government must consider the accumulation and distribution of knowledge, skill and expertise on refugee social and mental health issues; policies and procedures for relocation, and the development of treatment resources to meet the mental health needs.

Once refugees arrive in the United States of America, much of the actual implementation of policy and procedures has been left to state governments. At this level there have been neither the resources nor the expertise to develop programs for the mental health of refugees. Limited resources have been wasted and the mental health of refugees has been neglected or made worse by some state initiated programs.

Whiteis D. (1997). "Unhealthy cities: Corporate medicine, community economic underdevelopment, and public health." *International Journal of Health Services* 27: 227-242.

The growing corporate dominance in U.S. medical care has been a major factor in the increasingly inequitable distribution of health care resources and the declining public health conditions in poor and minority urban communities. Alongside this trend has been a parallel phenomenon of economic disinvestment and political neglect in these same at-risk neighborhoods. This article analyzes these trends as related components of austerity, retrenchment, and capital consolidation policies that have characterized the U.S. political economy for several decades. Emphasized are the relationships among corporatization, capital consolidation,

deindustrialization of the workforce, and medical indigence; the resulting economic stress placed upon community hospitals and other caregivers in poor and minority communities; and the marked discrepancy between conditions of development and underdevelopment in American cities. It is argued that the effects of these policies are pathogenic in nature; they place populations at risk for disease and social dysfunction, they reduce access to necessary preventive and curative services, and they weaken coping mechanisms. Community economic development, empowerment, and a direct challenge to the growing concentration of wealth and power in the corporate class are proposed as essential elements of public health policy.

Williams Crenshaw K. (1995). Mapping the margins: Intersectionality, identity politics, and violence against women of color. In: *Critical Race Theory: The Key Writings that Formed the Movement*. Crenshaw K., Gotanda N., Peller G. and Thomas K. eds. New York: The New Press, 357-383.

Over the last two decades, women have organized against the almost routine violence that shapes their lives. Drawing from the strength of shared experience, women have recognized that the political demands of millions speak more powerfully than do the pleas of a few isolated voices. For example, battering and rape, once seen as private (family matters) and aberrational behavior (errant sexual aggression), are now largely recognized as part of a broad-scale system of domination that affects women as a class. This process of recognizing as social and systemic what was formerly perceived as isolated and individual has also characterized the identity politics of African Americans, other people of color, and gays and lesbians, among others. However, embracing identity politics has created tension with dominant conceptions of social justice.

The issue with identity politics is not that it fails to transcend difference, as some critics charge, but rather the opposite—that it often ignores intragroup differences. In the context of violence against women, this omission of difference in identity politics is problematic because the violence that many women experience is often shaped by other dimensions of their identities, such as race and class. Focusing on two dimensions of male violence against women—battering and rape—this article considers how the experiences of women of color are frequently the product of intersecting patterns of racism and sexism, and how these experiences tend not to be represented within the discourses either of feminism or of antiracism. Because of their intersectional identity as both women and of color, within discourses shaped to respond to one or the other, women of color are marginalized.

Withorn A. (1996). "Why do they hate me so much?" A history of welfare and its abandonment in the United States. *American Journal of Orthopsychiatry* 66: 496-509.

This is an extensive, important discussion of the history of U.S. social welfare programs since 1935, with the consequent ideological and political overtones of the various eras. For example, in the 1980s, theories about the rise of the "underclass" by William Julius Wilson, by "arguing that class more than race dynamics led to the rise of the underclass...paved the way for many other social scientists to downplay the role of racism in deepening poverty. By dismissing the significance of race, social science made the theory of the underclass, and the politics of welfare reform, more credible." Withorn points out the potential implications of welfare reform on the lives of all women and families: "In anointing employment as the only legitimate source of economic security, social theorists and politicians have implied that women on welfare without jobs are irresponsible and have devalued all other forms of labor, including women's unpaid work and concentrating on the home." Further implications for the ideology reflected in welfare reform (i.e. emphasis on individualism, the moral failure of those who cannot find work) are presented: 1) the deflection of attention away from a market economy that cannot "provide enough work at livable wages for everyone;" 2) the "unachievable fantasy" that every woman of moral integrity and sound character "must find a place in the job market;" and 3) the new authoritarian state that monitors sexual habits, contraceptive choices, family structure and expansion, etc. This is an excellent discussion of how prevailing public ideology drives public policy, and in turn, how welfare reform policies have major implications not just of the lives of poor women, but for every person living in the United States.

Ziv T. and Lo B. (1995). "Sounding board: Denial of care to illegal immigrants." *New England Journal of Medicine* 332: 1095-1098.

In November 1994, California voters approved Proposition 187, which requires publicly funded health care facilities to deny care to illegal immigrants and to report them to government officials. Supporters argued that "an invasion of illegal aliens" is bankrupting California and that free health care and education are magnets attracting illegal immigrants. In a political climate favoring stricter control of illegal immigration, the federal government and other states are likely to consider similar measures.

Physicians, including those who support the denial of public funds to illegal immigrants, should understand how cooperating with Proposition 187 would undermine professional ethics. This article discusses how Proposition 187 endangers the public health, denies care to persons in need, and violates patient confidentiality in unprecedented ways.

C. Bioethics

Albiston C. (1994). "The social meaning of the Norplant® condition: Constitutional considerations of race, class, and gender." *Berkeley Women's Law Journal* 9: 9-57.

Although the application of Norplant® as a condition of probation may initially seem impartial, poor women of color are most likely to receive the condition because institutional biases make them most likely to be prosecuted for child abuse and drug use during pregnancy. Furthermore, the application of Norplant® as a condition of probation hides how this policy derives from and reinforces stereotypes of poor women of color, and precludes offering less punitive, more supportive means for addressing the problems of child and drug abuse. Because the Norplant® policy targets the procreative liberty of poor women of color, it raises serious concerns under both the Equal Protection and Due Process clauses of the Fourteenth Amendment.

Corbie-Smith G. (1999). "The continuing legacy of the Tuskegee syphilis study: Considerations for clinical investigation." *American Journal of the Medical Sciences* 317: 5-8.

The Tuskegee Study, an observational study of over 400 sharecroppers with untreated syphilis, was conducted by the U.S. Public Health Service to document the course of the disease in Blacks, and racial differences in the clinical manifestations of syphilis. The men were not told they had syphilis, not given counseling on avoiding spread of the disease, and were not given treatment throughout the course of the study. The study became the longest (1932-1972) nontherapeutic experiment on humans in the history of medicine, and has come to represent not only the exploitation of Blacks in medical history, but the potential for exploitation of any population that may be vulnerable because of race, ethnicity, gender, disability, age or social class. It is important for physicians who will be caring for an increasingly diverse nation to understand the lasting implications of this study for their patients, but the effects of the Tuskegee Syphilis Study are demonstrated most strikingly by unsuccessful attempts at improving representation of minority patients in clinical trials.

Davis A. (1986). Racism, birth control and reproductive rights. In: *All American Women: Lines that Divide, Ties that Bind*. Cole J., ed. New York: The Free Press, 239-255.

Birth control—the right to choice, safe contraception, as well as abortion—is a fundamental prerequisite for the emancipation of women. Since the right to birth control is obviously advantageous to women of all classes and races, it would appear that even vastly dissimilar women's groups would have attempted to unite on this issue. In reality, however, the reproductive rights movement has not succeeded in uniting women of different ethnic and socioeconomic backgrounds. Moreover, some of the political arguments advanced by the birth control advocates have been based on blatantly racist assumptions. Although the importance

and emancipatory potential of the reproductive rights movement is clear, the historical legacy of this movement leaves much to be desired in the realm of challenges to racism and class exploitation.

Frank G., Blackhall L., Michel V., Murphy S., Azen S. and Park K. (1998). "A discourse of relationships in bioethnics: Patient autonomy and end-of-life decision making among elderly Korean Americans." *Medical Anthropology Quarterly* 12: 403-423.

A two-year, multidisciplinary study (N=800) was conducted on attitudes about end-of-life decision making among elderly individuals in four ethnic groups (African American, European American, Korean American, and Mexican American). On a quantitative survey, Korean Americans reported negative attitudes about the use of life-sustaining technology for themselves but positive attitudes about its use in general. This article reports on an interview with a typical 79-year-old Korean American respondent to explain the contradiction in the survey data. Expectations among elderly Korean Americans include protecting family members with a life-threatening illness from being informed of their diagnosis and prognosis, and doing everything to keep them alive. Two conclusions, one substantive and the other methodological, are drawn: First, the bioethics discourse on individual rights (patient autonomy) is insufficient to explain the preferences of many Korean Americans and must be supplemented with a discourse on relationships. Second, the rigorous use of qualitative, narrative methods clarifies quantitative data and should not be dismissed as "anecdotal."

Koenig B. and Gates-Williams J. (1995). "Understanding cultural difference in caring for dying patients." *Western Journal of Medicine* 163: 244-249.

Experiences of illness and death, as well as beliefs about the appropriate role of healers, are profoundly influenced by patients' cultural backgrounds. As the United States becomes increasingly diverse, cultural difference is a central feature of many clinical interactions. Knowledge about how patients experience and express pain, maintain hope in the face of a poor prognosis, and respond to grief and loss will aid health care professionals. Many patients' or families' beliefs about appropriate end-of-life care are easily accommodated in routine medical practice. Desires about the care of the body after death, for example, generally do not threaten deeply held values of medical science. Because expected deaths are increasingly the result of explicit negotiation about limiting or discontinuing therapies, however, the likelihood of serious moral disputes and overt conflict increases. We suggest a way to assess cultural variation in end-of-life care, arguing that culture is only meaningful when interpreted in the context of a patient's unique history, family constellation, and socioeconomic status. Efforts to use racial or ethnic background as simplistic, straightforward predictors of beliefs or behavior will lead to harmful stereotyping of patients and culturally insensitive care for the dying.

Jones, James H. (1981) *Bad Blood: The Tuskegee Syphilis Experiment*. New York: The Free Press.

This is an excellent book which reveals the complex network of institutions and people that maintained a shameful 40 year experiment on Black sharecroppers. From 1932-1972, the United States Public Health Survey conducted a research study called the “Tuskegee Study of Untreated Syphilis in the Negro Male.” Their subjects were 400 Black sharecroppers in Macon, Alabama who were never told they were research subjects for a study on syphilis, the goal of which was to monitor the course of untreated syphilis. Researchers led the men to believe that they were receiving free medical care for a condition called “bad blood,” which was often interpreted to be an iron deficiency. If they consented to autopsies when they died, their families were given stipends toward burial.

The study had its roots in a project at a public health center where people were both monitored and treated for syphilis. When funding ran out, the U.S. government decided to follow the progress of syphilis on a smaller sample of people who lived in Macon County, Alabama—all African American. In a report written at the time, Taliford Clark of the United States Public Health Service explained his rationale. “Macon County,” he wrote, “is a natural laboratory; a ready-made situation. The rather low intelligence of the Negro population, depressed economic conditions, and the common promiscuous sex relations not only contribute to the spread of syphilis but the prevailing indifference with regard to treatment.”

James Jones was a Kennedy fellow in bioethics at Harvard University, when he began to research this shocking story which was exposed to the public by the Associated Press in 1972. Even more amazing, the story was not a new one in the medical community. Thirteen articles had been published in medical journals throughout the country.

Jones demonstrates that an intricate web of people and institutions maintained the experiment, which was initially only supposed to last six months. These key players included the Alabama State Department of Health, the Macon County Health Department, the Tuskegee Institute, the Veterans Hospital in Tuskegee, local physicians and members of the United States Public Health Service. Jones presents the history of the USPHS, and discusses attitudes of White physicians in the 19th century drawn from their own writings. He weaves together a fascinating mix of interviews, memoranda and records of principal persons and institutions participating in the study. One of the most interesting figures in this is the single public health nurse who worked with the study for 30 years; an African American woman named Eunice Rivers. Jones has been quoted as saying that his interviews with Rivers “increased my tolerance for ambiguity.”

Once the study became public knowledge, the uproar was tremendous. Survivors and the descendents of the men, some with congenital syphilis, sued the U.S. government and were awarded \$10 million. But it was not until 1997, that the government publicly apologized to the last 8 survivors, their families and all African Americans. *Bad Blood* is a must read as background for understanding why an attitude of deep distrust lingers between African Americans and the medical profession.

Mass B. (1976). Emigration and sterilization in Puerto Rico. In: *Population Target: The Political Economy of Population Control in Latin America*. Mass B. Ontario, Canada: Charters Publishing Company, 87-108.

In order to understand the extent and purpose of the demographic crimes committed against the people of Puerto Rico through sterilization abuse, it is essential to examine the diametrically opposed social and economic aims of the Island's developers and those of the Puerto Rican people in their struggle for independence. The law legitimizing sterilization in Puerto Rico was enacted in 1937, which allowed sterilization for "health reasons," and was not repealed until 1960. A survey taken in 1949 indicated that 21 percent of all women interviewed had been sterilized and that sterilizations were being performed in 18 percent of all hospital child deliveries on the Island. A later investigation indicated that close to one-third of Puerto Rican women of childbearing age had been sterilized by 1968. The economic exploitation and political domination of Puerto Rico by U.S. industrialists led to mass unemployment and other social conditions that were ripe for the systemic implementation of draconian population control measures, including widespread sterilization of Puerto Rican women.

Nolan L. (1994). "The unconstitutional conditions doctrine and mandating Norplant® for women on welfare discourse." *American Journal of Gender and the Law* 3: 15-37.

The current movement for welfare reform has caused both state and federal legislatures to seek quick solutions to revive a failed welfare system. The introduction of Norplant®, a contraceptive designed to provide up to five years of continuous birth control, has attracted the attention of decision-makers who have sought its use as a condition of probation in the criminal justice system, or as a condition or incentive for receiving benefits.

This paper argues that the unconstitutional conditions doctrine must be part of the discourse on welfare reform and contraceptives particularly if the government mandates the use of contraceptives such as Norplant®. Simply stated, the doctrine prohibits the government from forcing individuals to forego a constitutionally protected right (such as reproductive freedom) in exchange for the receipt of government benefits. As the principle provider of welfare benefits, the government has increased its power to dispense benefits with conditions that affect constitutionally protected rights, at least indirectly. In short, it encourages poor women to forego their reproductive rights in choosing whether or not to use a contraceptive as well as

what type of contraceptive to use. Moreover, by exacting a reproductive compromise in exchange for benefits, Norplant® legislation creates a caste system of rights allocation, by allowing the government to favor the reproductive rights of non-welfare mothers over women who are dependent upon welfare.

Randall V. (1996). "Slavery, segregation and racism: trusting the health care system ain't always easy! An African American perspective on bioethics." *Saint Louis University Public Law Review 15*: 191-235.

Many people are surprised at the level of distrust of the health care system held by African Americans. However, fear and distrust of the health care system is a natural and logical response to the history of experimentation and abuse African Americans have experienced in this country. It is this legacy that keeps African Americans from seeking health care treatment and from participating in medical research, from signing living wills, and from donating organs. Moreover, although this collective experience affects the health care African Americans receive, it is rarely acknowledged in traditional bioethical discourse. Bioethicists must begin to consider how the experiences of slavery, segregation, and racism, affect how African Americans perceive current bioethical issues such as abortion, barriers to health care, the Human Genome Project, genetic testing, reproductive technologies and organ transplantation.

Roberts, D. (1997) *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, New York: Pantheon Books.

In "Killing the Black Body," Rutgers law professor Dorothy Roberts considers how the laws and policies governing reproduction are based in the idea that Black fertility causes poverty. By looking at how laws have changed throughout U.S. history, she also points out the link between economics and attitudes towards Black women's reproduction. She says, "While slave owners profited from encouraging slave women to bear many children, modern-day taxpayers believe they save money by discouraging poor Black women from having children. But these practices share the common theme of denying a women's freedom to control her own reproductive life because of her race."

In chapters such as "Reproduction in Bondage," "The Dark Side of Birth Control," "The Welfare Debate," "Making Reproduction a Crime," Roberts looks at forced breeding, involuntary sterilization, and invasive forms of birth control. She challenges modern day use of reproductive technology that encourages White women to have children, while other technologies are used to control Black women's reproduction. Her arguments are tightly researched and well-documented, setting the stage for well-informed debate about the impact of race, politics, and genetics on the bodies of Black women.

Rutherford C. (1992). "Reproductive freedoms and African American women." *Yale Journal of Law and Feminism* 4: 255-290.

African American women seek "reproductive choice" and want the power to make genuine choices about their reproductive health. Such choices must be informed and supported by access to quality health care. Unfortunately, the term "reproductive choice" is used synonymously with reproductive rights, and the meaning of choice again is narrowed to focus on the right to abortion. This article challenges the reader to accept a definition of reproductive freedom which is broader than the right to abortion. African American women want and need reproductive freedoms that range from terminating unplanned and unwanted pregnancies to delivering healthy babies under healthy circumstances. This article also urges civil rights and women's groups to address in their respective agendas the reproductive health needs of African American women. Neither advocacy group has fought to recognize or secure the reproductive freedoms of African American women as they define them. Without the active support of advocacy organizations, African American women find themselves without a voice and often overlooked in discussions on reproductive issues.

Shapiro T. (1985). "Structure and process in social movement strategy: the movement against sterilization abuse." *Research in Social Movements, Conflicts and Change* 8: 87-108.

By analyzing one of the most successful radical feminist movements of the 1970s—the movement to end sterilization abuse—this essay explores the development of social movements with a particular focus on strategy, social context, and structure. A case study on the Committee to End Sterilization Abuse (CESA), the mainspring of the social movement to end sterilization abuse in the United States, provides the framework for understanding the processes and dynamics that shape strategies for organizing and why they succeed or fail.

D. Environmental Factors and Multicultural Health

Alaniz M. and Wilkes C. (1995). "Reinterpreting Latino culture in the commodity form: The case of alcohol advertising in the Mexican American community." *Hispanic Journal of Behavioral Sciences* 17: 430-451.

This article describes the ways in which the semiology of alcohol advertising in the Mexican-American community shapes attitudes and behaviors. The authors claim that the market-driven imperatives associated with the sale and purchase of liquor deny legitimacy to existing social practices in Latino communities and instead propagate a complex set of stereotypes that draw on traditional Mexican cultural armature for their influence. In this process, the sign system of Mexican American communities is encoded from the outside to reflect the needs of alcohol markets, while the authentic images of human lives are distorted.

Brown P. (1995). "Race, class and environmental health: A review and systematization of the literature." *Environmental Research* 69: 15-30.

This paper analyzes and systematizes the race and class differentials in exposure to toxic hazards and actual health outcomes. Research is categorized into the following: Proximity to known hazards includes 1) presence of hazardous waste sites and facilities (landfills, incinerators, Superfund sites), 2) exposure to air pollution, 3) exposure to various environmental hazards, e.g. toxic releases and hazards in pesticides and foods; regulation, amelioration and cleanup includes 4) record of decisions (RODs) and cleanups at NPL sites, 5) regulatory action, as measured by assessing fines for environmental pollution; Health effects include 6) specific health outcomes which are related to environmental burden (e.g. blood lead levels); proximity to prospective hazards includes 7) siting decisions for incinerators, hazardous waste sites, and nuclear storage sites. The overwhelming bulk of evidence supports the "environmental justice" belief that environmental hazards are inequitably distributed by class, and especially race.

Bullard R. (1993). Anatomy of environmental racism and the Environmental Justice Movement. In: *Confronting Environmental Racism: Voices from the Grassroots*. Bullard R., ed. Boston, MA: South End Press, 15-39.

This is an excellent book chapter documenting the sociopolitical and historical events leading up to the development of the Environmental Justice Movement. It is replete with many case examples of regional groups that have used coalition-building and community organizing strategies in their efforts to confront the geographic distribution of environmental hazards and toxic waste sites disproportionately borne by communities of color. A central theme of this discussion is the juxtaposition of the Environmental Justice Movement to that of the mainstream environmental movement (i.e. as exemplified by Earth Day or Greenpeace). "Indeed, the fastest growing segment of the environmental movement is made up by the grassroots groups in communities of color which are increasingly linking up with one another and with other community-based groups...As long as U.S. society remains divided into separate and unequal communities, such groups will continue to serve a positive function."

Gelobter M. (1992). Toward a model of 'environmental discrimination'. In: *Race and the Incidence of Environmental Hazards*. Bryant B. and Mohai P., eds. Boulder, CO: Westview Press, 64-81.

This paper seeks to fill the void in understanding the dynamics of environmental discrimination by exploring the connection between environmental regulation and discriminatory outcomes. The first section surveys the various ways of measuring distribution and/or discrimination that have been used in the environmental context and summarizes how these definitions may lead to different conclusions about the extent of environmental discrimina-

tion. Following this exploration of methodological issues, this paper develops a model of environmental regulatory activity that goes beyond measuring environmental inequities to actually understanding the discriminatory dynamics underlying them.

Herd D. (1993). "Contesting culture: Alcohol-related identity movements in contemporary African American communities." *Contemporary Drug Problems*, 20: 739-758.

This paper explores how alcohol is associated with complex and contradictory themes in hip hop culture and in surrounding Black communities. Drinking is being promoted as an accoutrement of identity, pleasure, sensuality, and personal power among major rap artists. Although some of the cultural functions attributed to alcohol in this milieu stem from themes indigenous to hip hop culture, such as the tradition of boasting about individual uniqueness, personal power, and sexual exploits, the association of these characteristics with drinking has been greatly amplified through the power of the mass media and the commodification of rap to sell alcoholic beverages. At the same time, message rappers and activists have linked alcohol to genocide, racism, crime, poverty, and social distress in Black communities. Both types of cultural images reflect broader themes in long-standing social movements in African-American communities.

Lavelle M. and Coyle M. (1993). Unequal protection: the racial divide in environmental law. In: Toxic Struggles: *The Theory and Practice of Environmental Justice*. Hofrichter R., ed. Philadelphia, PA: New Society Publishers, 136-142.

According to a *National Law Journal* (NLJ) investigation, the federal government, in its clean-up of hazardous sites and its pursuit of polluters, favors White communities over minority communities under environmental laws meant to provide equal protection for all citizens.

In a comprehensive analysis of every U.S. environmental lawsuit concluded in the past seven years, the NLJ found penalties against pollution-law violators in minority areas are lower than those imposed for violations in largely White areas. In an analysis of every residential toxic-waste site in the twelve-year-old Superfund program, the NLJ also found that the government takes longer to address hazards in minority communities, and it accepts solutions less stringent than those recommended by the scientific community. This racial imbalance, the investigation found, often occurs whether the community is wealthy or poor.

Lazarus R. (1993). "Pursuing environmental justice: the distributional effects of environmental protection." *Northwestern University Law Review* 87: 787-857.

Scholars have engaged in considerable debate over how the costs of environmental controls affect particular industries and how these costs place a disproportionate burden on new versus existing, and large versus small, industrial sources of pollution. But there has been only an ad hoc accounting of how the benefits of protection are spread among groups of persons.

There has been virtually no accounting of how pollution controls redistribute environmental risks among groups of people, thereby imposing a cost on some for the benefit of others. Prominent voices in racial minority communities across the country are now forcefully contending that existing environmental protection laws do not adequately reflect minority interests and in some instances, even perpetuate racially discriminatory policies. This article explores the distributional side of environmental protection and, more particularly, explains the significance of including environmental justice concerns into the fashioning of environmental protection policy.

Miller R. and Hazlett M. (1996). "The 'drunken Indian': Myth distilled into reality through federal Indian alcohol policy." *Arizona State Law Journal* 28: 223-298.

This paper examines the myth of the "drunken Indian" versus the reality, and the role of federal legislation in shaping both the political stereotype and the actual problem. This myth of the drunken Indian assumes first, that as a race or a distinct class, Indians are powerless over alcohol. Second, the myth assumes that the Indians' fight against alcohol is hopeless in light of the presumed demise of the cultures, despite the salvation efforts of the federal government. While serious alcohol-related problems exist in many native communities, reality rebuts the powerless, hopeless myth of the "drunken Indian." Native Americans develop and run the most successful substance abuse treatment programs for native populations. Many tribes actively fight in Washington, D.C. to gain enough funding to support treatment through health care services, which despite numerous treaty and legislative guarantees, the federal government still has not effectively delivered.

The paper is divided into several sections and provides an overview of many important topics regarding Native Americans and alcohol use. In part II, the authors discuss explanations regarding Indian alcohol use such as biologic or genetic predisposition; social and economic conditions; or the effects of prohibition. Part III discusses the historical background of Indian alcohol policy and legislation from the 1700s to the 1990s, with a focus on how the myth of the drunken Indian has been created and maintained. Part IV examines the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, including its rationale, passage, failure and the subsequent Indian Health Amendments of 1992. It also describes the continuing Native American efforts today to defeat the myth of the "drunken Indian." The paper concludes with suggestions for policy changes to address alcohol problems among native people and end the mythological perceptions of Indians and alcohol use. The authors suggest that a promising step forward would be to expand tribally and Indian-operated and native-oriented treatment programs that have shown great promise according to health and alcohol researchers.

Mobed K., Gold E., and Schenker M. (1992). "Occupational health problems among migrant and seasonal farm workers." *Western Journal of Medicine* 157: 367-73.

The authors begin this review by stating, "Migrant farm workers are one of the most underserved and understudied occupational populations in the U.S., even though they are working in one of the most, if not the most, hazardous occupations in the country." The lack of data is due primarily to a lack of precise documentation for the following reasons: 1) transient nature of the population; 2) ongoing migration into and out of the U.S.; 3) undercounting of migrant farm workers who meet the legal definition but do not fit ethnic stereotypes, for example; and 4) desire of immigrants to avoid government agencies. Mobed and others thoroughly describe the wide range of health problems faced by migrant farm workers, including accidents, pesticide-related illness, musculoskeletal and soft tissue problems, dermatitis, non-infectious respiratory conditions, climate-caused illnesses, communicable diseases, bladder and kidney disorders, and eye and ear problems.

Moses M., Johnson E., Anger W., Burse V., Horstman S., Jackson R., Lewis R., Maddy K., McConnell R., Meggs W; et al. (1993). "Environmental equity and pesticide exposure." *Toxicology and Industrial Health* 9: 913-959.

This work is a major contribution (nearly 50 pages long, including 10 pages of references) to the dialogue on environmental equity. It documents what is known from epidemiological and biochemical data regarding exposure to pesticides by race and ethnicity. Authors go on to discuss the health effects of occupational and environmental exposure in terms of differential (by race and ethnicity) rates of cancer (including childhood cancer), impact on lipid profiles, and impact on sperm counts, to name just a few areas covered.

They then discuss the sociopolitical realities that probably lead to widespread underreporting of especially acute exposure. They review methodological challenges to studying the impact and distribution of pesticide-related illnesses. Their urgent concerns for minority populations are summarized as follows: "Although people of color and low-income groups bear a disproportionate share of the health risks from exposure to pesticides, research attention has been meager, and data on acute and chronic health effects related to their toxic exposures are generally lacking...People of color should be a major research focus, with priority on long-term effects, particularly cancer, neurodevelopmental and neurobehavioral effects, long-term neurological dysfunction, and reproductive outcome." Finally, their recommendations for mitigating exposures, for using existing data or systems, and for undertaking new research are outlined in detail, with the following proviso: "Any plan for correcting environmental inequities must include community-based organizations, as well as providing for funding to implement the plan. Some funds should be allocated to organizations that represent at-risk workers, for technical assistance in making their environmental concerns be known and addressed."

Palerm J. (1992). "A season in the life of a migrant farm worker in California. In: Cross-Cultural Medicine, A Decade Later." *Western Journal of Medicine* 157: 362-366.

Palerm tracks the seven month sojourn of a Mexican national through the agricultural fields of California. The story gives a profile of the "push-pull" economic factors that brought the nineteen year-old to the U.S., the often deplorable housing conditions, the exploitative practices of his employers, the consumption of his wages by high priced lodging and basic necessities, and the physical ailments he endures secondary to his agricultural work. Palerm then summarizes the plight of California farm laborers and the historical and legislative events that led to and that will continue to ensure the large size of the agricultural workforce in California. Dispelling misconceptions that mechanization of agribusiness would decrease the need for migrant workers, "the steeply increasing demand...for specialty fruit and vegetables crops, which are labor intensive, has actually increased the need for migrant workers."

The health implications include recognizing 1) poor basic access to health care services in a population at increased risk for poor health because of overcrowding, unsanitary conditions, pesticide exposure and physically dangerous work; 2) financial and nonfinancial barriers to health care, including lack of insurance, and lack of knowledge regarding eligibility status for services and benefits; and 3) reliance on traditional home medications. Albeit written before the passage of Prop 187, Palerm writes, "There is no indication that the issues briefly described here will abate any time soon. Neither agricultural modernization nor immigration legislation has been capable of either diminishing California's hunger for low-wage seasonal farm jobs or deterring the massive flow of migrants from Mexico who meet the demand. It is paramount that we acknowledge, once and for all, that these issues are endemic to California agriculture so that we can get on with the job of addressing the myriad social problems they entail, problems that can no longer perfunctorily be dismissed as trivial, transitional or self-corrective."

Pulido L. (1994). "Restructuring and the contraction and expansion of environmental rights in the United States." *Environment and Planning A* 26: 915-936.

This paper examines the ways in which economic and political restructuring is impacting environmental rights as conceptualized and practiced by environmental justice activists in California and the Southwestern U.S. Using Iris Young's framework, this paper argues that the recent gains of the environmental justice movement have been based largely on procedural justice, which is insufficient to ensure universal environmental quality, a stated goal of the movement. The limits of procedural justice have become apparent through the processes of restructuring, internationalization, and immigration, all of which are creating a new landscape for activists. Activists in California find that their rights are being contracted, because of deregulation and capital flight, and at the same time are expanding to include residents of Mexico. Given these global realities, procedural justice must also be accompanied by efforts to address both uneven development and a lack of democracy over private production decisions.

Pulido L, Sidawi S and Vos R. (1996). "An archeology of environmental racism in Los Angeles." *Urban Geography 17*: 419-439.

This paper focuses on the historical evolution of discriminatory pollution patterns in Los Angeles. The authors argue that the historical processes leading to environmental racism can not be understood without employing qualitative research methods. Moreover, in order to move beyond viewing "race" and class as mutually exclusive static categories, they conceptualize "race" and class as social relations. The authors first conducted a spatial analysis of air toxins in urban Los Angeles County and then chose two of the most polluted communities (Torrance and East Los Angeles/Vernon) for detailed historical analysis. Each community illustrates a different set of historical processes. The early development of Torrance was characterized by a highly deliberate and conscious set of racist practices on the part of city planners in an effort to control a racialized division of labor. In the case of East Los Angeles/Vernon, minority communities developed in close conjunction with those industries dependent upon their labor. The negatively racialized and polluted nature of the place led to its continued role as an industrial area. In both cases, the investigators emphasize the need to focus on the simultaneous evolution of racism, class formation, and the development of industrial landscapes.

Wilk V. (1993). "Health hazards to children in agriculture." *American Journal of Industrial Medicine 24*: 283-290.

Working with the disadvantage of "a lack of good studies with solid data," Wilk nonetheless presents an excellent review of the hazards of agricultural work, specifically in reference to children. This occupation is the second deadliest in the country (behind mining); 300 children each year die and 27,000 are injured. She describes the agricultural workforce of the children and their families as "predominantly people of color: Latino, African American, Haitian, Asian, West Indian, and Native American."

The main reasons cited for families having their children work or present in the fields are 1) economics (annual income of migrant and farm worker families she quotes as \$4,700) and 2) lack of child care. The ability for parents to make a living wage and to have access to affordable child care are cited as interventions that may get children out of the fields. Wilk details the main hazards to children in the agricultural workforce: farm machinery, pesticides, poor field sanitation, unsafe transportation to and from the work site, and fatigue. In regard to pesticides, a 1990 survey of a group of migrant farm working children in New York found that 36 percent had been sprayed directly or indirectly by drift while working in the fields. In regard to poor field sanitation, a 1987 Occupational and Safety Health Administration study showed that 20–78 percent of farm worker adults and children in the U.S. had parasitic infections, compared with 3 percent of the general population. And in regard to fatigue, Wilk offers the example of a fourteen-year-old farm worker who was killed by a truck in Washington State when he lay down to rest in the field while cutting vines at 2:30 in the morning.

II. Cultural Dimensions of Health and Illness

Angel J. and Angel R. (1992). "Age at migration, social connections, and well-being among elderly Hispanics." *Journal of Aging and Health* 4: 480-99

This study employs data from the 1988 National Survey of Hispanic Elderly People to examine the impact of age at migration and social contacts on the self-assessed health, functional disability, and life satisfaction of elderly Cuban Americans, Mexican Americans, and Puerto Ricans in the United States. The results indicate that the difficulties associated with immigration late in life undermine an older person's morale and interfere with the ability to perform basic activities of daily living. Although children are important sources of social support for all Hispanic groups, the findings also reveal important group differences in the use of other community social resources and their impact on health. Older Cuban Americans, in particular, appear to benefit from residence in ethnic enclaves in which they have largely duplicated their culture of origin.

Arguelles L. and River A. (1997). Spiritual emergencies and psycho-spiritual treatment strategies among gay/homosexual Latinos with HIV disease. In: *In Changing Times: Gay Men and Lesbians Encounter HIV/AIDS*. Levine, M., Nardi P., Gagnon J., eds. Chicago, IL: University of Chicago Press, 83-98.

This chapter is about the various spiritual emergencies faced by some Latino gay/homosexual men living and dying with HIV disease and the psycho-spiritual strategies that they and some of their clinicians, traditional healers, and other helpers have accessed or developed. The types of experiences and struggles reported by clients and clinicians have resulted in a broadening of the term "spiritual emergency" to include less acute manifestations and culture-bound syndromes.

The chapter also illustrates some changes in conventional mental health treatment and traditional and alternative healing practices in various Latino communities in the context of the AIDS pandemic as gay/homosexual HIV sufferers have become more visible in communities of color. This chapter is based on many years of clinical and prevention education experiences with people with HIV/AIDS, as well as ongoing conversations with therapists and healers who approach the spiritual emergencies and spiritual searches catalyzed by the experience of AIDS using an eclectic combination of culturally sanctioned healing models and more conventional psychotherapeutic strategies. Topics discussed include: Meso-American/Chicano spiritually-based treatment strategies, Afro-Caribbean influenced psycho-spiritual treatment, and psycho-spiritual practices and HIV/AIDS prevention education. (©1997 APA/PsycINFO, all rights reserved.)

Birman D. (1998). "Biculturalism and perceived competence of Latino immigrant adolescents." *American Journal of Community Psychology*. 26: 335-54.

The present study investigated acculturation to the Hispanic and American cultures and self-perceptions of competence among 123 Latino immigrant adolescents. The study tested a contextual model of biculturalism by examining whether different acculturation styles predicted perceived competence in life spheres with different cultural demands. Perceived competence was assessed using Hatter's (1988) Self-Perceptions of Competence Profile for Adolescents for the life spheres of school, peers (both Latino and non-Latino), and global self-worth. In addition, an analogous scale to assess perceptions of competence in the family was constructed for that sphere. The study found some support for a contextual model of acculturation. Acculturation to American culture predicted positive self-perceptions of competence with American peers, while acculturation to Hispanic culture predicted positive self-perceptions of competence with Latino peers. Perceived family competence, however, was predicted by acculturation to American rather than Hispanic culture. Results with respect to biculturalism are tentative, with a trend relating biculturalism to positive self-perceptions of global self-worth. However, because many of the conditions stipulated by the model were not met, results with respect to biculturalism raise questions about current approaches to operationalizing the construct.

Boyce W. and Boyce J. (1983). "Acculturation and changes in health among Navajo boarding school students." *Social Science and Medicine* 17: 219-226.

A study from a Bureau of Indian Affairs boarding school in New Mexico in 1978 was conducted to assess the impact of cultural identity and acculturation on the health of sixty Navajo boys and girls, ages six to fifteen years. The degree of the children's level of acculturation, the degree of family acculturation and the acculturative fit between the family and the family's surrounding community were obtained. Controlling for age, sex and family size, authors identified the strongest predictor of students' visits to the medical clinic during the school year was the degree of cultural incongruity or the degree of absolute difference between the individual family and their surrounding community's cultural background/degree of acculturation. That is, the higher the level of incongruity for a given student, the more clinic visits the student made in that school year. Supporting this result, the study also found "that the healthiest Navajo boarding school children were those whose families and communities were well-matched with respect to cultural identity, regardless of their [the child's] absolute degree of acculturation." This suggests a more complex relationship between acculturation and health than is traditionally implicated, mediated through a child's family and community. It is a good example of how our social relations and experiences of culture become incorporated into our bodies and manifested as disease or illness.

Brookins G. (1993). "Culture, ethnicity, and bicultural competence: implications for children with chronic illness and disability." *Pediatrics* 91: 1056-1062.

Brookins begins this excellent, well-referenced discussion with an introduction to the nature of culture and its relation to child development. She highlights ethnic identity, whose components include 1) "the contextual lens through which the child begins to see self in relation to others;" 2) "the lens through which the child assesses the opportunity structure for self;" and 3) "the crucible for interpreting subjective experiences." Presenting a cogent, lucid discussion of the impact of racism on the healthy development of children of color, Brookins asserts, "If children of minority status are accorded disrespect and foreclosed options in life, one can only imagine the prospects for minority-status children with chronic and disabling conditions as their health states may be exacerbated by race and ethnicity."

Among other issues, she cites studies of culture, ethnicity and disability as they relate to the provision of health care services. For instance, Latinos have been shown to be more likely to care for a severely retarded child at home versus an institution, compared to Black or White families. Apparently among some Asian groups, there is no cultural concept of the notion of developmental disability. Brookins suggests a model of provider sensitivity, where the family is engaged as partner in what they consider to be the most appropriate care for their child. Finally, she speaks of the need for more research in this area: "Issues such as ethnic identity, cultural imperatives, bicultural competence, and racism require open discussion and scrutiny in relation to the health care delivery system as presently constituted. To date, there are few data regarding the course of development for children and youth who are minority status due to both race or ethnicity and disability. We especially have little information as to how we incorporate ethnic and cultural definitions of, and meanings attached to, disease and disability into appropriate mechanisms for health care provision."

Burnam M., Hough R., Karno M., Escobar J. and Telles C. (1987). "Acculturation and lifetime prevalence of psychiatric disorders among Mexican Americans in Los Angeles." *Journal of Health and Social Behavior* 28: 89-102.

Authors investigated whether the level of acculturation of adults of Mexican descent in Los Angeles was related to specific psychiatric disorders. They explored the proposed separate effects of acculturation from immigration status. Using 1,244 phone interviews (in the language of the interviewees' choice), acculturation was measured by a twenty-six item scale. After controlling for sex, age and marital status, rates of phobia, alcohol abuse or dependence and drug abuse or dependence increased with increasing levels of acculturation. Additionally, after controlling for sex, age and marital status, those of Mexican descent born in the U.S., compared with immigrants had higher levels of phobia, alcohol abuse/dependence, drug abuse/dependence, major depression, and dysthymia.

Authors conclude that higher rates of psychiatric disorders among native (born here) Mexican Americans and among all those of Mexican descent who were relatively more acculturated may in part be due to “higher expectations for status attainment fostered by the dominant culture” and resultant psychic distress “with their current circumstances.” That is, the psychic stress of acculturation and unrealized expectations, the “minority status” reflected in our social relations, may serve as an example of how our social relations become incorporated biologically, resulting in manifestations such as psychiatric disorders.

Chavez L., Hubbell F., McMullin J., Martinez R. and Mishra S. (1995). “Understanding knowledge and attitudes about breast cancer. A cultural analysis.” *Archives of Family Medicine* 4: 145-152.

The objective of this article was to evaluate knowledge and attitudes about breast cancer risk factors among Latinas, Anglo-American women, and physicians. Ethnographic interviews employing systematic data collection methods were used. Twenty-eight Salvadoran immigrants, 39 Mexican immigrants, 27 Chicanas, and 27 Anglo-American women were selected through an organization-based network sampling and a convenience sample of 30 primary care physicians in Orange County, California. Data analysis using qualitative content analysis and quantitative cultural consensus analysis, a mathematical technique that determines the degree of shared knowledge within groups and estimates “culturally correct” answers (cultural models), was employed. The content analysis revealed different beliefs about breast cancer risk factors, particularly between the Latinas and the physicians. The cultural consensus analysis found two broad cultural models (defined as groups with ratios between the first and second eigenvalues of $>$ or $=$ 3 and no negative competency scores). A Latina model (ratio = 3.4), formed by the Salvadorans, Mexicans, and Chicanas, emphasized breast trauma and “bad” behaviors, including drinking alcohol and using illegal drugs as risk factors. A biomedical model (ratio = 3.0), embraced by physicians and Anglo-American women, emphasized risk factors described in the medical literature, such as family history and age. Within these broad models, each group of respondents also differed enough in their beliefs to form their own, often stronger, cultural models. Ethnography can provide important insights about culturally based knowledge and attitudes about disease. An understanding of the distinctive cultural models regarding breast cancer risk factors will aid future cancer control interventions.

Chung R. and Kagawa-Singer M. (1993). “Predictors of psychological distress among southeast Asian refugees.” *Social Science and Medicine* 36: 631-9.

This paper analyzed data from one of the first needs assessment projects on a representative non-clinical population of Southeast Asian refugees in the United States in order to test two hypotheses: 1) whether or not premigration experiences still have an effect on psychological distress beyond the initial resettlement period and 2) whether or not interethnic group differences existed in the predictors of psychological distress between three Southeast Asian

refugee groups, the Vietnamese, Cambodians, and Lao. The results of the analysis of 2,180 subjects supported both hypotheses. Regardless of ethnicity and the number of years in the U.S., premigration trauma events and refugee camp experiences were significant predictors of psychological distress even 5 years or more after migration and significant group differences in the types of postmigration distress predictors were also found. Acculturation concerns for the Vietnamese and Lao were influenced by both premigration and postmigration variables. In contrast, the primary concerns of the Cambodians were still related to premigration issues. The results also indicated that Vietnamese and Lao women were more likely to experience distress than their male counterparts, but no gender differences emerged for the Cambodians. Age predicted distress for Vietnamese and Cambodians, but not Lao. Similar to previous findings in the literature, Cambodians reported the highest levels of distress, followed by Lao and then Vietnamese. Interpretations of these results for this community sample are proposed.

Connors J. and Donnellan A. (1993). "Citizenship and culture: The role of disabled people in Navajo society." *Disability, Handicap & Society* 8: 265-280.

This article discusses societal constructs of the Navajo relating to definitions of social competence and disability, and the degree of citizenship and respect that Navajo people with handicaps are accorded in their society. Data were gathered via interviews, surveys, and daily observations for thirty-four individuals (aged 9–29 yrs) with severe physical or mental disabilities. Since all Subjects were nonverbal, data were gathered from Subjects' families and other caretakers. Factors analyzed include child-rearing practices, the Navajo concept of childhood, and Navajo notions of health and unwellness. Historical attitudes toward disabled people were also explored, as well as changing attitudes due to the influence of Western biomedical explanations and interventions. (©1997 APA/PsycINFO, all rights reserved.)

Fowler C. and Wadsworth J. (1991). "Individualism and equality: Critical values in North American culture and the impact on disability." *Journal of Applied Rehabilitation Counseling* 22: 19-23.

The authors maintain that culturally shaped attitudes toward persons with disabilities pose significant barriers to full participation in employment. Even with the enactment of the Americans with Disabilities Act of 1990, implementation of the law will occur within the culturally defined stereotypes and assumptions that exist in society. A task for rehabilitation professionals is including positive perceptions of persons with disabilities in the conceptual ideology of individualism and equality. The discussion focuses on 1) the cultural difficulties of implementing civil rights legislation and 2) the role of rehabilitation professionals in promoting attitudinal changes in society. (©1997 APA/PsycINFO, all rights reserved.)

Joe J. (1997). "American Indian children with disabilities: The impact of culture on health and education services." *Families, Systems & Health* 15: 251-261.

Because tribal and familial diversity reflect the varying levels of acculturation to the non-Indian world, American Indian communities have become bicultural. In the context of disability, this bicultural world also is influenced by other factors including 1) the social construct of disability (within and outside native cultures), 2) the stigma associated with certain disabilities within the majority society and how this stigma influences public policies and practices that affect native communities, and 3) the apparent priority given to disability within Indian communities. This article examines the interplay of some of these complex forces. Specific topics discussed in the context of American Indians include the social construct of disability, the bicultural world, the historical perspective of disabilities, availability of services, lack of data about disabilities, and special education programs. (©1998 APA/PsycINFO, all rights reserved.)

McCallion P., Janicki M. and Grant-Griffin L. (1997). "Exploring the impact of culture and acculturation on older families caregiving for persons with developmental disabilities." *Family Relations: Interdisciplinary Journal of Applied Family Studies* 46: 347-357.

A series of focus group meetings were held with African American, Chinese American, Haitian American, Hispanic/Latino American, Korean American, and select Native American communities. Cultural issues in caring at home for family members with a developmental disability were discussed. Differences were found in the following themes: 1) how disability is perceived, 2) who are the family, 3) who provides care, 4) how the family makes decisions, 5) what family members expect of each other, 6) what support families receive from friends and community, 7) why the family moved, 8) cultural values important to family members, 9) family willingness to accept services from outside the family, 10) the family's first language, and 11) families' concerns about service providers. The results suggest that cultural and social patterns affect concepts and responses to disability among people from diverse ethnic backgrounds which should be acknowledged and addressed in approaches for intervening in disabilities in these population groups. (©1998 APA/PsycINFO, all rights reserved.)

Marbella A., Harris M., Diehr S. and Ignace G. (1998). "Use of Native American healers among Native American patients in an urban Native American health center." *Archives of Family Medicine* 7: 182-5.

To gain an understanding of the prevalence, utilization patterns, and practice implications of the use of Native American healers together with the use of physicians, the authors conducted semistructured interviews at an urban Indian Health Service clinic in Milwaukee, Wisconsin, of a convenience sample of 150 patients at least eighteen years old. The mean age of patients was forty years, and the sex distribution was 68.7 percent women and 31.3 percent men. Thirty tribal affiliations were represented, the largest groups being Ojibwa (20.7 percent), Oneida (20.0 percent), Chippewa (11.3 percent), and Menominee (8.0 percent).

Researchers measured the number of patients seeing healers and gathered information on the types of healers, the ceremonies used for healing, the reasons for seeing healers, and whether patients discuss with their physicians their use of healers. The results showed that 38.0 percent of the patients see a healer, and of those who do not, 86.0 percent would consider seeing one in the future. Most patients report seeing a healer for spiritual reasons. The most frequently visited healers were herbalists, spiritual healers, and medicine men. Sweat lodge ceremonies, spiritual healing, and herbal remedies were the most common treatments. More than a third of the patients seeing healers received different advice from their physicians and healers. The patients rate their healer's advice higher than their physician's advice 61.4 percent of the time. Only 14.8 percent of the patients seeing healers tell their physician about their use. The authors conclude that physicians should be aware that their Native American patients may be using alternative forms of treatment, and they should open a respectful and culturally sensitive dialogue about this use with their patients.

Nguyen H., Messe L. and Stollak G. (1999). "Toward a more complex understanding of acculturation and adjustment: Cultural involvements and psychosocial functioning in Vietnamese youth." *Journal of Cross-Cultural Psychology*. 30: 5-31.

This study examined possible links between acculturation and adjustment in 182 Vietnamese youths living in a primarily Anglo-American community. Extending past work, the present research employed a more complex perspective on both acculturation—cast as separate levels of involvement in the native and host cultures—and adjustment—measured across personal (distress, depression, self-esteem), interpersonal (family relationships), and achievement (school grade point average) domains. Results indicated that, as expected, involvement in the U.S. culture predicted positive functioning across all three adjustment domains, and involvement in the Vietnamese culture predicted positive family relationships. Contrary to hypotheses, involvement in the Vietnamese culture related negatively to personal adjustment (i.e., distress). These findings are discussed in terms of the apparent complexities of the acculturation-adjustment link particularly with regard to the utility of viewing acculturation from a two-dimensional framework and the need to consider the type of adjustment indices examined and the social contexts in which ethnic groups reside.

Phinney J. and Devich-Navarro M. (1997). "Variations in bicultural identification among African American and Mexican American adolescents." *Journal of Research on Adolescence* 7: 3-32.

To identify the ways in which minority adolescents deal with being part of two cultures, the authors studied forty-six middle- and working-class Mexican American and fifty-two middle-class African American students from ethnically diverse high schools in Southern California. Participants were interviewed about their sense of being ethnic, American, and bicultural, and they also completed questionnaire measures of ethnic identity, American identity, other-group

attitudes, self-concept, and anxiety. Qualitative analysis of the interviews revealed three types of identification patterns: blended biculturals, alternating biculturals, and separated adolescents. Scores on American identity and other-group attitudes differed significantly among the identification patterns. Ethnic and American identity were generally uncorrelated, supporting the multidimensional (vs. linear) view of being bicultural. The results illustrate the varied types of identification manifested by ethnic minority adolescents in relation to their two reference groups, ethnic and American.

Rogers-Dulan J. and Blacher J. (1995). "African American families, religion, and disability: A conceptual framework." *Mental Retardation* 33: 226-238.

This paper explores issues of religion, disability, and ethnicity, with emphasis on how these factors relate to adjustment for families, particularly African American families, who have a child with disabilities. Findings gathered from diverse literature sources are reflected in a proposed framework to guide future research and policy development. Data indicate that for most families who have a child with disabilities, religion helps interpret the meaning of the event, facilitates acceptance, and influences the tendency to keep the child in the home. (©1997 APA/PsycINFO, all rights reserved.)

Sandoval M. (1979). "Santeria as a mental health care system: An historical overview." *Social Science and Medicine* 13B: 137-151.

Santeria, an Afro-Cuban cult organization which had previously flourished in certain parts of the island of Cuba, has taken root in several areas of the United States, primarily in Florida, New York, New Jersey and California. This Afro-Cuban religious system has an essentially African world view and ritual. It has not only survived the impact of acculturation but has expanded its influence. It may be said that Santeria now constitutes a vital and dynamic mental health care system. Using Dade County, Florida, as context, this article examines some of the reasons for Santeria's broadened scope and its success in attracting more followers. The author's extensive experience is drawn upon to provide, first, an abbreviated description of this religious institution. Second, an overview is offered of the historical process that led to its inception and helped shape the religious and health-seeking behavior of Cubans in their homeland. Third, a phenomenological view is introduced which touches upon some of the problems confronting Cubans in Dade County. Finally, consideration is given to the function of Santeria in this setting, the kind of people who look to it for support and the type of support it provides. It is concluded that Santeria's intrinsic flexibility, eclecticism and heterogeneity have been advantageous. These characteristics have allowed function, dogmatic and ritual changes which enable it to meet the different needs of its many followers. In its continuing adaptation, Santeria has the potential to become a collaborating institution which can handle matters of the soul, while the orthodox health care system deals with matters of the mind. There is no conflict between the two in the eyes of either santeros (priests) or clients.

Singer M. and Borrero M. (1984). "Indigenous treatment for alcoholism: The case of Puerto Rican spiritism." *Medical Anthropology* 8: 246-273.

The authors focus on the religio-therapeutic tradition known as Espiritismo (spiritism), especially one Espiritismo healing center (centro) in Hartford, Connecticut, as a culturally appropriate treatment modality for treating alcoholism within the Puerto Rican community. They describe Espiritismo as a syncretization of European spiritism, traditional Native American and African curing practices, and folk Catholicism. This article explains the basic ideology and general treatment practices of Espiritismo as an indigenous healing system, analyzes the treatment approaches to alcoholism and alcohol abuse used in their research site, and identifies culturally relevant features of this therapeutic modality. Finally, they discuss clinical and service implications of the findings.

Suarez M., Raffaelli M. and O'Leary A. (1996). "Use of folk healing practices by HIV-infected Hispanics living in the United States." *Aids Care* 8: 683-90.

Authors conducted a survey in the waiting room of a hospital-based HIV/AIDS clinic in New Jersey. Ninety percent of respondents were of Puerto Rican descent. Of the seventy-six respondents, 73 percent believed in good and evil spirits, and of these 39 percent believed that spirits played a causal role in their illness, along with the AIDS virus. Over three quarters reported engaging in folk, religious or other alternative health practices. The most common practices were spiritualist prayers, making a promise; and lighting of candles. "Physical relief (relief from pain, cure, general relief) was the most common reason for practicing folk healing." Two fifths said they were seeking spiritual relief (peace, enlightenment, salvation or absolution). Twenty-five percent said they hoped to "ward off evil" through their practices. Authors suggest that these coping mechanisms may help participants to gain a sense of control over their illness (Authors cite one study where this sense of control was beneficial psychologically and physically.) Authors conclude, "Health care professionals treating HIV-infected Hispanics should be sensitive to the prevalence of alternative healing practices which may be used by many of their patients and attempt to integrate their medical treatments into a culturally appropriate model."

Tafoya T. (1996). Native two-spirit people. In: *Textbook of Homosexuality and Mental Health*. Cabaj R. and Stein T., eds. Washington, DC: American Psychiatric Press, 603-617.

The Native term of two-spirit comes from the concept that one has both a male and a female spirit within; to be male means seeing through the eyes of a male; to be female means seeing through the eyes of a female, but to be two-spirit means seeing through both sets of eyes, and therefore being able to see further, or more holistically, than someone who is only male or female. The author notes that it can be of great value to expose Native people to their own rich heritage of the two-spirit, with its connections to homosexuality, gender roles, and history. It should never be assumed that Native patients have had the opportunity to find out

about their own traditions. This chapter explores cross-cultural dimensions of sexuality and is valuable for providing a Native view of gender and sexual orientation. It also highlights research and therapeutic concerns regarding sexuality and Native peoples; historical and colonial factors that affect sexual expression; and the relationship between ethnic and cultural identity in these groups. (©1997 APA/PsycINFO, all rights reserved.)

Tatum, Beverly Daniel, Ph.D. (1997) *Why Are All the Black Kids Sitting Together in the Cafeteria? And Other Conversations about Race*. New York, Basic Books.

Clinical psychologist Beverly Daniel Tatum has written a book on racial identity in the United States that is wonderfully conversational and compassionate. The book draws on her years of experience teaching classes and workshops about race. In her introduction, she says, “I was convinced that helping students understand the ways in which racism operates in their own lives and what they could do about it was a true calling that I should accept.”

Tatum points out that we learn early not to talk about race. When she asks the participants in her workshops to think about their earliest race related memories, they usually recall experiences that carry the emotions of “anger, confusion, surprise, sadness, and embarrassment.” Most have never talked about these experiences. Therefore, Tatum asks, if as young people we didn’t figure these things out, “are we as adults prepared to help the children...make sense of their own race-related observations?” This insightful book includes chapters on the development of White identity in a White context, the development of Blackness in a White context, as well as noting critical issues in Latino, American Indian, and Asian-Pacific American identity development. There is also an annotated list of other books and resources for children and adults. The book provides valuable tools for students and health care workers interested in developing critical thinking and cultural sensitivity on racial issues.

Tran T. (1993). Psychological traumas and depression in a sample of Vietnamese people in the United States. *Health and Social Work. 18:* 184-194.

This article investigates the relationships among pre-migration stresses, nightmares, acculturation stresses, personal efficacy, and depression in a sample of 147 adult Vietnamese Americans. The analysis revealed that premigration stresses, nightmares, and acculturation stresses had significant indirect effects on depression. Acculturation stresses diminish personal efficacy, and a weakness of personal efficacy leads to higher depression. Age, gender, marital status, and English language ability also exert differential effects on premigration stresses, nightmares, acculturation stresses, personal efficacy, and depression. Health care professionals, social workers, health care organizations, and social work researchers who work with Vietnamese clients should be more culturally sensitive when planning and implementing services and developing research instruments.

Westermeyer J., Bouafuely M. and Vang T. (1984). "Hmong refugees in Minnesota: Sex roles and mental health." *Medical Anthropology 8*: 229-245.

Ninety-seven Hmong refugees residing in Minnesota were studied to assess the influence on mental health of the rapid change in gender roles brought about by forced migration. Self-rating scales of psychological symptoms and a survey of pre and post-migration domestic, social and occupational activities were administered at baseline and two years later. Among the many findings, Hmong men experienced increased psychological symptoms as they came into contact with American institutions, such as hospitals and welfare offices. Contact with these institutions was not associated with increased psychological symptoms in Hmong women. Employment within the first twelve months post-migration was associated with depression in men and phobic anxiety in women. The "natural experiment" of forced Hmong migration provided researchers an opportunity to assess the impact of altered social relations (new contact with American institutions, forced alterations in gender roles) manifested in rates of psychological symptoms, and how that impact differed by gender.

Young Y., Lujan P. and Dixon L. (1998). "I can walk both ways: Identity integration of American Indians in Oklahoma." *Human Communication Research 25*: 252-274.

Several theories have been developed to explain the structure of cross-cultural experiences and responses of Native American groups. One theory adopts an either/or premise of conflicting identities, one tribal, one national. Another posits that adaptation occurs according to minority individuals' responses to the dominant environment. Case studies demonstrate that these two theories are interrelated, and reflect both Native American values of family-oriented collectivism and American values of individuality. This article analyzes the identity experience of American Indians in Oklahoma. The state offers a sociocultural milieu in which life activities of Indians closely interface with those of non-Indians in relative harmony. Berry's (1970, 1980, 1990) acculturation model serves as a conceptual template to help locate different modes of Oklahoma Indians' identity experience. Kim's (1988, 1995a, 1995b, in press) communication theory of cross-cultural adaptation provides the basis for offering a multidimensional system for explaining the linkage between identity experience and other facets of cross-cultural adaptation.

The analysis uses portions of both the quantitative data and the verbal transcripts obtained through 182 one-on-one interviews during 1988 to 1989 at six research sites in the state. Results show a preponderance of integrative identity mixed with varying degrees of separatist orientation. Evidence is also provided for Kim's theoretical articulation of cultural-intercultural identity continuum. Positive correlations are seen between identity integration, interpersonal engagement with non-Indians, functional fitness, and psychological health.

III. Health Care Services and Multicultural Health Issues

- A. Racial and Socio-economic Disparities
in Health Care Delivery*
- B. Language and Cultural Barriers
in Health Care Delivery*
- C. Addressing Gender, Sexual Orientation,
and Disability Status*
- D. Managed Care Issues*

A. Racial and Socioeconomic Disparities in Health Care Delivery

Allison J., Kiefe C., Centor R., Box J. and Farmer R. (1996). "Racial differences in the medical treatment of elderly Medicare patients with acute myocardial infarction." *Journal of General Internal Medicine* 11: 736-43.

Given the extensive literature on racial differences in use of invasive procedures to treat coronary artery disease, the authors undertook a study to assess racial differences in use of medical management of the same. Data were obtained from an extensive chart review study of approximately 300 clinical elements per patient. While there were no racial differences in use of Beta Blockers and aspirin on the treatment of acute myocardial infarction, African Americans were half as likely to receive thrombolytics as were Whites, despite controlling for whether or not they were "ideal candidates" for thrombolysis, and for disease severity, age, gender, rural or urban location, and teaching status of the hospital. Of those offered thrombolysis, African Americans and Whites refused this at similar rates, an indication that patient preferences can not explain racial differences in rates of thrombolytic use. Authors state, "African Americans received thrombolysis less frequently, and our analysis suggests... that this resulted from inappropriately withholding treatment from African Americans."

Ayanian J. (1993). "Heart disease in Black and White." *New England Journal of Medicine* 329: 656-657.

Ayanian points out the racial disparities still existent in many dimensions of American society and that "health care is no exception." He argues that racial "disparities [in health status] are rooted in the unequal social and economic opportunities available to Blacks in a predominantly White society." He summarizes the literature on racial disparities in cardiovascular procedures and other areas of health care, and makes the clear link to patient outcomes. He posits that racial disparities may be mediated through suboptimal patient-physician communication. He suggests that improvement in the health care of Blacks will come with the following changes: [1] when "the health care system... ensures access to effective medical care and educates patients to take full advantage of it"; [2] when there is a "commitment by physicians to eliminate racial bias, even subtle forms, from clinical decisionmaking and communication with patients; and [3] when "socioeconomic opportunities in American society are not limited by race."

Ayanian J., Udvarhelyi I., Gatsonis C., Pashos C. and Epstein A. (1993). "Racial differences in the use of revascularization procedures after coronary angiography." *Journal of the American Medical Association* 269: 2642-2646.

Authors tracked 27,185 MediCare enrollees between 65 and 74 years of age who underwent inpatient angiography for coronary artery disease in 1987. Controlling for age, sex, region, Medicaid eligibility, principal diagnosis, comorbid diagnoses, hospital characteristics, teaching status of hospital, urban/suburban or rural location, and availability of procedures, Whites were 78 percent more likely to receive a revascularization procedure than were Blacks.

Burns R., McCarthy E., Freund K., Marwill S., Shwartz M., Ash A. and Moskowitz M. (1996). "Black women receive less mammography even with similar use of primary care." *Annals of Internal Medicine* 125: 173-82.

"Having a regular source of care is the most important determinant of mammography use." Authors studied whether primary care access explained differences in mammography rates between Black and White women. 1990 Health Care Financing Administration data of 3,187,116 Black and White elderly women on Medicare from 10 states were analyzed. Only 9 percent of Black women had mammography, compared to 15 percent of White women. At each primary care visit level (1, 2, or more than 3 visits), this racial disparity was found for Black and White women, respectively: 1 visit: 7 percent vs. 15 percent; 2 visits: 12 percent vs. 21 percent; 3+ visits: 12 percent vs. 20 percent. The disparities persisted after controlling for income level. "These results suggest that the nature of primary care may vary... between White and Black women." The authors raise the important point that 40 percent of mortality differentials in breast cancer are explained by differences in the stage of presentation. Racial disparities in mortality (2 times higher in Blacks than in Whites) can be explained in part by racial differences in the content of primary care.

Carlisle D., Leaker B. and Shapiro M. (1997). "Racial and ethnic disparities in the use of cardiovascular procedures: Associations with type of insurance." *American Journal of Public Health* 87: 263-267.

Authors studied 105,000 residents of Los Angeles County hospitalized with coronary artery disease between 1986 and 1988. African American and Latino patients were less likely than Whites to undergo either coronary artery bypass, coronary artery angioplasty, or arteriography, in all insurance categories (HMO, Medicaid, Medicare, uninsured) except that of private insurance. Asians had procedure rates that were not significantly different from Whites. Authors controlled for age, gender, severity of illness and hospital procedure volume.

Diehr P., Yergan J., Chu J., Feigl P., Glaefke G., Moe R., Bergner M. and Rodenbaugh J. (1989). "Treatment modality and quality differences for Black and White breast-cancer patients treated in a community hospital." *Medical Care* 27: 942-948.

This was a study of 7,781 White and Black patients treated in 197 hospitals in 45 U.S. communities between 1982 and 1985. Standards of care used in this analysis were based on those set by an expert National Cancer Institute-appointed committee. Black patients were significantly less likely to have a progesterone receptor assay or to have been referred for post-mastectomy rehabilitation (both deemed desirable patterns of care). Black patients were also more likely to receive liver scans and radiation treatment in clinical scenarios where these procedures were deemed "inappropriate." In regard to this latter result, this is a rare finding of Blacks receiving more intense care than Whites. Unfortunately, this care was inappropriate or

inferior. In controlling for health insurance, hospital and physician characteristics, patient age, and stage of disease, racial disparities persisted. Authors surmise that differential patterns of care may help explain higher rates of breast cancer mortality in Black women.

Escarce J., Epstein K., Colby D. and Schwartz J. (1993). "Racial differences in the elderly's use of medical procedures and diagnostic tests." *American Journal of Public Health* 83: 948-954.

1,204,022 Medicare enrollees aged 65 and older were studied for their use of medical procedures and diagnostic tests. Of the services studied, Whites were more likely than Blacks to receive twenty-three of the thirty-two services. For instance, Whites were three times as likely to receive coronary artery bypass surgery, angioplasty and carotid endarterectomy. Racial disparities increased when looking at Whites and Blacks residing in rural areas. For instance, rural Whites were twenty times as likely as rural Blacks to receive coronary angioplasty. Differences persisted in looking at Medicare beneficiaries who also received Medicaid (a subset of patients with low out-of-pocket expenses). For the twenty-three procedures and tests studied, Whites were more likely to use higher technology or newer services than Blacks. Authors recommended further studies to assess the relative contributions of financial and organizational barriers, as well as physician and patient decisionmaking.

Friedman E. (1994). "Money isn't everything: Nonfinancial barriers to access." *Journal of the American Medical Association* 271: 1535-1538.

Friedman argues for greater attention to nonfinancial barriers to quality medical care, barriers that would not necessarily be remedied by universal financial access (coverage). In this brief review, she presents data and concepts reflecting differential allocation of services by race, gender, diagnosis (i.e. chronic illness), location (rural vs. urban), class and culture. She presents the following strategies for remedying these disparities and for further exploration: 1) stronger enforcement of protective statutes, such as the Civil Rights Act and the Americans With Disabilities Act; 2) requirement of outcomes data collection and feedback that include data on patient race, age, gender, diagnosis, income, etc. 3) further understanding of the market forces in health care delivery that put populations at risk, and 4) understanding the limits of insurance.

Geiger H. (1996). "Race and health care—An American dilemma." *New England Journal of Medicine* 335: 815-816.

A brief but excellent summary of racial disparities in allocation of health services. He reports that a recent search of the literature on racial and ethnic disparities in health care, prepared for the American Medical Association's board of trustees, covering only the ten-year period 1984 to 1994 and restricted to articles, commentaries, and letters in the *New England Journal of Medicine* and the *Journal of the American Medical Association*, filled sixty-six single-spaced

pages. Geiger goes on to state, “With major confounding factors increasingly controlled and adjusted for, investigators tend to invoke unspecified cultural differences, undocumented patient preferences, or a lack of information about the need for care as reasons for the differences. The alternative explanation is racism—that is, racially discriminatory rationing by physicians and health care institutions.” He recommends steps we can take now: 1) monitoring of racial disparities in use of services as part of the quality assurance protocol of every health care delivery system, and 2) cultural awareness as part of every physician’s training.

Gemson D., Elinson J. and Messeri P. (1988). “Differences in physician prevention practice patterns for white and minority patients.” *Journal of Community Health* 13: 53-64.

This study consisted of phone interviews of 120 primary care physicians in New York City in 1984. Physicians were described as serving greater than or equal to 50 percent Black and Hispanic patients or greater than or equal to 50 percent White patients. Compared with physicians serving a majority of White patients, physicians seeing a majority of patients of color saw more Medicaid patients, and saw more patients per hour and per week. Physicians with predominantly non-white patients were less likely to recommend mammography (23 percent vs. 67 percent), influenza vaccine for the elderly (47 percent vs. 7 percent), and smoking cessation programs for patients who smoked (27 percent vs. 54 percent). In controlling for possible confounding factors, the majority of differences in prevention practices was explained by physician’s background (physicians serving predominantly non-White patients were less likely to be board certified and, more likely to not have graduated from a U.S. medical school), the proportion of Medicaid patients seen, and the time spent with each patient.

Gittelsohn A., Halpern J. and Sanchez R. (1991). “Income, race, and surgery in Maryland.” *American Journal of Public Health* 81: 1435-1441.

Surgical and medical admission rates were studied for Blacks and Whites from hospital discharge abstracts from 1985 to 1987. Coronary artery bypass, angioplasty, and carotid endarterectomy rates were lower for Blacks in each income class. These procedures increase with income, apart from the impact of race. For other surgeries, the more discretionary (elective) the procedure, the lower the surgical rates in Blacks.

Gornick M., Eggers P., Reilly T., Mentnech R.; et al. (1996). “Effects of race and income on mortality and use of services among Medicare beneficiaries.” *New England Journal Of Medicine* 335: 791-799.

This is a study of 1993 Medicare administrative data for 24.2 million Whites and 2.1 million Blacks, age 65 and older. Data were age and gender-adjusted. For every 100 White and every 100 Black women, rates of mammography were 26.0 and 17.0 respectively. For every 1000 Whites and 1000 Blacks respectively, patients received 515 and 313 influenza vaccines. Blacks were over three and a half times as likely as Whites to undergo amputations (diabetes is 1.7

more prevalent in Blacks). “Blacks may be at higher risk for procedures associated with less than optimal management of chronic disease.” Effects of racial differences in income decreased the racial disparities in utilization only a small amount. Similar rates for hip replacement (a non-elective procedure) suggest race and income are not significant factors in access to non-elective procedures for the elderly. Financial access alone is not enough to ensure equality of effective care.

Haas J., Weissman J., Cleary P., Goldberg J., Gatsonis C., Seage G. 3rd, Fowler F., Massagli M., Makadon H. and Epstein A. (1993). “Discussion of preferences for life-sustaining care by persons with AIDS: Predictors of failure in patient-physician communication.” *Archives of Internal Medicine* 153: 1241-1248.

Interviews of 289 patients with AIDS in Boston were conducted at an HMO, a group practice at a private teaching hospital, and at a public clinic. Authors found that although patient desire to discuss life-sustaining care did not vary by race, non-White patients were half as likely as Whites to have discussed life sustaining care with their physicians. Among nonwhites, those with non-White physicians were more than 4 times as likely to have discussed resuscitation. Age, gender, income, and level of education of the patients were all controlled for. Authors, recognizing that patient-physician communication of life-sustaining treatment in AIDS patients is “a component of high-quality care,” concluded the following: “Interventions to improve patient-physician communication about resuscitation for nonwhites and other groups at risk of inadequate discussion might lead to clinical decisions that are more consistent with patient preferences.”

Hofmann J., Wenger N., Davis R., Teno J., Connors A., Jr, Desbiens N., Lynn J. and Phillips R. (1997). “Patient preferences for communication with physicians about end-of-life decisions. Study to Understand Prognoses and Preference for Outcomes and Risks of Treatment.” *Annals of Internal Medicine* 127: 1-12.

Authors reviewed the charts of and interviewed 1,589 patients to assess the correlation of patient characteristics and patient preferences for life-sustaining measures to whether physicians actually had this discussion with them. Patients were hospitalized at the time of the interview with one of nine conditions that subsequently were found to have a six month mortality rate of ~50 percent. Seventy-seven percent of patients had not discussed their preferences for end-of-life care with physicians. Of these, 42 percent said they had wanted to discuss them. Black patients were 1.5 times as likely as Whites to have wanted to discuss resuscitation (CPR) with their doctors and to have not done so. Authors conclude that, “Just as non-Whites receive less intensive use of resources, they may also be less likely to have their needs met for discussions about care preferences at the end of life.”

Horner R., Oddone E. and Matchar D. B. (1995). "Theories explaining racial differences in the utilization of diagnostic and therapeutic procedures for cerebrovascular disease." *The Milbank Quarterly* 73: 443-460.

Through an extensive review of the literature, authors posit alternative explanations to discrimination for racial disparities in carotid endarterectomy and other procedures. They present data that support the following possible explanations for these racial disparities: differences in disease severity incompletely measured in previous studies (i.e. differences in location of the stenosis of carotid arteries makes carotid endarterectomy a more appropriate surgery for Whites); economic factors especially ability to incur costs of procedures done on an outpatient basis (most are studies of hospitalized patients); role of patient decisionmaking, including beliefs in disease susceptibility and treatment efficacy, and self-perceived barriers to care (distrust or dissatisfaction with care). Authors state that further studies documenting disparities are unnecessary. They recommend further exploration of the ability to pay, exploration of what clinical factors influence physicians' decision to recommend a procedure, and in-depth exploration of the patient and physician decisionmaking process.

Javitt J, McBean A, Nicholson G, Babish J, Warren J. and Krakauer H. (1991). "Undertreatment of glaucoma among Black Americans." *New England Journal of Medicine* 325: 1418-22.

Blindness from glaucoma is six to eight times higher in Blacks than in Whites, while glaucoma itself is four to six times higher in Blacks. Authors studied a random sample of 9841 White and 1821 Black Medicare beneficiaries sixty-five years and older between 1986 and 1988. Rates of laser and incisional surgery for glaucoma were obtained. Surgical incisional rates were 45 percent lower than expected among Blacks. That is Blacks, "who are at least 4 times more likely to have glaucoma than Whites, are only twice as likely to receive surgical treatment for it." These findings were consistent in all regions of the country. Hypotheses to explain these racial disparities in sight-saving procedures included uncertainty among providers regarding the appropriate treatment for Blacks, and economic and social factors (i.e. public awareness, differences in willingness or trust in the care of physicians, differences in ability to pay for ancillary costs, differences in access, differences in physician practice patterns by race).

Kahn K., Pearson M., Harrison E., Desmond K., Rogers W., Rubenstein L., Brook R. and Keeler E. (1994). "Health care for black and poor hospitalized Medicare patients." *Journal of the American Medical Association* 271: 1169-1174.

Authors studied 9,932 patients who were at least sixty-five years of age with congestive heart failure, acute myocardial infarction, pneumonia or stroke. Patients were hospitalized in one of 279 hospitals across five states. "Process of care" was meticulously defined and extracted and included a variety of different dimensions such as "the extent to which intensive care

units... were used by patients sick enough to be there” and “how well providers performed as data gatherers.” Black and poor patients were more likely to receive worse “process of care” than other patients. In addition, patients who were Black or poor were significantly more likely to be discharged in an unstable condition than other patients. Mortality was not worse for Black and poor patients because they were more likely to receive their care from urban teaching hospitals, which were stated to offer better quality care. Authors state that “further research is needed to clarify whether sociocultural and educational incongruity between providers and patients translates into misunderstanding about patients’ preferences and expectations, and to evaluate the extent to which stereotyping, discrimination, or bias exist in the hospital setting.”

Kogan M., Kotelchuck M., Alexander G. and Johnson W. (1994). “Racial disparities in reported prenatal care advice from health care providers.” *American Journal Of Public Health* 84: 82-88.

Authors studied 8,310 Black and White women in a nationally representative sample from the 1988 National Maternal and Infant Health Survey Database. White women were more likely to report having received prenatal care advice on alcohol, smoking and breastfeeding than were Black women (i.e. 70 percent of White women reported receiving advice on alcohol cessation, compared to 60 percent of Black women.) After adjusting for education, income, marital status, insurance status, site of prenatal care, trimester of initiation of prenatal care, and whether women engaged in healthy behaviors, Black women were still significantly less likely to have received advice on alcohol and smoking cessation. Authors conclude that “The content of prenatal care is not uniform across racial groups... and differential prenatal care may lead to differential efficacy and could be a factor in the huge differential rates of birth outcomes by race seen in the U.S...”

Komaromy M., Lurie N. and Bindman A. (1995). “California physicians’ willingness to serve the poor.” *Western Journal of Medicine* 162: 127-132.

A series of focus groups with twenty-four physicians from four California communities resulted in survey questions that were administered to a random sample of 177 California general internists, family physicians, and general practitioners. Although over 80 percent of physicians said there were far too few physicians in their communities serving Medicaid and uninsured patients, only 31 percent of the respondents said they accepted new Medicaid patients and only 41 percent said they accepted uninsured patients unable to pay the full fee.

Non-White physicians were more likely to accept new Medicaid and uninsured patients. Several strategies for avoiding these patients were gleaned from this study, including assigning a resident physician to see the patient, having office staff screen them out at the initial phone call phase, and assigning these patients to a public hospital clinic.

Physicians' self-reported reasons for avoiding the uninsured and Medicaid patients included inadequate reimbursement, difficulty providing the "standard" of adequate care given financial restraints (i.e. inability to order appropriate lab tests, obtain x-rays or secure specialty consultations), perception of increased malpractice risk and patient characteristics (psychosocial problems, ingratitude, and noncompliance). While universal insurance would improve financial access, it may not remove financial barriers to care faced by physicians who find it difficult to make ends meet serving a substantial number of poor patients. Adequate reimbursement, coverage of lab tests and outpatient specialty referrals, tort reform, and elimination of burdensome paperwork, are all cited as needed policy reforms to encourage and enable care for the poor. In addition authors state that recruiting non-White physicians may be an important and effective way of overcoming financial and nonfinancial barriers to access for the poor.

Leppert P., Partner S. and Thompson A. (1996). "Learning from the community about barriers to health care." *Obstetrics and Gynecology* 87: 140-141.

In an attempt to identify barriers that keep women from obtaining preventive and prenatal care, a series of focus groups was conducted in a region of Rochester, New York. Patients were poor and African American. Major barriers identified were: 1) lack of insurance or embarrassment over the need to negotiate payment; 2) disinterest of doctors; 3) long waiting time; 4) lack of respect from doctors for patients on public assistance; 5) inability to see the same doctor; 6) lack of transportation; 7) fear of losing their children or of incarceration if they became involved in the health care system; and 8) fear of medications and medical tests. In addition many believed that patients on public assistance were the subject of experiments.

Mayer W. and McWhorter W. (1989). "Black/White difference in non-treatment of bladder cancer patients and implications for survival." *American Journal of Public Health* 79: 772-774.

This is a study of 20,764 White and Black cancer patients from tumor registries across the country between 1978 and 1985. Controlling for age, stage at diagnosis, and tumor histology, Blacks were 1.8 times more likely than Whites to go untreated for bladder cancer. Those untreated were over three times as likely as treated patients to die within five years, suggesting that differences in treatment status among Blacks and Whites may account in part for the higher bladder cancer mortality rate among Blacks.

Moore R, Stanton D, Gopalan R. and Charisson R. (1991). "Racial differences in the use of drug therapy for HIV disease in an urban community." *New England Journal of Medicine* 330: 763-768.

Among 838 patients presenting to the Johns Hopkins Hospital HIV Clinic for the first time, there were no racial differences in stage of HIV disease. However, 63 percent of eligible Whites and only 18 percent of eligible Blacks received antiretroviral therapy, while 87 percent of eligible Whites and only 58 percent of eligible Blacks received PCP prophylaxis. These racial differences were not related to age, sex, mode of HIV transmission, type of insurance, income, education, or place of residence. No racial differences were found in prescription after 6 months of clinic visits.

Nickens I.. (1996). "A compelling research agenda." *Annals of Internal Medicine* 125: 237-239.

In a brief commentary, Nickens presents why race remains a factor in American society when it comes to health care delivery and health status. He presents the search agendas and unanswered questions that make for a potentially "complex and elegant science," rather than simply an opportunity to splinter into special interest groups. He states. ". . . research in minority-health should be viewed as a scientific and intellectual challenge and not, as is so often the case, a special interest issue."

Seddon J. (1991). "The differential burden of blindness in the United States." *New England Journal of Medicine* 325: 1440-1442.

Sedden raises the concern that Blacks suffer from blindness at twice the rate of Whites and that at least one third of this blindness is preventable (operable cataracts). She offers possible explanations for this disparity: 1) socioeconomic factors, the disproportionate number of Blacks represented among the poor, and the poor health status of the poor; 2) varying ideas about blindness and its significance (i.e. health beliefs); 3) lack of access and/or lack of trust in providers; and 4) differential treatment by providers.

Sommer A., Tielsch J., Katz J., Quigley H., Gottsch J., Javitt J., Martone J., Royall R., Witt K. and Ezrine S. (1991). "Racial differences in the cause-specific prevalence of blindness in East Baltimore." *New England Journal of Medicine* 325: 1412-1417.

A sample of 2,395 Blacks and 2,913 Whites forty years and older underwent ophthalmologic evaluation. Controlling for age, Blacks were overall five times as likely as Whites to have unoperated cataracts. "Whites appear to have been well-served by the rapid increase in cataract-extraction rates over the past two decades." The leading cause of blindness among the Black subjects, on the other hand, was unoperated cataracts. The study controls only for

age, not other measures of socioeconomic factors or insurance status. Authors make only passing reference to the “existence of socioeconomic or other cultural barriers to appropriate care” as an explanation for the disparities in surgical intervention rates.

Todd K., Samaroo N. and Hoffman J. (1993). “Ethnicity as a risk factor for inadequate emergency department analgesia.” *Journal of the American Medical Association* 269: 1537-1539.

Authors studied the medical records of 139 patients presenting to the UCLA Emergency Medical Center with what are normally very painful longbone (humerus and femur) fractures. Latino patients were half as likely as White patients to receive pain medication while in the emergency room. This finding persisted after controlling for type of insurance, English proficiency, total time in the emergency room, mechanism of injury, gender, or injury severity.

Todd K., Lee T. and Hoffman J. (1994). “The effect of ethnicity on physician estimates of pain severity in patients with isolated extremity trauma.” *Journal of the American Medical Association* 271: 925-928.

This was a follow-up study to the one immediately preceding (Todd et al). Physicians’ assessments of severity of pain did not differ for Latino and White patients (i.e. the authors presume that the differences in prescription of pain medication found in the previous study could not be explained by assessing the level of pain differently in Whites and Latinos).

Wenneker M. and Epstein A. (1989). “Racial inequalities in the use of procedures for patients with ischemic heart disease in Massachusetts.” *Journal of the American Medical Association* 261: 253-257.

Authors studied 109,575 hospital admissions for Blacks and Whites for circulatory diseases or chest pain in Massachusetts in 1985. Controlling for age, sex, principal diagnosis, disease severity, insurance type, hospital and income, Whites were more likely to undergo coronary artery bypass or coronary angioplasties than Blacks. Authors conclude, “If medical decisions are being made on the basis of race, we need to understand more about the complex interaction between physician and patient that leads to this inequality and the implications of these patterns for the appropriateness and efficacy of medical care.”

Whittle J., Congliano J., Good C. and Lofgren R. (1993). “Racial differences in the use of invasive cardiovascular procedures in the Department of Veteran Affairs medical system.” *New England Journal of Medicine* 329: 621-627.

Authors studied Black and White male veterans thirty years of age and older who were discharged with a primary diagnosis of chest pain or cardiovascular disease between 1987 and 1991. Rates of cardiac catheterization, percutaneous transluminal coronary angioplasty and

coronary artery bypass surgery for Whites and Blacks respectively were 19.3 percent vs. 11.8 percent, 1.8 percent vs. 0.8 percent. and 5.0 percent vs. 1.6 percent. Authors controlled for age, marital status, disease severity, income, and whether or not the hospital was equipped to perform coronary artery bypass or angioplasty. Authors conclude, "Our data, coupled with the results of previous studies, suggest the existence of race-related inequities in our health care system." This study is distinctive because racial disparities were persistent under the following conditions: 1) financial incentives in fee-for-service systems are minimized in VA centers; 2) patients' finances do not affect the incomes of salaried VA physicians; 3) patients are not billed for services; 4) differences in personal income did not account for these differences; 5) disparities were found regardless of whether the procedure was performed often or rarely in specific hospitals; and 6) this study used a national database.

B. Language and Cultural Barriers in Health Care Delivery

Chilton E. (1996). "Ensuring effective communication: The duty of health care providers to supply deaf language interpreters for deaf patients." *Hastings Law Journal* 47: 871-910.

For most profoundly deaf people, effective communication in medical settings can be achieved only through the use of qualified sign language interpreters. Unfortunately, health care providers routinely fail to obtain and utilize such interpreters, even when requested by deaf patients. This failure to provide interpreters often leaves deaf patients or family members unable to communicate vital information to health care staff, such as the patients' health history and current symptoms. Further, doctors are unable to explain medical procedures and options; nor can providers obtain patients' consent to perform such procedures. This lack of communication between deaf patients and their doctors can lead to misdiagnoses and problems in treatment. Indeed, studies indicate that the lack of sign language interpreters and the resultant communication problems that occur has negatively impacted the health of the deaf population as a whole.

This paper argues that hospitals, doctors, and other health care providers have an affirmative obligation to create and implement an effective policy for supplying qualified sign language interpreters to deaf patients and their families. In addition to discussing the anti-discrimination provisions contained within the Americans with Disabilities Act that require providers to ensure effective communication with deaf patients, the article offers practical solutions to assist practitioners in obtaining qualified interpreters and financing the cost of such services.

Fadiman, Anne. (1997) *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York: Farrar, Straus, Giroux.

Anne Fadiman has written a moving and descriptive book that describes a cultural clash between a Hmong family and Western doctors. In 1982, the Lee family brought their infant daughter into Merced County Community Hospital's emergency room because she was convulsing. "Lia had her first epileptic seizure when she was just three months old. According to the Lees, recent immigrants from the Secret War of Laos who did not speak English and could not even communicate their infant daughter's sickness to the doctors, the seizure stemmed from spiritual causes." The family called her illness *qaug dab peg* (the spirit catches you and you fall down). "After several seizure episodes, and only when Lia was brought in still convulsing did the doctors properly diagnose her as suffering from epilepsy. From the American doctors' perspective, Lia's condition was biological in origin and could be alleviated with drugs. Over the next four years Lia's anticonvulsant prescriptions changed 23 times. Gradually, the Lees doubted the effects of these complicated multiple prescriptions. When they refused to administer the drugs to Lia, the doctor had Lia placed in foster care." The cultural misunderstandings reflected in these events eventually had devastating results for both Lee and her family. (Quotes from a review by Mai Lee.)

In fact, Fadiman shows that the repercussions of this family's experience spread throughout both the Hmong community and the medical establishment in Merced County. Fadiman immerses herself in the details of Lee's case; she talks with Lee's family, the doctors that treated her, Hmong community members, and Lee's foster family. She demonstrates a deep commitment to describing the facts without blaming any of the participants. It is a huge task. While there are undoubtedly challenges to an outsider's attempt to understand the culture of another group, Fadiman does a tremendous job of making sense of a difficult case, and raising the questions that must be asked about the role of doctors as ultimate experts, the place the soul has in medicine, and the dilemmas of practicing medicine in cultural and social isolation from the worlds of patients, issues that have impact for us all. This book should be read by all students and health care workers interested in developing critical thinking and cultural sensitivity on issues of multi-cultural health delivery.

Haffner L. (1992). "Translation is not enough. Interpreting in a medical setting in: Cross-cultural medicine—a decade later [Special Issue]." *Western Journal of Medicine* 157: 255-259.

The author describes her day as a professional interpreter, presenting several case vignettes to illustrate the complexities of not just linguistic translation, but cultural translation as well. She presents an excellent discussion of the suboptimal, albeit common, practice of using a child of a patient as that patient's interpreter.

Hornberger J, Gibson C. D, Jr, Wood W, Dequeldre C, Corso I, Palla B. and Bloch D. (1996). "Eliminating language barriers for non-English-speaking patients." *Medical Care* 34: 845-56.

Authors studied two styles of medical translation: remote-simultaneous interpretation (where the interpreters are at a site that is different from the patient and provider, and his/her translation is heard almost simultaneously as it is being said by the provider or patient, by way of headsets) and proximate-consecutive interpretation (where the interpreter is present with the patient and provider). The former is adapted for the medical setting from the "high quality" translation that occurs in international settings, where interpreters repeat phrases almost instantaneously in the first-person tense. Advantages include the ability to be at a distant location, although providing translation to a number of different clinical sites. Researchers compared the two styles by how much information is exchanged in the encounters, accuracy of interpretation, and patient and provider satisfaction. Forty-nine monolingual Spanish-speaking mothers attending a well baby clinic were separated into an experimental and control group, to receive either of the two modes of translation described. Results showed 10 percent and 28 percent more physician and patient "utterances" with the remote simultaneous translation than in the proximate consequent translation group.

The largest increase in types of utterances was in the number of explanations given by both physicians (18 percent) and mothers (22 percent). Mothers also asked significantly more questions with the remote simultaneous method. The duration of each type of encounter was nearly equal. The remote simultaneous interpretation had a 13 percent lower rate of inaccurately interpreted mother information per visit. All physicians and mothers preferred the remote simultaneous interpretation to the proximate consecutive interpretation, though interpreters preferred the latter. The pros and cons of each style are discussed. Authors state that beyond what was measured, further studies are needed to assess the cost-effectiveness of this new form of medical interpretation.

Jackson J., Rhodes L., Inui T. and Buchwald D. (1997). "Hepatitis B among the Khmer: Issues of translation and concepts of illness." *Journal of General Internal Medicine* 12: 292-8.

Interviews and participant observation of thirty-four Cambodian refugees in Seattle, Washington, were conducted to assess the "comprehensibility of hepatitis B translations." Authors found that the term *rauk tlaam*, typically used in medical translation and in patient education pamphlets to refer to hepatitis B was "a meaningless phrase" to 82 percent of interviews, including those with active hepatitis.

The direct translation of "hepatitis" into Cambodian as "liver disease" (*rauk tlaam*) suggested a "benign rash" to most of the interviewees. The authors described how Cambodians tend to categorize illness by its symptoms, not by anatomic parts or physiological processes as is the Western medicine tradition. The authors offer a useful extended discussion of the interplay of

medical linguistics and medical translation. Their practical suggestions from this study included the following: first, unless interpreters and public health educators are given special instructions to interpret culturally meaningful information, hepatitis translations will continue to focus on vocabulary equivalents of disease that are anatomically correct, but meaningless to many non-Western groups; second, clinicians and public health workers should form partnerships with interpreters to identify vocabulary, experiences, and concepts that will educate clinicians about the meaning and experience of common illnesses in immigrant communities and will help health workers shape their educational efforts; and third, health professionals in patient education must have better training to choose words appropriate for audience and context, be it professional or lay, Western or non-Western.

Kleinman A. (1978). "Concepts and a model for the comparison of medical systems as cultural systems." *Social Science and Medicine* 12: 85-93.

This is a dense, critically important treatise of the potential conflict between the culture of medicine and of those people "served" by medicine. The author presents the concept of medical systems (health care delivery organizations and the practitioners who work within them) as cultural systems: "Just as the cultural construction of the illness experience and of the criteria for evaluating therapeutic outcomes are built into health care systems, so too are institutionalized conflicts between lay and practitioner views of clinical reality and evaluations of therapeutic success. These conflicts, which are heightened by increasing differentiation (specialization of knowledge and social role)...systematically produce problems for clinical care... In other words, on the level of the cultural system, certain obstacles to effective health care, such as major discrepancies between the therapeutic goals of practitioners and patients, are built into the workings of the health care systems..." One specific example to illustrate this conflict is when professional practitioners see sickness only as disease and proffer explanations that transmit technical information and treatments that are technical "fixes," whereas patients seek not only symptom relief but also personally and socially meaningful explanations and psychosocial treatments for illness."

Further, Kleinman comments on the challenge and dilemma inherent in the most pressing questions for further research in this area: "...The study of explanatory model transactions in health care is only one component of the larger comparative study of clinical realities. That larger study, which almost certainly will extend and change our knowledge of the cultural context of sickness and care, requires methods which are not yet available. Those methods, given the nature of the problem, must be interdisciplinary, they must draw from ethnographic, clinical, epidemiological, and social psychological sources. They must relate sociopolitical and environmental determinants to biological and cognitive processes through the medium of cultural systems of meaning. Clearly, they will require models and concepts which consider

health and sickness to be the results of complex multi-factor interactions, on biological, psychological and social levels, not the results of single determinants operating on only one level of analysis.”

Levy D. (1985). “White doctor and Black patients: Influence of race on the doctor-patient relationship.” *Pediatrics* 75: 639-643.

Levy begins with several brief examples from the literature on the impact of racism on the patient encounter with the system and with individual providers. He presents manifestations of racism in the White practitioner: an unconscious overidentification with the patient which leads to overindulgence, paternalism and condescending interactions; negative countertransference, e.g. manifesting as calling the patient by the first name or making the patient wait inappropriately, ignorance about the Black experience; the color blind orientation denying the impact of racial identity, discrimination and negative stereotyping; and the inability to address the anxiety that is secondary to racial dynamics. The impact of racism on the Black patient may manifest as anger, resentment, distrust, despair, and demoralization. Levy offers several practical suggestions for pediatric practitioners to improve communication.

Manson A. (1988). “Language concordance as a determinant of patient compliance and emergency room use in patients with asthma.” *Medical Care* 26: 1119-1128.

A study of ninety-six patients in a New York City hospital showed that, compared with patients with language concordant physicians, patients with language discordant physicians were slightly more likely to omit medication, to miss office appointments, and to make at least one emergency room visit. However, for those patients with over eight office appointments during the study period, an average of four years for this subgroup, patients with language discordant physicians (patients monolingual Spanish; physicians English-speaking only) were three times more likely to be noncompliant with medications as those patients whose physicians spoke Spanish. Monolingual Spanish speaking patients whose physicians did not speak Spanish were three times more likely to miss appointments, and two times more likely to make an additional visit to the emergency room.

Metzger R. (1993/1994). “Hispanics, health care, and Title VI of the Civil Rights Act of 1964.” *Kansas Journal of Law and Public Policy* 3: 31-42.

The purpose of this article is to examine the application of Title VI of the Civil Rights Act of 1964 in the context of health care delivery to Hispanics. Low rates of access to health care services are, to a significant degree, the result of barriers to access that are related to language use and culture. Title VI compels linguistic and/or cultural accommodation for a significant number of Hispanic health care consumers. This article recommends promulgation by the U.S. Department of Health and Human Services (HHS) of a specific regulation compelling accommodation of limited-English proficient persons in the delivery of health services.

Ong A. (1995). "Making the biopolitical subject: Cambodian immigrants, refugee medicine and cultural citizenship in California." *Social Science and Medicine* 40: 1243-57.

Linking the health profession to the normalization of citizenship, scholars influenced by Michel Foucault claim that while biomedicine attends to the health of bodies, it is also constitutive of the social and bureaucratic practices that socialize subjects of the modern welfare state. Yet, we seldom learn about how patients themselves draw the medical gaze, nor how their resistances to biomedical intervention both invite and deflect control. The author tries to show this by means of clinicians' and Khmer refugees' interpretations of their encounters. This study illustrates that refugee medicine is a mix of good intentions, desire to control diseased and deviant populations, and the exigencies of limited resources which often favor medicalization. Californian clinicians, many of them Asian-Americans, display a deep faith in the efficacy of modern medicine for third world patients so that they can function in the new country. Khmer refugees, in contrast, seek rather specific resources while wishing to elude control over the body and mind that goes with medical care. The author argues that the biomedical gaze is not such a diffused hegemonic power but is itself generated by the complex contestation of refugee subjects pursuing their own goals. Clinicians and refugees are equally caught up in webs of power involving control and subterfuge, appropriation and resistance, negotiation and learning that constitute biopolitical lessons of what becoming American may entail for an underprivileged Asian group.

Pederson P. (1987). "Ten frequent assumptions of cultural bias in counseling." *Journal of Multicultural Counseling and Development* 15: 16-25.

In this brief, but critically important article, Pederson contends that there is a distinct "Western" perspective of reality, and a perspective on illness in particular, to which most of the world's people do not subscribe. He states, ". . . many social scientists, including psychologists depend on textbooks, research findings and implicit psychological theory based almost entirely on assumptions specific to European and American culture. These assumptions are usually so implicit and so taken for granted that they are not challenged even by broad-minded and insightful psychologists. The consequences of the unexamined assumptions are institutionalized racism, ageism, sexism, and other forms of cultural bias." He presents 10 assumptions reflecting a Western-oriented cultural bias: assumptions regarding what is normal behavior, an emphasis on individualism; fragmentation by academic disciplines; overemphasis on interdependence; neglect of clients' support systems; dependence on linear thinking; a focus on changing the individual, not the system; neglect of history, and dangers of cultural encapsulation (providers' unwillingness or inability to challenge his or her own assumptions).

Poplin M. and Phillips L. (1993). "Sociocultural aspects of language and literacy: Issues facing educators of students with learning disabilities." *Learning Disability Quarterly 16*: 245-255.

This article explores differences in language development, experience, and use by various cultures. The authors propose that some of the characteristics identified as disabilities are actually language differences. It is argued that American culture (AMC) defines literacy narrowly; many who work in schools are unaware of discrepancies between school structure and the way students learn. AMC's strict adherence to time colors its perception of disability, and AMC's assumptions about language and its relationship to intelligence are particularistic, not universal. A lack of understanding of multiple views and the characteristics of various languages may lead to a result of misdiagnosis and inappropriate instruction of persons called learning disabled. The authors suggest that AMC's assumptions about oral and written language and its preference for written language intelligence have, in part, created the category of learning disabilities as a handicapping condition. (©1997 APA/PsycINFO, all rights reserved.)

Putsch R. (1985). "Cross-cultural communication: The special case of interpreters in health care." *Journal of the American Medical Association 254*: 3344-3348.

This is an excellent article reviewing the complexities inherent in clinical encounters with non-English proficient patients, as well as the legal imperatives to mitigate language barriers in health care delivery. Through a series of clinical case vignettes, Putsch illustrates the complexities involved in the patient-interpreter-provider triad. He concludes with an excellent series of three extensive lists of very practical guidelines for monolingual providers, provider-interpreter-patients' interactions, and language use in interpreter-dependent interviews.

Ridley C. (1984). "Clinical treatment of the nondisclosing Black client: A therapeutic paradox." *American Psychologist 39*: 1234-1244.

Ridley first outlines the importance of self disclosure in achieving a "talking cure" in psychotherapy. Next, the Black passive "survival technique" of nondisclosing to White therapists the details of one's life are discussed, as are the historical and sociopolitical underpinnings that engender this phenomenon. Ridley offers 3 approaches that may assist in the resolution of this paradox: sound clinical judgment that includes appreciating within group differences as well as between group differences; individualized treatment plans in recognizing the aforementioned variability among Blacks, and; addressing the personal psychology of White therapists.

Smith M. and Ryan A. (1987). "Chinese-American families of children with developmental disabilities: An exploratory study of reactions to service providers." *Mental Retardation* 23: 345-350.

Authors conducted interviews of fifty-nine Chinese families in New York City's Chinatown in regard to their experiences with providers and the health care system in seeking care for their disabled children. The families had children who were mentally retarded or had neurological impairments, learning disabilities, autism, cerebral palsy, and epilepsy. All but one family spoke primarily Chinese, and their experiences were profoundly affected by this language barrier. At the time of diagnosis of the developmental disability, the most formidable problem families encountered was not comprehending the diagnosis, in large part due to language barriers. ("It was very hard for me to understand what was going on. Sometimes I was so frustrated I didn't want to see anyone at all.") Families also cited the unresponsiveness of providers ("Very difficult, because we don't understand English and the doctors don't understand Mandarin. We didn't know what they were talking about, and we didn't know how to ask questions." And, "The only thing we could do was think about it all the time.") Language barriers also affected their access to services that were theoretically available to them, and the usefulness of those services accessed. ("Sometimes I only understood 20-30 percent and I made a lot of guesses.") The authors recommend, "Considerable work needs to be done to integrate Asian perspectives into professional work with these families. It does not appear that either Asian or Anglo professionals possess adequate explanations of mental retardation or other disabilities that are satisfactory from the parents' point of view. "

Ventres W. and Gordon P. (1990). "Communication strategies in caring for the underserved." *Journal of Health Care for the Poor and Underserved* 1: 305-314.

This excellent, dense, albeit brief article contains an invaluable review of the patient-physician communication literature, specifically as it relates to race, ethnicity and class. Authors cite evidence on how "consciously or unconsciously, physicians alter their communication styles depending on the socioeconomic status of their patients." Specifically, poor and minority patients, despite wanting as much information as others regarding their conditions, "receive less information about their conditions, less positive and reinforcing talk, and less talk or communication overall than do patients of higher socioeconomic status. The authors discuss how physicians' use of language is often the vehicle through which the power imbalance between physician and patient is mediated. They describe in a practical manner, how physicians can use speech, active listening, and interviewing techniques (patient- or language-focused interviewing) that are respectful of the "patient's story". They conclude, "Physicians need to open their ears to the issues of poor patients. Improved language skills can help physicians recognize the disempowering forces of illiteracy, racism, and discrimination their poor patients face, and assist them in explicitly acknowledging their patients' strength and courage in surviving these forces."

Vinh P. (1997). *Implementation of Linguistic Access Policy: Recommendations for Health Plans in Meeting California's Medi-Cal Managed Care Cultural and Linguistic Standards.* Graduate School in Public Policy. Berkeley, California, University of California, Berkeley.

A critically important, well-referenced piece addressing health care organizations' obligation and task of providing adequate linguistic services to their Medi-Cal managed care recipients. Vinh sets out to answer, "Given the cultural and linguistic (CLS) requirements set forth by the State, how can plans operate to 1) achieve compliance with CLS requirements and 2) function optimally within their organizations. The paper analyzes the efficacy and cost of six options for meeting Medi-Cal standards for linguistic competence: 1) bilingual providers, 2) bilingual staff, 3) in-house interpreters, 4) contract interpreters, 5) subcontract the technical expertise of community health centers, and 6) language banks. Vinh recommends as the most pragmatic option the use of in-house, bilingual and bicultural interpreters. She concludes with recommendations to health plans regarding the implementation of the CLS requirements: "Tailor solutions to the organization; construct an implementation timetable; educate providers and administrators; establish infrastructure; train interpreters; conduct needs assessments; explore different evaluation methods; explore new approaches to medical interpretation; pursue private/public partnerships and county collaborations; and participate in the next round of policy formulation."

Woloshin S. and Bickell N. (1995). "Language barriers in medicine in the United States." *Journal of the American Medical Association* 273: 724-727.

Authors present an excellent, well-referenced review of this topic and its implications for clinical practice. Clinical implications of inadequate interpretation are discussed: 1) the impairment of the exchange of information, often resulting in the provider ordering more tests or missing important cues, and certainly not understanding patients' culturally-determined disease models; 2) impairment of communication from provider to patient, and resultant decreased patient compliance, follow-up and satisfaction; 3) ethical conundrums, including the profound difficulties of truly informed consent and of shared decision-making with language barriers; and 4) difficulty on the part of patients in accessing needed services within an institutional structure. Authors discuss the legal imperative, at the risk of loss of federal funds, of providing inadequate translation services. Difficulties in health care organizations complying with these statutes are presented. A number of solutions to mitigate language barriers are then discussed. Authors suggest, "Unfortunately, enforcement agencies may have to play a more active role and aggressively monitor compliance with language access regulations as well as investigate complaints."

C. Addressing Gender, Sexual Orientation and Disability Status

Garofalo R., Wolf R., Kessel S., Palfrey S. and DuRant R. (1998). "The association between health risk behaviors and sexual orientation among a school-based sample of adolescents." *Pediatrics 101*: 895-902.

This study is one of the first to examine the association between sexual orientation and health risk behaviors among a representative, school-based sample of adolescents. The study was conducted on an anonymous, representative sample of 4,159 9th- to 12th-grade students in public high schools from Massachusetts' expanded Centers for Disease Control and Prevention 1995 Youth Risk Behavior Survey. Sexual orientation was determined by the following question: "Which of the following best describes you?" A total of 104 students self-identified as gay, lesbian, or bisexual (GLB), representing 2.5 percent of the overall population. Of GLB youth, 66.7 percent were male and 70 percent were White (not Hispanic). Health risk and problem behaviors were analyzed comparing GLB youth and their peers. Those variables found to be significantly associated with GLB youth were then analyzed by multiple logistic regression models. The results show that GLB youth who self-identify during high school report disproportionate risk for a variety of health risk and problem behaviors, including suicide, victimization, sexual risk behaviors, and multiple substance use. In addition, these youth are more likely to report engaging in multiple risk behaviors and initiating risk behaviors at an earlier age than are their peers. These findings suggest that educational efforts, prevention programs, and health services must be designed to address the unique needs of GLB youth.

Gochros H. and Bidwell R. (1996). Lesbian and gay youth in a straight world: Implications for health care workers. In: *Health Care for Lesbians and Gay Men: Confronting Homophobia and Heterosexism*. Peterson K. J., ed. New York: Haworth Press, 1-17.

This chapter discusses the sub-populations among gay and lesbian youth, as well as the psychological risks, interpersonal stresses and health risks experienced by this group. Health care providers have a unique opportunity to recognize the special needs of their gay and lesbian adolescent patients, but face formidable barriers to providing these services. There are also enormous opportunities for developing innovative and early intervention programs on behalf of gay and lesbian youth. Special issues which need to be considered in developing these programs are discussed. (©1997 APA/PsycINFO, all rights reserved.)

Hanson M., Gutierrez S., Morgan M., Brennan E. and Zercher C. (1997). "Language, culture, and disability: Interacting influences on preschool inclusion." *Topics in Early Childhood Special Education 17*: 307-336.

The interplay among language, culture, and disability in children's experiences in inclusive preschool environments was examined as part of a larger study of preschool inclusion. A qualitative research design was employed using an ecological systems perspective. Data were

collected through observations of preschool sites and through interviews with parents, classroom personnel, and program administrators. Themes related to the influence of culture and language on children's participation in preschool programs were identified. These issues included a lack of identified goals related to language on Individualized Education Programs, the interaction of language with disability, the influence of communication skills on children's interactions and abilities to form friendships, the effects of language differences on communication between home and school, and the need for more translation services and training for service providers related to cultural and linguistic issues. (©1998 APA/PsycINFO, all rights reserved.)

Hitchcock J. and Wilson H. (1992). "Personal risking: Lesbian self-disclosure of sexual orientation to professional health care providers." *Nursing Research*. 41: 178-183.

Authors interviewed thirty-three lesbian women 18–68 years of age with regard to their process of disclosing their sexual orientation to their health care provider. Results indicate a complex multidimensional process of deciding whether it is "safe" (to the integrity of the health care to be received in the future and to the person's psyche in general) and necessary to disclose to a provider. This "personal risking" process is determined by the interaction of at least three components: the personal attributes of the lesbian patient, the health care context (i.e. provider characteristics, the health care environment), and the relevance of any disclosure to the woman's health status and medical care quality.

Kalyanpur M. and Rao S. (1991). "Empowering low-income Black families of handicapped children." *American Journal of Orthopsychiatry* 61: 523-532.

An insightful and important article detailing the nature of "empowering" and "unempowering" relationships and encounters between health and human service agency professionals and parents of disabled children. The authors describe "the conflict that arises between low-income, minority parents who are seeking the authority to determine the services their children need and professionals who define their own roles as experts." Authors conducted in-depth interviews with African American low-income mothers and observed their interactions with agency professionals over an eleven-month period. All of the children were enrolled in special education classes because of learning and emotional disabilities.

The mothers described two basic types of parent-professional relationships: 1) a "demeaning" unempowering type, where "the professionals considered themselves the experts." These interactions were characterized by disrespect, a focus on deficits of the children, and a discounting of differences in parenting styles. In regard to the latter characteristic, for example, mothers had "a sense that their skills as parents were always being evaluated. "One parent said of a psychologist's assessment, "She is judging me. I met this lady once, one time and she judged me... She kept saying his environment is making him act like that. [But] I am his

environment. So what is she trying to say? That I am not a good mother or something?" 2) An empowering type of relationship between parent and professional, "in which they felt their input was valued." These interactions were characterized by responsiveness to mothers' needs, for example by providing emotional support and specific services, by establishing rapport with respectful counseling, and helping parents to articulate what they need.

Krieger N. and Sidney S. (1997). "Prevalence and health implications of anti-gay discrimination: A study of black and white women and men in the CARDIA cohort. Coronary Artery Development in Young Adults." *International Journal of Health Services* 27: 157-76.

This study investigates the prevalence of self-reported experiences of discrimination based on sexual orientation among Black and White men (twenty-five to thirty-seven-years-old) who are members of CARDIA, a multi-site longitudinal study of cardiovascular risk factors. Among the 1,724 participants who responded to a 1989 questionnaire obtaining data on lifetime number of sexual partners and who participated in the Year 7 exam (1992-1993), which included questions about discrimination, 204 (12 percent) reported having at least one same-sex sexual partner: 27 (7 percent) of the 412 Black women, 13 (6 percent) of the 221 Black men, 87 (14 percent) of the 619 White women, and 77 (16 percent) of the 472 White men.

Among these four groups, 33, 39, 52, and 56 percent, respectively, reported having experienced discrimination based on sexual orientation. Additionally, 85 percent of black women and 77 percent of the Black men reported having experienced racial discrimination, and 89 percent of Black women and 88 percent of the White women reported having experienced gender discrimination. In the light of research associating negative stressors with poor health outcomes, including elevated blood pressure, future studies should assess public health implications of discrimination based on sexual orientation, in conjunction with racial and gender discrimination

Leads from the Morbidity and Mortality Weekly Report. (1989). "Leading major congenital malformations among minority groups in the United States, 1981-1986." *Journal of the American Medical Association* 261: 205-209.

These data from the CDC's Birth Defect Monitoring Program (covering 21 percent of all U.S. births) were compiled to detect future changes and trends in 18 major congenital anomalies. Rates of these anomalies varied considerably by race and ethnicity. American Indians had the highest rates for the following: hydrocephalus without spina bifida, atrial septal defect, valve stenosis and atresia, cleft palate, fetal alcohol syndrome (thirty-three times higher than the rate in Whites), and autosomal abnormalities excluding Down's Syndrome. Whites had the highest rate of the following: clubfoot, hip dislocation, and hypospadias. African Americans had

the highest rates of: microcephalus, patent ductus arteriosus and pulmonary artery stenosis: Hispanics had the highest rates of: spina bifida without anencephaly and Down's Syndrome. Asians had the highest rate of anencephaly and ventricular septal defect.

Lishner D., Richardson M., Levine P. and Patrick D. (1996). "Access to primary health care among persons with disabilities in rural areas: A summary of the literature." *Journal of Rural Health 12*: 45-53.

This comprehensive review details barriers to access of disabled rural residents by the following groups: children and adolescents, working-age adults, the elderly, the mentally ill, and persons with HIV infection. In reference to children and adolescents, for example, authors state that "while efforts have recently focused on improving services to children with special health care needs by emphasizing family-centered, community-based, and coordinated services... barriers to health care exist, especially among culturally diverse, low income and rural families."

Martin A. and Hetrick E. (1988). "The stigmatization of the gay and lesbian adolescent." *Journal of Homosexuality 15*: 163-183.

Authors detail the health and social impact of the societal stigmatization of gay and lesbian adolescents. Using data from a New York City social service agency which served over 2,000 economically and ethnically diverse clients in its first two years of existence, they describe the most common presenting problems of the youth: isolation, alienation from family and violence. In terms of emotional isolation, 20 percent of clients had in the past attempted suicide before coming to the agency, citing the lack of anyone to talk to. In terms of violence, 40 percent report they had suffered violence because of their sexual orientation; half of these say that the violence against them occurred within their families. Nearly one quarter of the clients reported sexual abuse. The article provides poignant examples of how societal relations and ideology put subgroups of the U.S. population at risk for, among other things, psychosocial disease and illness.

Patrick, D. (1994). "Towards an epidemiology of disablement." (editorial) *American Journal of Public Health 84*: 1723-1725.

This is a brief discussion of the urgency of the research agenda for the disabled. "Estimates of prevalence and identification of high risk groups are building blocks for inquiries on the service needs, self-help strategies, and impact of interventions for people with disabilities." The author presents the relatively recent conceptual development of "the triad of concepts of impairment... impairment (disorder at the organic level); disability (physical or psychological dysfunction at the person level)..., and handicap or disadvantage (refers not to an individual but to a societal state, a status assigned to the person with impairment or disability by societal expectations that shape interactions)." He argues that research "placed in this broadened

context of the determinants and consequences of disease and injury helps to identify opportunities for prevention activities.” So, for example, the question of the older adult with a hip fracture needs to go beyond the description of the individual’s physical function, to include the extent and nature of social supports that could prevent institutionalization, which, present research shows, would in turn prevent further disability.

Phillips M. (1990). “Damaged goods: Oral narratives of the experience of disability in American culture.” *Social Science & Medicine* 30: 849-857.

The study focused on personal experience stories from thirty-three 21–64 year old people with visible physical disabilities. The stories illuminated the study participants’ perceptions of how popular American notions about disability frame social interactions between disabled and nondisabled individuals, how such interactions affect the self-images of disabled persons, and how the predictability of such interactions constitutes a disabled experience that may be uniform across U.S. culture. (©1997 APA/PsycINFO, all rights reserved.)

Rankow E. (1995). “Lesbian health issues for the primary care provider.” *Journal of Family Practice* 40: 486-493.

Lesbians’ unique physical and mental health concerns often go unnoticed in a medical setting that assumes heterosexuality. By signaling openness and acceptance, primary health care providers promote a safe environment for rapport and disclosure of crucial information, including a thorough social history. Involving a patient’s significant other in her care supports this goal. Providers should strive to accept alternative sexual orientation as a matter of routine, neither under- nor over-emphasizing it, and to make appropriate referrals. Educational materials and information about community and national resources should be provided. (©1997 APA/PsycINFO, all rights reserved.)

Solomon S. (1993). “Women and physical distinction: A review of the literature and suggestions for intervention.” *Women & Therapy* 14: 91-103.

Women with physical distinctions (PDs) are perceived negatively and are devalued and marginalized in the American culture. They face a double discrimination due to their gender and their disability. These women are ostracized by society, constantly challenged, and frequently oppressed. The situation is even more acute for ethnic minority women with PDs. The author reviews the literature on women with PDs and explores some of the issues for ethnic minority women with PDs. Recommendations are offered for feminist therapists who work with this population. The therapists can improve the women’s self-esteem and can serve as advocates for them. Feminists should be willing to examine their own biases and preconceptions about disability and work to change the misconceptions and biases harbored by others. (©1997 APA/PsycINFO, all rights reserved.)

Steinberg A., Sullivan V. and Loew R. (1998). "Cultural and linguistic barriers to mental health service access: The deaf consumer's perspective." *American Journal of Psychiatry* **155**: 982-984.

This study investigated knowledge, attitudes, and beliefs about mental illness and providers held by a group of deaf adults. The American Sign Language interviews of fifty-four deaf adults were analyzed using a text-based, qualitative analysis software program. Recurrent themes included mistrust of providers, communication difficulty as a primary cause of mental health problems, profound concern with communication in therapy, and widespread ignorance about how to obtain services. (©1998 APA/PsycINFO, all rights reserved.)

Stevens P. (1993). Lesbian health care research: A review of the literature from 1970 to 1990. In: *Lesbian Health: What Are the Issues?* Noerager Stern P., ed. Washington, DC: Taylor & Francis, 1-30.

This chapter critically examines the research about health care providers' attitudes toward lesbians and the research about lesbians' experiences in health care encounters. Results of the review suggest that caregivers hold prejudiced views of lesbians and are generally condemnatory and ignorant about their lesbian clients. Implications for practice and policy are identified, and directions for future research about lesbian health care are suggested. (©1997 APA/PsycINFO, all rights reserved.)

Stevens P. (1994). "Protective strategies of lesbian clients in health care environments." *Research in Nursing & Health* **17**: 217-229.

In this feminist narrative study, a multiethnic, socioeconomically diverse sample of forty-five lesbians recounted their actions in health care in a total of 332 health care stories. Findings suggest that subjects experienced compounded vulnerability in health care environments. A repertoire of protective strategies intended to meet needs for safety characterized their actions in health care, including rallying support, screening providers, seeking mirrors of one's experience, maintaining vigilance, controlling information, bringing a witness, challenging mistreatment, and escaping danger. (©1997 APA/PsycINFO, all rights reserved.)

Stevens P. (1998). The experiences of lesbians of color in health care encounters: Narrative insights for improving access and quality. In: *Gateways to Improving Lesbian Health and Health Care: Opening doors*. Ponticelli C., ed. New York, Haworth Press, 77-94.

In this feminist narrative study, lesbians of color gave testimony to the effects of prejudice in face-to-face health care interactions. A major objective was to involve participants from a broad range of ethnic/racial backgrounds and socio-economic circumstances in open-ended interviews about their experiences receiving health care. Half of the forty-five women (aged 21-56 years) in the sample were lesbians of color: African American, Latina, Asian/Pacific

Islander, and Native American. Results suggest that if we wish to improve access to and quality of health services, those in the health care field must address race, class, gender, and sexual orientation prejudice in health care interactions, and acknowledge the role discriminatory behavior plays in diminishing the availability of health care for lesbians of color. (©1998 APA/PsycINFO, all rights reserved.)

Wallick M, Cambre K. and Townsend M. (1992). "How the topic of homosexuality is taught at U.S. medical schools." *Academic Medicine* 67: 601-603.

Authors surveyed the 126 U.S. medical schools as to the number of curriculum hours devoted to the topic of homosexuality. Of the seventy-eight respondents (65 percent response rate), the mean number of hours spent on the topic of homosexuality during the entire 4 year curriculum was 3 hours and 26 minutes total, with schools in the West reporting a mean of 5 hours and 56 minutes, and schools in other regions reporting 2 hours and 37 minutes or less.

Wang C. (1992). "Culture, meaning and disability: Injury prevention campaigns and the production of stigma." *Social Science & Medicine* 35: 1093-1102.

The potential production of stigma through health promotion campaigns is a problem that has not received attention in the current literature on the sociology of health promotion. Cultural production studies can shed light onto the ways in which injury prevention campaigns, and public health campaigns more generally, may call for life-saving interventions at the social expense of people with disabilities or other stigmatized conditions. Questioned here are not only the presumed benefits of health promotion campaigns, but also our conventional understandings of health and disability. This study examines the way in which cultural production studies can contribute to a theory of the production of stigma by public health professionals. Focusing on a case study of injury control and disability rights, health promotion campaigns are seen as potentially contributing to the production of stigma for people who already possess the attributes targeted for prevention. This analysis moves toward a broader theoretical foundation with which to grasp the unintended, even harmful consequences of prevention strategies, and the shared and oppositional interests of people with stigmatized conditions, targeted audiences of prevention, and public health advocates.

D. Managed Care Issues

Brooks T. (1997). "The political agenda of health care for African Americans." *Journal of Health Care for the Poor and Underserved* 8: 377-82; discussion 382-3.

Health care reform presents both challenges and opportunities for African Americans. On the one hand, reform could result in the closure of Black medical institutions and fewer Black physicians. On the other hand, reform gives African Americans an opportunity to bargain for

available resources to gain equality in health care services. To this end, the Volunteer State Medical Association has been involved in state health care reform. Its goals are to resolve the current financial crisis at Black medical institutions; to assist in the survival and development of local Black managed care organizations; to assure that all licensed Black physicians have continued access to patients; and to develop Black-owned health-related businesses. The association has formed the Tennessee Coalition for Quality Health Care, a group of African American politicians, physicians, educators, and health care administrators who can negotiate with state and federal officials on the issue of health care reform.

Coye M. and Alvarez, D. (1999). *Medicaid Managed Care and Cultural Diversity in California*. New York: The Commonwealth Fund.

This study examined California's implementation of a strategy to require managed care plans to provide appropriate services to the state's highly diverse Medicaid population. Like many other states, California has shifted a large proportion of its Medicaid-insured population into managed care plans over the past several years. Approximately one-third of beneficiaries in the state's twelve counties with mandatory Medicaid managed care enrollment in 1997 indicated a language other than English as their primary language, making California's the largest Hispanic and Asian American population in the United States. California has created detailed plan contract requirements to ensure culturally competent care. Interviews with Medi-Cal staff, officials of private and public health plans and providers serving the Medi-Cal managed care population reveal that California's contract requirements have had a substantial impact on health plan services and operations. Plans have hired additional staff and established member services to make access to plan services easier and more effective for non-English speaking populations. However, efforts to provide culturally competent services linked to patients' health status and health outcomes are still in their infancy. One of the primary barriers to implementation of culturally competent services is lack of data. Efforts need to be initiated to develop and validate meaningful tools to assess the specific health needs of multicultural populations as well as providers' and plans' ability to meet these needs.

Dana R. H. (1998). "Problems with managed mental health care for multicultural populations." *Psychological Reports* 83: 283-94.

Managed mental health care has developed a system of care-giving that does not recognize that acceptable and effective services must acknowledge individual differences and cultural or racial identities. This approach is unacceptable in an era when a psychology of differences is necessary to provide services for nearly one-third of the population. This paper suggests that the adequacy of contemporary psychopharmacological and psychological interventions for multicultural populations is either unknown or unsatisfactory. Historically, interventions in the United States were designed primarily for Euro-Americans and thus were culture-specific in derivation. Managed care has reduced the availability and quality of these interventions for all

patients and further limited the range of possible options. Culturally competent mental health services are described and related to quality of care. A societal agenda for implementing cultural competence is suggested.

Halfon N., Wood D., Valdez R., Pereyra M. and Duan N. (1997). "Medicaid enrollment and health services access by Latino children in inner-city Los Angeles." *Journal of the American Medical Association* 277: 636-41.

Authors surveyed 817 Latino families in South Central and East Los Angeles in 1992 to assess how parental factors of language preference and other socioeconomic characteristics are associated with Medicaid insurance and utilization of services. Results indicate that only 40 percent of eligible children had had continuous Medicaid coverage since birth. Children of parents with a partner who was working had less chance of having had continuous Medicaid coverage. Length of U.S. residency was not associated with continuous Medicaid enrollment. Continuity of care was strongly associated with insurance coverage and the source of well child care (public clinic, HMO, etc.). Insurance coverage and the location where children received primary care were the dominant factors predicting access and utilization, rather than residency status, language preference, and other family-related characteristics. The authors conclude, "An emerging and growing policy dilemma facing those with improving health insurance coverage for all children in the United States is one of the looming barriers that Latino children may face in the future because their parents are immigrants. Given the threat of Proposition 187 in California and recently enacted federal sanctions against immigrants (authorized and unauthorized), the prospect for improving access to this vulnerable population of children will be ever more challenging... In the future, the residency status of parents will probably play an even greater role in determining whether children are insured and receive appropriate care."

Lavizzo-Mourey R., Clayton L., Byrd W., Johnson G., 3rd and Richardson D. (1996). "The perceptions of African-American physicians concerning their treatment by managed care organizations [editorial]." *Journal of the National Medical Association* 88: 210-4.

This study explored whether African American physicians perceive unequal treatment by managed care organizations. A convenience sample of 305 physicians attending a medical conference was surveyed regarding their participation in managed care plans, effects of managed care on their medical practice and experiences of discrimination. The results indicate that the majority have a contract with at least one managed care organization. However, a large proportion of physicians reported being denied contracts, and about one-fourth stated that they had experienced contract termination, usually without stated reason. Almost all of the respondents believed that African American physicians have contracts terminated more often at managed care organizations than White physicians. These results indicate that the community of African-American physicians perceive themselves to be more vulnerable to dif-

ferential treatment by managed care organizations than their European American counterparts. More research is needed to explore the nature and extent of these kinds of inequities as well as strategies to eliminate them.

Murray-Garcia J. (1997). "Professionalism vs. commercialism in managed care: The need for a National Council on Medical Care (letter)." *Journal of the American Medical Association* 278: 20.

The author responds to an article citing the need for a national oversight body on managed care quality. She cites studies of differential and often deficient allocation of services by race and ethnicity, and the need to monitor the care given to people of color. "Apparently, the quality and content of each unit of health care, prepaid or otherwise financed, can frequently be inferior for patients of color... With or without the realization of the [national oversight body], the commercial ethic in medical care and the intensifying pressures of cost-containment should be addressed as putting communities of color at further risk for inferior care and widening already tragic disparities in health status."

Randall V., Giess S., Boller G., Tinkler C., Bayless S., Romero A. Henry S., and Whipple C. (1996). "Section 1115 Medicaid Waivers: Critiquing the State Applications." *Seton Hall Law Review* 26: 1069-1142.

Section 1115 Medicaid waivers have been used as an alternative to traditional Medicaid programs that are subject to spiraling costs and limited coverage of the population needing care. The waivers rely on the use of managed care plans to provide health care services to Medicaid patients instead of reimbursing private physicians for these services. This article evaluates the experience of seven states that have applied for Medicaid waivers with a focus on whether or not they increase access and quality of care for minority patients. The analysis concludes that the waivers seldom address these issues in an adequate manner. Managed care operates under inverse incentive, where the providers make more money and the third party payers spend less as they reduce services. This incentive may encourage plans to cut services, particularly to vulnerable populations, which are marginally necessary. Most waivers provided little discussion of standards to assure quality of care to minority patients or to address the special health care needs of minority populations. Other vital areas that need to be examined in future research are patient protection from experimentation and antidiscrimination provisions of the waivers.

Randall V. (1994). "Impact of managed care organizations on ethnic Americans and underserved populations." *Journal of Health Care for the Poor and Underserved* 5: 224-36; discussion 237-9.

Health care reform focuses on cost containment, which in turn focuses on managed care organizations (MCOS). MCOS use strict utilization review and financial risk-shifting to assure that doctors and providers act as gatekeepers to health care services. The gatekeepers are assumed to continue to order necessary care and to eliminate only "unnecessary" care. However, significant potential for abuse exists. In fact, the very foundations on which MCO decisions are made are culturally biased, because they are based on information from largely middle-class, European-American, healthy males. Ultimately, MCOS will change the perceptions and expectations of society regarding health care. These altered perceptions may be contrary to the needs of ethnic Americans, and without safeguards, could worsen existing disparities in health status.

Watson S. (1993). "Health Care in the Inner City: Asking the right question." *North Carolina Law Review* 71: 647-1674.

The article reviews the complexity of health problems faced by America's poor and minority residents from the perspective of the role of health care reform in challenging the current segregated system of health care. The author argues that improving the health of America's inner-city Blacks and poor must include universal coverage for all residents, comprehensive coverage of preventive and primary care, no serious financial barriers to participation, and provider reimbursement rates for any public system comparable to those of privately provided insurance. In addition to universal health care financing, the author contends that improving America's health system requires programs to attract providers to the inner city, to enforce vigorously existing civil rights laws that combat discrimination in providing health care services, and to develop new health delivery systems that meet the needs of those who continue to dwell in the inner city. Even with these changes, improving the health of inner-city minorities requires more than better access to health care. What is also needed are jobs that pay a living wage and programs that deliver decent housing, adequate sanitation, and good education.

IV. Diversity in the Health Care Workforce

Bathen S. (1997). "Minorities at UC: Going, going, gone?" *California Medicine* F18.

This article documents the drop in application and admission rates for students of color in the UC medical schools: "At UC's medical schools, the decline in minority admissions has been so severe that now even Ward Connerly is calling for outreach programs." While the number of applications from underrepresented minorities declined nationally by 5 percent last year, the decline was between 16 and 20 percent for UC medical schools. Concerns include the notion that not only are "deserving" students of color not being admitted, but well-qualified minority students are actually staying away from UC, perceiving it as a less attractive and more unwelcome environment.

Chatman V. and Sandler H. (1996). "Recruitment and training of minority health care managers: A case study." *Journal of Health Administration Education* 14: 327-344.

This paper describes a cooperative learning model that uses six critical points of intervention at which learning can be facilitated for minority students. These six points were identified in the Health Career Opportunity Program (HCOP). The HCOP initiative model is used because it has been demonstrated that this strategy has been successful in increasing the number of minority health care professionals. The paper is presented in two parts. The first part gives an overview of the six critical points of intervention. The recommendations presented will focus on incorporating mechanisms that can facilitate the learning and achievement of minority students once they have been identified and admitted. The second part presents a case study of how these intervention strategies were implemented in the Health Services Administration Program at Meharry Medical College between the years of 1989 through 1993.

Cregler L. (1994). "Careers in academic medicine and clinical practice for minorities: Opportunities and barriers." *Journal of the Association for Academic Minority Physicians* 5: 68-73.

This article describes the need for minority physicians in clinical practice and in academic careers in the U.S. Primarily through lack of role models and mentors, they state that the lack of minority physicians in academic medicine is an important barrier to increasing the overall number of minority physicians. Barriers to successful completion of medical school are discussed, including cost of medical education, recruitment and retention trends, academic support and retention, and challenges at the residency level. Strategies and model programs to increase the number of physicians of color by "strengthening the pipeline" from kindergarten to college are discussed. Programs to encourage medical students and physicians of color to pursue academic careers are presented. Barriers to people of color in academic positions include the following: administrative work, hospital and medical school committee assignments, student counseling by minority faculty, and the resultant reduced time for research. "The need to 'publish or perish' may cause great conflict for minority faculty, who see the great service needs of their community, minority students, and housestaff."

Davidson R. and Lewis E. (1997). "Affirmative action and other special consideration admissions at the University of California, Davis, School of Medicine" (published erratum appears in JAMA 1998, Feb 18; 279: 510.) *Journal of American Medicine* 278: 1153-1158.

The study, conducted by Robert C. Davidson and Ernest L. Lewis, documents the experience of students at the University of California, Davis, School of Medicine, who were admitted through a special admissions process that included race as one consideration. Published on Oct 8, 1997, the study tracked students from 1967–1987 and compared the careers of 356 special consideration admission students with those of a similar sample of regular admission students. Of special consideration admissions, 94 percent graduated vs. 97 percent of regular admissions. Regular admission students were more likely to receive honors or an A grade on core basic and clinical science courses. There was no difference in failure rates of core courses between the two groups. Following graduation, the experience of the special consideration admission students was very similar to that of regular admission students. There was no difference in completion of residency training or evaluation of performance by residency directors. Both populations selected primary care disciplines at the same rate. The practice characteristics of the two populations were remarkably similar. The study concluded that affirmative action programs broaden diversity without compromising quality.

de Guzman M. (1997). "Benchmarks: Investing in civil rights and diversity." *Health System Leader* 4: 17-20.

The article highlights discussions with leaders of several health care organizations in various states of developing programs for ensuring a workforce representative of the communities they serve. St. Louis Health Care Network is struggling with how to translate a faith-based ministry, respectful of the dignity and freedom of each person into a more structured system. As part of the emphasis on diversity, SLHCN participates in the Institute for Diversity in Health Management's twelve-week internship for future leaders. Henry Ford Health System has several initiatives to promote diversity in the workforce including a training program for lower-income community members, a mentoring program pairing senior leaders with front line managers, and a Center for Medical Treatment and Effectiveness Programs that studies illness, treatment, and disease prevention in African Americans. The University of Michigan Hospitals in Ann Arbor, Michigan has developed the concept of diversity ambassadors to promote multicultural values and also conducts focus groups and an employee survey on diversity.

de Guzman M. (1997). "A civil rights primer for healthcare organizations." *Health System Leader* 4: 6-16.

This article highlights the serious nature of civil rights abuses and their legal and social consequences in corporations and health and social services agencies. It explores the need for diversity and cultural sensitivity in health-care organizations and provides an overview of progress and challenges in achieving these goals since the 1970s. In addition, the author

describes steps that leaders can take to improve diversity in the workforce. The steps include developing policies that address civil rights issues; involving the entire workforce in promoting diversity values; conducting ongoing employee training and management development; and devising new performance indicators.

Drake M. and Lowenstein D. (1998). "The role of diversity in the health care needs of California." *Western Journal of Medicine* 168: 348-54.

Socioeconomic, racial, and ethnic diversity influence many facets of health care, including access to health services, the morbidity and mortality of disease, and the process of training health care professionals. California has an increasingly diverse population, and it is essential that the University of California medical schools carefully address the role of diversity in medical education and in education for the many other professionals who have a key role in the provision of care and services to Californians. In this paper, the authors provide evidence in support of the belief that the University of California system must train a physician workforce that reflects the racial, ethnic, and socioeconomic characteristics of California's population in order to provide equitable health care to all segments of the state's people.

Dreier P. and Freer R. (1997). "Saints, sinners, and affirmative action." *Chronicle of Higher Education* 44: B6-8

A research study, published on Oct 8, 1997, evaluated the effects of the affirmative action program of the School of Medicine at the University of California at Davis from 1967 through 1987. The study, conducted by Robert C. Davidson and Ernest L. Lewis, compared the careers of 356 affirmative action students with those of a similar sample of regular students. It found that affirmative action students were just as likely to graduate, complete residencies and practice medicine successfully as regular students. The study concluded that affirmative action programs broaden diversity without compromising quality.

Harvard Law Review (1995). "The impact of managed care on doctors who serve poor and minority patients." *Harvard Law Review* 108: 1625-1642.

An excellent, well-referenced critically important article on how the "irreversible momentum towards managed care" puts physicians serving poor and minority communities at risk for exclusion and potential financial ruin. Health care maintenance organizations are likely to discriminate against physicians who serve poor and minority patients on the basis of the higher costs in taking care of this sicker population. HMOs' selection of physicians is often based on subjective criteria in a profession with a history of exclusionary practices toward minority physicians. Likely consequences of excluding physicians who serve poor and minority communities will be a decline in the number of physicians and a decrease in access to physicians who are uniquely qualified by experience and willing to serve poor and minority patients.

The article concludes by describing, albeit not optimistically, legislative responses and reforms that could protect this group of physicians, and by implication, protect the health status of poor and minority communities.

Glenn G. (1996). "Examining higher education's role in health care. (educating personnel for allied health services) (special report: health sciences)." *Black Issues in Higher Education* 13: 24-27.

Colleges and universities are revamping their courses to provide the health industry with more physical therapists, occupational therapists, and other health professionals. However, most historically Black colleges and universities lack funds for introducing allied health programs. A report issued by the National Society of Allied Health recommends better collaboration between higher learning institutions, accrediting bodies, employers, and consumers for meeting the needs of health care delivery. It also emphasizes the need for recruiting more minorities in the field.

Heimoff S. (1995). "Affirmative action: Not dead yet say UC medical school deans." *Northern California Medicine* Aug/Sept.

This article reports the intention of UC medical school deans and other administrators to maintain diversity of their schools, despite the passing of Proposition 209. They argue that based on their understanding of the proposition, their admission strategies will be changed little. They point to clauses in the proposition that encourage the use of "supplemental criteria" to admit students from disadvantaged backgrounds (up to 25 percent of students can be admitted based on other than academic performance) and to reflect the State's diversity. This is an interesting article, written in 1995, in light of the dramatic decreases in enrollment of students of color in 1996 and 1997 in the State's medical schools.

Hummel J., Cortte R., Ballweg R., and Larson E. (1994). "Physician assistant training for native Alaskan community health aides: The MEDEX Northwest experience." *Alaska Medicine* 36: 183-188.

From 1980 through 1990, sixteen Native Alaskan community health aides and twenty-one non-native Alaskans began physician assistant training at MEDEX Northwest at the University of Washington. This study was done to assess the outcome of training Native Alaskan health workers as physician assistants, specifically whether native Alaskan graduates are working in settings that serve Alaskan natives. The backgrounds, educational experiences and deployment locations of native and non-native Alaskans accepted for training were compared using MEDEX Northwest student records. The 1991 graduate survey was used to compare differences in practice setting, specialty and salary between native and non-native graduates working in Alaska in 1991.

All of the non-natives and 81 percent of the natives completed the program. Of those completing the program, 100 percent of the natives returned to Alaska where 91 percent found work as primary care physician assistants in clinics serving predominantly native communities. By comparison 78 percent of the non-native graduates returned to Alaska to work as physician assistants, 60 percent of them in primary care and 15 percent of them in predominantly native communities. There were no significant differences in salary or benefits between native and non-native graduates. The study showed that physician assistant training for entry level health workers is a viable strategy for increasing the number of under-represented minorities in the health professions. The native graduates of MEDEX Northwest are returning to communities where they serve native people both as health care providers and as professional role models.

Komaromy M., Grumbach K., Drake M., Vranizan K., Lurie N., Keane D. and Bindman A. (1996). "The role of Black and Hispanic physicians in providing health care for underserved populations." *New England Journal of Medicine* 334: 1305-10.

Authors analyzed primary care physicians' practice locations in California and the racial and ethnic composition and socioeconomic status of community residents. 718 primary care physicians in California were also surveyed. Communities with the lowest physician to population ratios had the highest proportions of Black and Latino residents. Race and ethnicity of the community residents were stronger predictors of the adequacy of primary care physician supply than was income. Black and Latino physicians respectively practiced in communities where the percentage of Black and Latino residents was five and two times as high as in those communities where White physicians practiced. Black and Latino physicians respectively cared for six and three times as many Black and Latino patients as did other physicians (higher than would be expected given the demographic profile of the communities in which their practices were located). Black physicians were more likely than other physicians to care for Medicaid patients. Latino physicians were more likely than other physicians to care for uninsured patients. Authors conclude that Black and Latino physicians serve a critical need not being met by other physicians. They express their concerns that the dismantling of affirmative action programs will negatively impact on minority patients' access to medical care.

Lecca P., Gutierrez J., and Tijerina G. (1996). "A model to improve the utilization of health and social services in Latino communities." *Journal of Health and Social Policy* 8: 55-70.

The focus of the article is on gaps in health care access for Latino Americans and how the lack of Latino participation in the workforce limits utilization of health services. The article reviews the serious under-representation of Latinos in the ranks of health workers and describes barriers to recruiting and retaining these employees. Organizational barriers for recruiting Latino staff include discriminatory hiring practices such as those that deny employment on the basis of language or accent. Other problems include over reliance on Latino staff for translation

services and “burn out” from taking on the role of managing ethnic relationships and conflict in non-Latino organizations. Several issues are discussed to help overcome these barriers. They consist of reviewing hiring practices and procedures, networking with schools and institutions to help recruit Latino staff, investment in job development for Latinos, and research on the effects of ethnicity on the worker-client relationship. Recommendations to increase the utilization of health care services by Latinos include having an ethnic-sensitive management, staff who are bicultural and bilingual, cultural training of non-Latino staff, and ethnic sensitive service delivery.

Lewis C. (1996). “A state university’s model program to increase the number of its disadvantaged students who matriculate into health professions schools.” *Academic Medicine* 71: 1050-1057.

Health professions schools often provide support for minority and disadvantaged students in high school or in a single college summer program. However, long-term support for students during their undergraduate years is also crucial. Since 1990, San Diego State University (SDSU), a large urban public university, has implemented the Health Careers Opportunity Program (HCOP) to increase the number of the university’s disadvantaged students (most of whom are from minority groups) who matriculate into medical, dental, veterinary, and physician assistant schools. The program’s eleven components, each dedicated to some form of educational intervention and support, emphasize developing students’ collaborative learning skills, fostering their pride in accomplishment, and helping them achieve positive self-images and self-confidence; these goals are linked with building students’ analytical and problem-solving skills. Weekly journals kept by students’ mentors serve as an “early warning system” for “bad” feelings, attitudes, and behaviors that reflect students’ personal problems and correlate with lower grades, and help the program staff work intensively with students immediately, before problems become severe.

The SDSU’s HCOP increased the number of disadvantaged (mostly minority) students staying in the prehealth career path (not counting those in the schools of nursing and public health) from seventy in 1989 to 360 in 1995. In 1992 through 1994, the students who had completed the HCOP’s Summer Academic Program (to help them bridge into a science curriculum) had pass rates for entry-level math, writing competency, and math placement that were consistently higher than the rates for other SDSU students. The overall grade-point average of HCOP students in the spring of 1995 (3.05) was significantly higher than the overall GPA of all minority students in prehealth training before the HCOP began (2.59 in 1988). The number of SDSU’s minority students accepted by health professions schools (primarily medical schools) rose significantly from six in 1990 to twenty-three in 1995. It is clear that the labor-intensive interventions of the HCOP throughout students’ years at SDSU until they matriculate into health professions schools are working.

Moy E. and Bartman B. (1995). "Physician race and care of minority and medically indigent patients." *Journal of the American Medical Association* 273: 1515–1520.

In this study from the National Medical Expenditure Survey, non-White adult patients were 4 times as likely to receive their care from a non-White physician than non-Hispanic White patients. The patients of non-White physicians were more likely to be sicker, have functional limitations, report psychological symptoms, and have longer physician visits. Authors conclude that "caring for less affluent and sicker patients may financially penalize non-White physicians and make them particularly vulnerable to capitation arrangements."

Pati G. and Bailey E. (1995). "Empowering people with disabilities: Strategy and human resource issues in implementing the ADA." *Organizational Dynamics* 23: 52-69.

This article discusses the dimensions involved in integrating people with disabilities (PWDs) into organizational work systems in response to the Americans with Disabilities Act (ADA). Forces behind equal opportunity for PWDs are reviewed, and the idea that diversity training may ignore PWDs as a minority group is suggested. Key provisions of the ADA are reviewed, including the topic of reasonable accommodation. Strategies for creating a work culture conducive to the true implementation of the ADA and the empowerment of PWDs are presented, and a refocused human resource function is recommended to increase productivity while integrating PWDs into the total organizational scheme. Attitude management, awareness of adaptive technology, and knowledge of collaborative partnership models are areas where key organizational members will require training and understanding. Case vignettes of organizational approaches to dealing with PWDs are presented. (©1997 APA/PsycINFO, all rights reserved.)

Petersdorf R., Turner K., Nickens H. and Ready T. (1990). "Minorities in medicine: past, present, and future." *Academic Medicine* 65: 663-670.

This article outlines in a straightforward manner, the impact of the broader societal issue of disparate educational opportunities at all levels (primary grades through college level) as a terrain of intervention in increasing minority participation in medicine. The article was in response to then recent trends showing a decrease in minority medical students in the 1980's. A shift in the policies of the federal government to decrease the number of physicians overall, "deep-rooted" inadequacies in systems educating minority students from kindergarten onward, decreasing the competitiveness of these individuals, and a change in the country's political climate all are cited as reasons. Remedies to this situation include unwavering and broad-based institutional commitment; a credible, identifiable and well-endowed source of leadership; and institutional flexibility to mount "more than one line of attack". Three successful programs are presented, including one at Baylor College of Medicine, which sponsors approximately 20 health and silence education programs at elementary through college schools in its area. A different uni-

versity strategy of broader societal involvement is described, with faculty who have become deeply involved in their local school system and who put pressure on the community's political leadership to recognize that education needs to be its first priority.

Steinbrook R. (1996). "Diversity in medicine." *New England Journal of Medicine* 334: 1327–1328.

Authors present a recent summary of the trends in minority medical schools admissions, including a record number of Blacks, Hispanics and Native Americans who entered in 1994. Five out of ten of the U.S. medical schools with the highest number of underrepresented minorities were in California at the writing of this article, including the public universities of UCSF, UCI, UCD and UC San Diego. It provides a brief review of the legislative events around the country concerning affirmative action since 1978 (the Bakke decision).

U.S. Department of Health and Human Services. (Sept. 1993) *Minority Physicians: A Profile.*

This excellent document contains a wealth of data on the demographic profile, geographic distribution, debt burden, practice characteristics, et cetera of minority physicians in the U.S.

Witmer A., Seifer S., Leslie J. and O'Neil E. (1995). "Community health workers: integral members of the health care work force." *American Journal of Public Health* 85: 1055-1058.

Authors present a well-referenced and cogent case for the value and unique contributions of community health workers (CHW) in meeting an urgent need in health care delivery to underserved and high risk populations. CHWs increase access to care by decreasing nonfinancial barriers to care, chiefly by cultural and often linguistic facilitation of patients' treks through a complex health care delivery system. CHWs increase quality by providing coordination and continuity of care and by being an important educational and consultative resource for providers regarding community needs and health beliefs. They potentially decrease costs of care by enhancing efficiency of consumer use (i.e. decreasing the number of emergency room visits for primary care issues). And they can potentially engender community empowerment and development, for instance, as they represent the provision of employment opportunities for community residents. Barriers to expansion of this concept include standardizing the definition of and training for CHW tasks, the lack of "legitimacy" of CHWs in the eyes of other health care workers, and lack of funding. Recommendations are mainly in the realm of providing more financial support for training, continuing education and program evaluation. "By identifying community problems, developing innovative solutions, and translating them into practice, community health workers can respond creatively to local needs."

V. Cultural Competency

American Academy of Pediatrics (1994). Report of the AAP Task Force on Minority Children's Access to Pediatric Care. Elk Grove, IL: *American Academy of Pediatrics*.

The Task Force discussed the generally poorer health status of minority children and the barriers often faced by these children and their families in accessing excellent health care. They advocate measures that will increase the racial and ethnic diversity of the pediatric workforce in this country and in the representation among teaching faculty and within the AAP leadership ranks. They state, "The ability to interact and communicate competently with minority group parents and children enhances the effectiveness of the pediatrician. A special bond is needed between the patient/patient's family and the pediatrician to promote a sense of trust and improved patient compliance with the management plan. Unfortunately, the education and/or training of medical and other health care professionals often lack adequate experience or observation of role models in dealing with cultural issues as they relate to minority group children." The Task Force recommends specific education and training in cultural competence during medical school and residency training, and in the Continuing Medical Education course offerings for practicing pediatricians.

Bennett M. (1986). Towards ethnocentrism: A developmental model of intercultural sensitivity. In: *Cross-cultural Orientation: New Conceptualizations and Applications*. Paige R., ed. London: University Press of America.

This critically important, often-referenced model of cross-cultural training gives essential attention to trainees' varying levels of personal development, specifically in regard to intercultural sensitivity. Bennett posits that taking these different developmental levels into account is critical in planning and establishing realistic educational objectives for individuals, each of whom is on a continuum of personal development, and for choosing appropriate instructional strategies and activities for individuals and groups. Bennett summarizes his thesis and its relevance: "Education and training in intercultural communication is an approach to changing our "natural" behavior. With the concepts and skills developed in this field, we ask students to transcend traditional ethnocentrism and to explore new relationships across cultural boundaries. This attempt to change must be approached with the greatest possible care.

We should understand why people behave as they normally do in the face of cultural difference, how they are likely to change in response to education, and what the ultimate goal is toward which our efforts are expended. In short, we should be operating with a clear model of how intercultural sensitivity is developed...This conceptualization of personal growth posits a continuum of increasing sensitivity to difference, moving from "ethnocentrism" through stages of greater recognition and acceptance of difference, here termed "ethnorelativism"...This greater specificity allows trainers and educators to use the model for diagnosis of groups or individuals and for sequencing material in ways that will clearly facilitate development towards well-defined goal states."

Berlin E. and Fowkes W. (1983). "A teaching framework for cross-cultural health care." *Western Journal of Medicine* 139: 934-938.

The authors present their popular, often-quoted model of improved patient-physician communication in cross-cultural encounters, which assists practitioners in soliciting patients' explanatory models of illness and treatment preferences: L-E-A-R-N (Listen with sympathy and understanding to the patient's perception of the problem; Explain your perception of the problem; Acknowledge and discuss the differences and similarities; Recommend treatment; Negotiate treatment options.) Illustrative case examples for each component of the model are presented.

Borkan J. and Nehen J. (1991). "A developmental model of ethnosensitivity in family practice training." *Family Medicine* 23: 212-217.

The authors present an excellent, pragmatic approach to the application of Bennett's model of a continuum of personal development in the acquisition of multicultural sensitivity. (See Bennett in this section, above). They take Bennett's discussion further by offering practical implications for residency training programs, including specific, realistic expectations for individuals at each point on the continuum as well as the most appropriate educational activities for individuals, depending on where they are identified on the continuum.

Braveheart-Jordan M. and DeBruyn L. (1995). So she may walk in balance: Integrating the impact of historical trauma in the treatment of Native American Indian women. In: *Racism in the Lives of Women: Testimony, Theory, and Guides to Antiracist Practice*. Adleman J., Enguidanos G., eds. New York: Haworth Press, 345-368.

The impact of traumatic historical events on the indigenous peoples of the Americas by European cultures has powerful implications for clinical interventions with Native peoples today. This paper introduces the general concept of "historical trauma" and outlines the specific history of the Lakota/Dakota (Sioux) of the Northern Plains as it relates to historical trauma and unresolved grief. The authors explore several critical issues for working with Native American Indian women. First, they focus on the importance of integrating historical trauma and traditional cultural perspectives into the therapeutic content of clinical interventions with these women. Second, they address issues of transference and countertransference as well as what it means to become a culturally competent therapist, and caution against utilizing feminist theory without consideration of cultural and historical factors relevant to Indian women clients. Third, they explore the effectiveness of psychoeducational groups that are semistructured, based on an empowerment model of providing coping skills and other skills development for Native women. Finally, they conclude that healing Native American women must involve the incorporation and reclaiming of their communal traditional spiritual, social, and cultural power, regardless of, and with all respect for, different individual contemporary Indian women's beliefs and religious affiliations.

California Tomorrow (1996). *Drawing Strength from Diversity: Effective Services for Children, Youth and Families*. San Francisco, California: Tomorrow Publications.

This important source begins with a series of case examples that make a compelling case for more culturally effective and relevant services for California's diverse population of children and families. Subsequently, case studies of model programs from communities throughout the State are presented. This monograph is based on information gathered from an extensive literature review, a demographic survey of 98 collaborative programs in California, interviews with individuals, and site visits. The authors do not espouse a "one size fits all" approach to developing cultural competence within organizations and service providers. ("It was clear from our research, for example, that no single initiative or person had all the answers. More likely, every community must build its own unique solutions.") They present a balance to the approach of cultural competent service provision, giving attention to the practices of individual service providers and to the need to examine and modify institutional policies and practices.

Donaldson M., Yordy K. and Vanselow N., eds. (1994). *Defining Primary Care: An Interim Report*. Washington, DC, Institute of Medicine: National Academy Press.

The committee on the Future of Primary Care of the Institute of Medicine was charged with revising the definition of "Primary Care" developed in 1978, and this revision was to reflect the greater interdependence of health care professionals and the greater complexity of the U.S. health care system. At the time of this interim report, the provisional definition of primary care adopted by the Committee was as follows: "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." [the Committee's emphases] The Committee also stated that the effective and desirable coordination of care which should be an integral part of primary care, incorporates "an understanding of the cultural, nutritional, and belief systems of patients and communities that may assist or hinder effective health care delivery..."

Gibbs J. and Fuery D. (1994). "Mental health and well-being of Black women: Toward strategies of empowerment. (Special Issue: Empowering the Silent Ranks)." *American Journal of Community Psychology* 22: 559-582.

This review of the literature on Black women's mental health has three goals: 1) to describe the mental health issues, needs, and adaptive behaviors of Black women; 2) to discuss the research, intervention, and public policy efforts of mental health professionals and Black women's groups to address the multiple needs of this population; and 3) to identify effective strategies by which community psychologists can improve environmental stressors affecting Black women, to increase their resources and access to services, and to facilitate their empow-

erment in American society. The authors propose a number of recommendations to improve Black women's mental health, including changes in research paradigms, changes in education and training programs, and the development of culturally competent service delivery systems.

Kavanaugh K. and Kennedy P. (1992). *Promoting Cultural Diversity: Strategies for Health Care Professionals*. Newbury Park, CA: SAGE Publications.

After well-referenced and useful introductory chapters setting the theoretical context for the book, the authors present an excellent, nuts and bolts approach to experiential learning of specific skills in cross-cultural communication. Particularly useful are sections entitled, "Recognizing and Managing Defensiveness [in both patient and provider]" and "Developing Recovery Skills." In reference to the latter section, unique in the literature on patient-provider communication, the authors state, "Affirming and managing diversity sometimes means venturing into unknown or potentially uncomfortable interactive situations." Often all goes smoothly, but mistakes occasionally occur. The authors explain that whether passive or overt, all behaviors communicate, therefore mistakes in communication are inevitable. They emphasize "the goal is to be ready to manage [mistakes], to recognize, acknowledge, be nondefensive about, and intervene in them so as to facilitate mutual communication." Meant for the trainer or health professions educator, the latter sections of this book contain many cases and role play scenarios for trainees.

Kendall J. (1996). "Creating a culturally responsive psychotherapeutic environment for African American youths: A critical analysis." *Advances in Nursing Science* 18: 11-28.

Examines the role of psychotherapeutic mental health care as an emancipatory action for Blacks, seeking to create a more culturally responsive psychotherapeutic environment for African American youths. Fitting psychotherapy, with its epistemic origins and emphasis on the interior self of emotions, thoughts, and perceptions, a holdover from 19th-century individualism, to the African American social and cultural experience, which is more embedded in communal activities of church, neighborhood, and family, is considered. (©1997 APA/PsycINFO, all rights reserved.)

Lum C. and Korenman S. (1994). "Cultural sensitivity training in U.S. medical schools." *Academic Medicine* 69: 239-241.

Authors surveyed the deans of the 126 U.S. medical schools in 1992 to assess the extent to which multicultural education was offered, as well as the perception of its value. Of the ninety-eight respondents, only thirteen stated that their schools offered coursework in cultural sensitivity. All but one of these courses were optional. Only thirty-three schools were planning to implement new courses.

Malgady R. and Rogler L. (1990). "Hero/Heroine modeling for Puerto Rican adolescents: A preventive mental health intervention." *Journal of Consulting and Clinical Psychology* 58: 469-474.

Authors report the results of an intervention with ninety Puerto Rican adolescents in Brooklyn. The intervention, termed hero/heroine modeling, highlights "achievement-oriented adult role models fostering ethnic pride and identity, self-concept, and adaptive behavior for coping with the stress of poverty, discrimination, and urban life." Students were selected for participation based on teachers' rating of those with the most severe behavioral problems. By way of small discussion groups including role plays, students highlighted the adaptive resolutions of the role models, after an exploration of "the similarity of their own stressful experiences to the role models' experiences and...how the models coped adaptively with stress." Compared to controls, pre- and post-test measures indicated significant increases in measures of adolescents' ethnic identity, self-concept, and significant reductions in levels of anxiety, compared with controls. Authors conclude, "The hero/heroine modality, as a preventive mental health intervention, is a promising innovative approach to culturally sensitive treatment of Puerto Rican adolescents."

Morrow D. (1996). "Coming out issues for adult lesbians: A group intervention." *Social Work* 41: 647-656.

Authors describe an intervention to assist lesbian clients in the coming out process, by way of a two hour, once per week series of ten group sessions that included both an educative and an experiential format. A brief discussion of each of the ten sessions is presented. Pre and post-measures of ego development, lesbian identity development, empowerment, and disclosure were used to assess the impact of the program on thirteen women in the experimental group and thirteen in a control group. Following the ten-week course, members of the experimental group made significant gains in the level of their disclosure to others, and on the dimension of "empowering participants to make their own coming out decisions." Modest gains in ego development and lesbian identity development were also achieved. Authors discuss the implications of the success of this group intervention model in mitigating the "emotional toll" of the struggle regarding coming out issues.

Nkongho N. (1992). "Teaching health professionals transcultural concepts." *Holistic Nurse Practitioner* 6: 29-33.

The author describes a college course offered to health professions students on issues of cultural diversity. The course's unique and central strategy is to engender students' self-reflection as a means of producing cultural competencies. The course goes beyond vague generalities about cultural groups to a teaching strategy that will "require students to focus on themselves

as members of whatever culture they were born into, and to examine ways in which their own heritage affects their thinking and behavior.” Among other activities, students participate in group projects, teaching one another, as a means of developing respect for differences.

Nora L., Daugherty S., Mattis-Peterson A., Stevenson L. and Goodman L. (1994). “Improving cross-cultural skills of medical students through medical school-community partnerships.” *Western Journal of Medicine* 161: 144-147.

This article describes the Spanish Language and Hispanic Cultural Competence Project offered to students at Rush Medical College (Chicago). The program consisted of Spanish language training, didactic and small group sessions led by community experts (conducted by a community-based organization and including topics such as gender roles in the Hispanic community and traditional healing practices), and an eight-day international seminar conducted in Mexico, emphasizing health issues of a developing Latin American country. Students showed a significant increase in Spanish language proficiency, and an increase in knowledge on a test of cultural knowledge (the latter compared to controls). Participants rated their experience in the overall course as positive and highly valuable.

Pew Health Profession Commission (1995). *Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century*. San Francisco, CA, UCSF Center for the Health Professions.

Seeking to give direction to the task of educating health professionals to meet the health care needs of the country into the next century, the Pew Health Profession Commission offers a number of recommendations. Among many other recommendations, from reducing the number of medical schools to advocating training at community-based sites, the Commission was clear about the imperative of cultural competency in health professions education: “There is a substantial body of literature which concludes that culturally sensitive care is good care. This means two things for all health professions schools. First, they must continue their commitment to ensuring that the students they train represent the rich ethnic diversity of our society. Important investments and many successes have been achieved, but this is an obligation that must be continued at each institution and one that is continued until it is no longer an issue. Second, diversifying the entering class is not sufficient to ensure understanding and appreciation of diversity. Cultural sensitivity must be part of the educational experience that touches the life of every student.”

Pinderhughes E. (1989). *Understanding Race, Ethnicity and Power: Keys to Efficacy in Clinical Practice*. New York: The Free Press.

This is an excellent book, illustrating the value of carefully guided self-reflection as a tool to developing trainees’ competency in cross cultural encounters. Pinderhughes shares her rich experience of several decades of teaching about cross-cultural dynamics in clinical encoun-

ters. She highlights her experience in small group settings wherein participants made a long-term commitment to participation and to risking the vulnerability of honesty about their own experiences and attitudes towards issues of racism, sexism, etc. The result is a powerful instructive integration of theoretical concepts and illustrative anecdotes. The book is an important example of the instructional strategy of going beyond the acquisition of facts about others' cultures (traditional healing practices, diet, etc.) to engendering an essential process of self-reflection in training providers: "The ability to become comfortable with culturally different others and to recognize the relativity of one's own values are critical elements in professional training but are extremely difficult to develop. The development of cultural sensitivity requires first an awareness and understanding of one's own cultural background and its meaning and significance for one's interaction with others...[This book] will draw upon the experiences of people engaged in the search for cultural self-awareness and consider the implications for what happens and what should happen at the cross-cultural helping interface...most importantly, it will demonstrate that the changes which are needed may well need to occur in the practitioner as well as in the client."

Rankin S. and Kappy M. (1993). "Developing therapeutic relationships in multicultural settings." *Academic Medicine* 68: 826-827.

This is a brief report of an innovative program in multicultural education at Children's Center of St. Joseph's Hospital and Medical Center in Phoenix, Arizona. Described are the processes of 1) first developing consensus within the organization regarding the need for and critical elements of a multicultural curriculum; 2) the identifying and gathering of community resources and the formation of a community advisory committee; 3) and the securing of consensus and participation within the health care organization's leadership and administration. Program activities included full and half day workshops, shorter lectures, small group sessions, elective rotations for the pediatric residents, and other program activities designed specifically for patients and families (the latter including a summer internship program for young people). Authors point to impressive attendance rates, the institution's funding of a part-time coordinator, implementation of a patient/provider interview format that elicits cultural needs, a new partnership with Native American healers who now are invited to the hospital to work with hospitalized patients, expanded translation services, linguistically appropriate patient education handouts, and new efforts to recruit linguistically and ethnically diverse staff members.

Ridley C. (1995). *Overcoming Unintentional Racism in Counseling and Therapy: A Practitioner's Guide to Intentional Intervention*. Thousand Oaks, CA: SAGE Publications.

This is an excellent and practical work, which begins by setting the context and sense of urgency for diversity training in clinical encounters. Subsequent chapters include such practical discussions as, "Set Culturally Relevant Goals," "Make Better Clinical Decisions," and

“Manage Resistance.” One of the most useful concepts presented by Ridley is that of “idiographic counseling,” wherein the intersection of the unique cultural roles of clients is considered and the intersection of these roles (i.e. husband, father, Catholic, Mexican American, resident of East Los Angeles, etc.) that defines the individuality of the client (“the idiographic center”) is explored in partnership with the client as a basis for present clinical insight and effective, relevant intervention.

Robinson T. and Ward J. (1991). “A belief in self far greater than anyone’s disbelief’: Cultivating resistance among African American female adolescents.” *Women & Therapy 11: 87-103.*

This article discusses the process of identity formation and self-creation among African American adolescent girls. The African American female can be consciously prepared for the sociopolitical environment in which she will live by fostering development of a resistance that will provide her with the necessary tools to think critically about herself, the world, and her place in it. A distinction is made between resistance for survival vs. resistance for liberation. In resistance for liberation, Black women are encouraged to demand change in an oppressive environment. Potentially destructive elements of the sociocultural environment that young African American women may choose as strategies of resistance for survival include self-denigration, excessive autonomy at the expense of connectedness to the collective, and quick fixes such as early pregnancies and substance abuse. (©1997 APA/PsycINFO, all rights reserved.)

Rogler L., Malgady R., Costantino G. and Blumenthal R. (1987). “what do culturally sensitive mental health services mean? The case of Hispanics.” *American Psychologist 42: 565-570.*

Three broad approaches to the development of culturally sensitive therapy programs were uncovered in the mental health literature on Hispanic populations: first, rendering traditional treatments more accessible to Hispanics; second, selecting available therapeutic modalities according to the perceived features of Hispanic culture; and third, extracting elements from Hispanic culture to modify traditional treatments or to use them as an innovative treatment tool. The conceptual order introduced into the meaning of culturally sensitive mental health services proceeds with descriptive accounts of diverse therapeutic programs within each of the three approaches. The article raises a fundamental question as to how the relationship between culture and therapy is conceived by clinical practitioners and how it ought to be conceived: Must the content of all culturally sensitive therapies stand in isomorphic, mirror-like relationship to the client’s culture? Research seeking to evaluate a culturally sensitive therapy modality for children examines this question and invites more appropriate formulations relating culture to therapy.

Ruth R. (1995). More than one life story in a life: Working with disability across cultures. In: *Sometimes You Just Want to Feel Like a Human Being: Case Studies Of Empowering Psychotherapy With People With Disabilities*. Blotzer M., Ruth R. eds., Baltimore, MD: P.H. Brookes, 173–181.

This paper presents a case study of psychotherapy with Don Rogelio, a Salvadorean construction site painter suffering from work-related injuries. The author explores the importance of cultural nuances in understanding disability and life history from a cross-cultural perspective. Differences in language, interactional dynamics, and in social class all come into play in developing cultural competence for working with disabled clients from other cultural backgrounds. The approach described in this engaging case analysis suggests that North American health practitioners need to push against the limits of ethnocentrism and to attack social injustice to work effectively with immigrant patients from the Third World.

Sabnani H., Ponterotto J. and Borodovsky L. (1991). "White racial identity development and cross-cultural counselor training: A stage model." *Counseling Psychologist 19: 76-102*.

This article incorporates an integrative model of White ethnic identity development in the planning of cultural competency training programs. Authors begin by stating the need for such a model: "Although contributing to the current status of multicultural training and practice, the literature...assumes that most cross-cultural counseling related beliefs and attitudes, knowledge and skills can be adopted by any counselor at any time, without taking into consideration the possibility that counselors within minority groups or the White middle-class majority differ among themselves in terms of their level of readiness for the assimilation of these learnings...Perhaps the single most significant advancement in cross-cultural counseling practice and research in the last decade centers on the salience of both the client and counselor's racial identity development to the cross-cultural encounter." Authors propose a six-stage, nonlinear, fluid model of White ethnic identity development. Identifying where in the continuum trainees are is critical so that training activities and realistic outcomes and expectations are chosen that are appropriate to the trainees' developmental level. The authors conclude with guidelines for evaluating this development model, and future directions for research and policy.

Sue D. (1991). "A model for cultural diversity training." *Journal of Counseling and Development 70: 99-105*.

This is perhaps one of the most comprehensive and insightful models detailing a theoretical and practical approach to cultural competence of both individuals and a wide spectrum of human service organizations. Sue presents the pragmatic (economic) rationale for organizations to address seriously the issue of incorporating diversity into their institutional practices and policies. Three levels of organizational interaction in specific reference to the diversification of an organization's workforce are identified: recruitment and the need to develop effective outreach to the labor pool; retention and the need to be attentive to corporate culture;

and promotion and facilitation of career paths that fulfill individuals' professional potentials. Barriers to incorporating diversity into organizations include differences in communication styles and characteristics of people of color, interpersonal discrimination and prejudice, and systemic barriers within an organization that parallel the country's problematic race relations. Interventions to mitigate these barriers are detailed. Competencies to be achieved by individuals employed by the organization are presented in three dimensions: beliefs and attitudes, knowledge, and skills.

After presenting this complex and elegant model, which incorporates the entirety of the preceding concepts, Sue warns against focusing on only a few of the many dimensions of cultural competence of individuals and organizations: "Cultural diversity training, when applied to organizations, is a complex and long-term process...Individual consciousness raising without consequent economic-structural-behavioral change may have limited success in the workplace and may actually thwart multiculturalism." Finally, Sue offers, "It is important to realize that any multicultural training program must ultimately contain a strong antiracism component. Moving toward multiculturalism is more than acquisition of knowledge and skills. If that were not the case, we would have eradicated racism years ago. Our biases, prejudices, and stereotypes run deep and die hard! If we are to truly become a multicultural society, we cannot continue to avoid this battleground."

Sue D., Arredondo P. and McDavis R. (1992). "Multicultural counseling competencies and standards: A call to the profession." *Journal of Counseling & Development* 70: 477-486.

After a well-referenced rationale of the need for a multicultural perspective in counseling practice, the authors offer a detailed, explicit listing of over thirty specific clinical competencies and training outcomes. These competencies were written for the counseling psychologist, but are easily transferable and applicable to all health care practitioners and human service providers. The recommendations represent the work of the Professional Standards Committee of the Association for Multicultural Counseling and Development. The recommendations include sections on "Counselor Awareness of Own Assumptions, Prejudice and Biases," "Understanding the World View of the Culturally Different Client," and "Developing Appropriate Intervention Strategies and Techniques." Under each of these sections, competencies are organized as "beliefs and attitudes," "knowledge," and "skills." Skills for institutional and community advocacy are included in addition to communication skills.

The authors highlight the importance of clarity in defining multicultural training outcomes and clinical competencies: "Too often, lip service is given to multicultural concerns, without the commitment to translate them into ethical standards and see that they become part of the accreditation criteria. If we truly believe that multiculturalism is central to our definition of a competent counselor, then monoculturalism can be seen as a form of maladjustment in a plu-

realistic society...It seems that a major obstacle in getting our profession to understand the negative implications of monoculturalism is that White culture is such a dominant norm that acts as an invisible veil that prevents people from seeing counseling as a potentially biased system.”

Takeuchi D., Sue S. and Yeh M. (1995). “Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles.” *American Journal of Public Health* 85: 638-643.

This was a study to assess return rate, length of treatment, and treatment outcomes for 1,516 African Americans, 1,888 Asian Americans, and 1,306 Mexican Americans who used 1 of 36 White or 1 of 18 ethnicity-specific mental health centers in Los Angeles between 1982 and 1986. After controlling for age, gender, MediCal eligibility, and diagnosis, African Americans, Asian Americans, and Mexican Americans were respectively two, fourteen, and eleven times more likely to return for a second appointment to ethnicity-specific programs than those of these ethnicities attending predominantly White programs. These higher return rates in the ethnicity-specific programs occurred whether or not there was an ethnic match between client and therapist. Attendance at ethnicity-specific programs was also associated with a greater number of treatment sessions compared to White programs. In their discussion the authors raise the unanswered question of what components of ethnic-specific programs result in higher return rates and utilization rates. They posit that the answer to this question will improve the services offered both at White and ethnicity-specific programs. They conclude, “From our perspective, analysis of ethnicity-specific services is an essential and exciting area of investigation that has been almost completely ignored, despite much discussion about the need for such services.”

Tervalon M. and Murray-Garcia J. (1998). “Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education.” *Journal of Health Care for the Poor and Underserved*. 9: 117–125

Authors begin by stating how critically important it is to carefully and attentively define training outcomes in multicultural medical education. Pointing out that much of the evaluation of physicians in training is invested in quantitative measures of competence (MCAT and Board Scores), the authors offer that the traditional notion of “competence” as a static, measurable endpoint is probably not appropriate for assessing training outcomes that are thought to reflect the notion of culturally effective and respectful care. Cultural humility is an ongoing “process that requires humility as individuals continually engage in self-reflection and self-critique, as lifelong learners and reflective practitioners:...it is a process that requires humility in how physicians bring into check the power imbalances that exist in the dynamics of patient/physician communication...and it is a process that requires humility to develop and maintain respectful, non-paternalistic, mutually beneficial partnerships with communities on behalf of individual patients and communities.”

Weaver H. (1998). "Indigenous people in a multicultural society: Unique issues for human services." *Social Work* 43: 203-211.

Indigenous peoples have a unique place within a multicultural society. The history of indigenous people in the United States differs from those who came here as immigrants. For many Native Americans a primary goal has been self-preservation through separation and isolation rather than seeking a place within a multicultural society. Many people are not aware that the federal government and some state governments have specific moral and legal rights and responsibilities toward Native Americans, unlike other groups in the United States. Human services providers who work with Native Americans must understand the issues specific to indigenous people in a multicultural society. This article examines the unique status of Native Americans in the United States and explores the practice implications of that status. The article begins with an overview of the components of culturally competent social work with Native Americans, then examines specific issues such as historical trauma, citizenship, cultural identity, and sovereignty with which social workers and other human services workers should be familiar to serve Native American clients effectively. (©1998 APA/PsycINFO, all rights reserved.)

Welch M. (1997). "Enhancing awareness of diversity and cultural competence: A workshop for department chairs and course directors." *Academic Medicine* 72: 461-462.

This is a brief report describing a training program at UCSF, unique for its focus on cultural competence training for faculty members, particularly those in leadership and decision-making positions. Organizers began with department chairs and course directors "to facilitate the future expansion of the training to faculty, students and residents." Administrative support and legitimization for this training activity were explicit, and included an encouragement to attend issued directly from the Dean's Office in the School of Medicine. The series of workshops illustrated the pedagogy of moving from initial awareness to knowledge and skills application: "Building Knowledge and Personal Awareness of Differences"; "Building Knowledge and Skills (Focus on the Individual);" and "Building Knowledge and Skills (Focus on the Organization)". The workshops were rated very highly on a variety of dimensions. Participant feedback included recommendations to "offer the workshop annually, continuing to use role play and experiential activities, needing more time, and requests for more workplace-specific activities."



VI. Intervention Models and Multicultural Health

A. Community Based Interventions

*B. Lifestyle and Self-Care Approaches for Multicultural
Health*

A. Community Based Interventions

Andrus N., Partner S. and Leppert P. (1997). "Analyzing strategies for developing a prenatal health care outreach program to reduce social and cultural barriers." *Journal of Health and Human Services Administration* 20: 230-41.

Beginning in March, 1994, a multi-cultural, interdisciplinary team of health care providers at Rochester General Hospital in Rochester, New York, planned and implemented a prenatal outreach program in partnership with the Rochester YWCA. The purpose of the project is to increase access to obstetric and gynecological services for low-income African-Americans, Hispanic, and White women. The processes involved in developing an outreach intervention program, Opening Doors, are described and the conflicts that surfaced during the initial stages of program development are analyzed. The problems which occurred can be attributed to role boundary conflict and differences in philosophy regarding ethnicity and health behavior. Through interviews with the anthropologist on the management team and some changes in the overall structure of the program administration, resolution of the conflicts became possible.

Butterfoss F., Goodman R. and Wandersman A. (1996). "Community coalitions for prevention and health promotion: Factors predicting satisfaction, participation, and planning." *Health Education Quarterly* 23: 65-79.

This is a comprehensive and critically important discussion of the nature of coalitions, replete with real world examples to illustrate the theoretical concepts. Varying definitions and distinctions of coalitions are reviewed. The importance of coalitions is defined in several ways: 1) "...coalitions can enable organizations to become involved in new and broader issues without having the sole responsibility of managing or developing those issues...; 2) coalitions can demonstrate and develop widespread support for issues, actions or unmet needs...; 3)...coalitions can maximize the power of individuals and groups through joint action,...by helping individuals achieve objectives beyond the scope of any one individual or organization...; 4)...coalitions can minimize duplication of effort and services." Stages of coalition formation are discussed (formation, implementation, maintenance, and accomplishment). Authors state, "The most important element in coalition formation appears to be articulation of a clear mission or guiding purpose for the coalition...It occurs when potential members reconcile the pursuit of individual goals with a sense of common purpose." Factors contributing to coalition implementation and maintenance are also discussed in detail (degree of formality, characterizations of leadership and membership, organizational climate, and relationship with external supports). Four sources of conflict during the life of the coalition are cited: "the mixed loyalties of members to their own organization and the coalition; the autonomy a coalition requires and the accountability it has to its member organizations; the lack of clarity about the coalition's purpose as either a means for specific change, or a model for sus-

tained inter-organizational cooperation: and the diversity of interests of its members.” The authors emphasize that “coalitions have not been studied in an organized and systematic way,” and they raise questions for future research throughout the article and in its conclusion.

Chavis D. (1995). “Building community capacity to prevent violence through coalitions and partnerships.” *Journal of Health Care for the Poor and Underserved* 6: 234-245.

Chavis describes ten primary functions of coalitions from his review of the literature: “1) broaden the mission of member organizations and develop more comprehensive strategies; 2) develop wider public support for issues; 3) increase the influence of individual community institutions over community policies and practices; 4) minimize duplication of services; 5) develop more financial and human resources; 6) increase participation from diverse sectors and constituencies; 7) exploit new resources in a changing environment; 8) increase accountability; 9) improve capacity to plan and evaluate; 10) strengthen local organizations and institutions to respond better to the needs and aspirations of their constituents.” He states, “Coalitions show promise in the prevention of violence, alcoholism, drug abuse, and juvenile delinquency because of the complexity and interdependence of these problems, and the systematic and community basis of their causes.” Coalitions also can attain the goal of developing a “learning community” and thus develop community capacity. Presented are two successful examples of community coalitions, engaged in community capacity building. Though formal outcome data are not available from these two examples, Chavis states, “The decentralization of planning and the implementation of strategies through committees and neighborhood coalitions was an effective structure for responding to a chaotic and rapidly changing environment...what you can see most clearly from the accomplishments of the first 22 months was that the leaders of organizations were getting smarter, better skilled, and more motivated to try new practices. These two partnerships demonstrated their capacity to create a better learning community.”

Conway T., Hu T. and Harrington T. (1997). “Setting health priorities: Community boards accurately reflect the preferences of the community’s residents.” *Journal of Community Health* 22: 57-68.

Authors conducted phone interviews with 286 households from three underserved communities in Chicago and with all eighty members of Chicago’s Local District Health Councils (DHC). Questions concerned twenty-two of the most common diseases and conditions known to impact health care. The central question was whether community advisory boards “reflect their communities’ perception of their own health needs [in representing] their communities in advice and policymaking.” DHC members were more likely to be White than those communities’ members who they represented, with 25 percent of board members being White, and 89 percent of the local residents being African American. Results indicate that both DHC members and community residents ranked social problems as more important than

chronic diseases. Of the seven leading concerns, only two were disease-oriented: hypertension and heart disease. The other five leading concerns were violence, illegal drugs, alcoholism, murder/homicide, and teenage pregnancy. "Overall, local residents have a substantial agreement with DHC members." Authors state, "This study demonstrated that a board composed of community residents, local health care providers, and local government officials accurately presents communities' priorities in terms of needs. The needs are not those conventionally identified [social problems versus chronic disease], yet the health services currently present in the communities are relatively conventional...In a sense, community boards may bring a view of health that is sophisticated and insightful to health planning."

El-Askari G., Freestone J., Irizarry C., Kraut K., Mashiyama S., Morgan M. and Walton S. (1998). "The healthy neighborhoods project: A local health department's role in catalyzing community development." *Health Education and Behavior* 25: 146-159.

Studies show that community development approaches to health education may lead not only to improved social, economic, and health status but also to increased individual participation in health education and preventive health care activities. However, because of categorical funding restraints and philosophical issues, local health departments have rarely given control of defining project outcomes to the community. One such project was in a low-income urban neighborhood in the San Francisco Bay Area. In this Healthy Neighborhoods Project, the health department catalyzed community development and organization in a multiethnic public housing complex. As a result, an empowered community successfully advocated to improve public safety by installing street speed humps and increased street lighting. After project completion, residents initiated several additional health actions, including the removal of a neighborhood tobacco billboard. This article describes the project, which may serve as a model for other urban public health programs to explore their role in community empowerment.

Elliott Brown K., Jemmott F., Mitchell H. and Walton M. (1998). The Well: A neighborhood-based health promotion model for Black women. *Health and Social Work*. 23: 146-152.

The Well is a community-based self-help wellness center located in a high-quality low-income housing complex in Los Angeles. It represents an empowerment approach to developing culturally appropriate neighborhood-based health promotion for African American women. Wellness is defined by Well members as achieving and maintaining, physical, emotional and spiritual well-being. The Well offers health promotion and wellness activities such as self-help groups, exercise classes, sister circles, and Walking for Wellness programs. It is affiliated with services and jointly sponsored programs such as the L.A. Birthing Project for improving birth outcomes; the Dunbar Economic Development Corporation, which provides low cost housing; the Partners in Prevention weight loss program; and outreach programs for HIV and substance abuse prevention. Several factors have indicated its effectiveness such

as the increased number of self-help groups and changes in women's attitudes toward personal health. The strengths and weaknesses of the program, as well as its application in other communities, are described.

Eng E. and Hatch J. (1991). "Networking between agencies and Black churches: The lay health advisor model." *Prevention in Human Services 10*: 123-146.

In this detailed article, authors present their theoretical model of using lay health advisors and coalitions from Black churches for health promotion. It is replete with practical examples, model programs, and a discussion of the model's limitations. Authors point out that the Black church in the U.S. is a force to be considered in population-based health promotion for several reasons: first, it has historically been the prime institutional force in the Black community; 70 percent of Black folks report church membership. Second, the church is one of the few institutions controlled by Black people. Third, it has an extensive range of modalities for communication, including publications. Fourth, it has organized committees assembled to meet the basic and political needs of members and non-members, on both individual and community levels. Finally, those Blacks who are not church members usually are connected with someone who is. The authors describe the potential for their lay health advisor model of health promotion to: 1) increase health information and knowledge of available sources for members to share; 2) improve communication techniques for members to expand their outreach; 3) teach self-care skills to members at risk; 4) establish links with agencies to negotiate a more efficient system of access and referrals; and 5) provide channels for exchanging and coordinating resources among networks experiencing common needs. As a specific example, they offer the North Carolina General Baptist State Convention (GBSC) Health and Human Services Program, funded by the Kellogg Foundation and the Z. Smith Reynolds Foundation. Staff of this program were involved in identifying and securing natural helpers within church congregations, training of lay health advisors in health education and screening techniques, and facilitating the links between church networks and health care delivery systems.

The program was "recognized with a national award for being one of the most innovative programs in health promotion from the DHHS and with a state award for excellence in community service from the governor's office." Evaluation data indicate "an increase in knowledge and service utilization...and significant decreases in health risk among members of the participating congregations." In concluding, authors point out that "...it is through this Black religious system of social support that linkages to the professional service delivery system can shift the dynamics from a provider-client mode to a group-collaborator mode. The LHA model represents a mediating strategy between people and their environments to secure the basics for health, information and life skills; opportunities for making health choices; and physical, social, and economic conditions of living which enhance health."

Glasgow R, Lichtenstein E, Wilder D, Hall R, McRae S. and Liberty B. (1995). "The tribal tobacco policy project: Working with Northwest Indian tribes on smoking policies." *Preventive Medicine 24*: 434-40.

The authors describe an opportunity to consult with thirty-nine tribes/tribal councils to effect changes in tribal tobacco policies, with an emphasis by researchers on policies regarding environment tobacco smoke (ETS). The consultative process consisted of regional workshops with tribal representatives, the presentation and explanation of a thirty-page workbook with recommended steps for policy formation, visits by project staff to tribal meetings, additional phone consultations, and the final goal of a policy resolution to be presented to each Tribal Council. In this preliminary analysis, authors present characteristics of those tribes that participated in the policy project. Sixteen of nineteen of the tribes in consultation have tobacco policies, with almost half drafting new or revised policies. Preliminary lessons learned from this early phase of this culture-specific advocacy training project are presented. Authors conclude, "Consultation processes and products, such as policy guidebooks, that are sensitive to traditional uses of tobacco and to differences among tribes can help to modify policies so that they can effectively reduce exposure to ETS."

Goldsmith D. and Sisneros G. (1996). "Cancer prevention strategies among California farmworkers: Preliminary findings." *Journal of Rural Health 12*: 343-348.

Hispanics have twice the rate of cervical cancer incidence and mortality than White women, yet nationally they are less likely to have ever had a Pap smear. An innovative, multi-stage educational outreach program was designed and implemented in Merced and Stanislaus Counties to increase the number of Latina women receiving Pap smears and mammograms. The first stage consisted of community focus groups and community health fairs to help in the design of culturally appropriate outreach strategies and materials. Themes that emerged from the focus groups regarding barriers to women seeking these preventive services included "fatalismo" (a perspective that there is nothing a person can do to prevent cancer), shame regarding the exam, fear of the medical system, prohibitive costs, and time constraints. Volunteer peer educators (promotoras), recognized community leaders, were recruited and trained. The promotoras gave educational presentations within their own social networks, including "Pap Parties," hosted in volunteers' homes or in a migrant camp. At these parties, the promotoras used informal teaching methods, including featuring the instruments used in a pelvic exam. Attendees were encouraged to recruit other social contacts.

Other support provided by the program's outreach workers included provision of transportation, assistance in filling out registration forms, and translation during clinic visits. There were significant changes in knowledge level regarding cervical and breast cancer prevention. At the writing of this article, 20 percent of the 1,700 health education encounters resulted in clinic visits (300+). Authors attribute the success of their program to the bilingual peer health edu-

cators. They state, "This approach builds upon existing cultural values, trust, and leadership skills of the promotora to provide cancer education and encourage more participation in cancer screenings." They state that successful prevention efforts among rural underserved groups include "needs assessments involving the target population in focus groups, innovative and culturally appropriate interventions, outreach support activities, collaboration with the community," involvement of bilingual culturally appropriate role models, and culturally appropriate clinic staff (in this case including female practitioners).

Leaven D., Becker D. and Bone L. (1992). "Narrowing the gap in health status of minority populations: A community-academic medical center partnership." *American Journal of Preventive Medicine* 8: 319-323.

This is perhaps one of the most important and effective model programs to be highlighted in the public health literature in this decade. Authors present the fifteen-year experience of a collaboration between the Johns Hopkins Medical Institutions and an African American community with the highest rates of premature disease, morbidity, and mortality in Maryland. Authors clearly outline their diagnostic, intervention, and evaluation model of a population-based approach to health promotion and disease prevention that led to significant improvement in rates of controlled (from previously uncontrolled) hypertension (38 percent to 79 percent), and decreases, 36 percent and 65 percent respectively, in rates of hospitalization and mortality from uncontrolled hypertension.

Authors outline the five steps they took in developing the program: "1) selection of a targeted minority population; 2) development of a coordinated, community-medical care system task force to direct the program, including representation from neighborhood centers, churches, offices in city government, the city health department, community providers of care, and the Johns Hopkins Medical Institutions; 3) assessment of current patterns of preventable and controllable premature morbidity and mortality; 4) selection of specific health and behavioral priorities to be addressed and goals to be achieved; 5) design of intervention and evaluation methods, including intervention strategies that provide training and skill building for members of the community served ["As the program moved into a population-based approach, a key feature was the training of community residents to become certified health workers to provide outreach, linkage and monitoring services, including screening and counseling for high blood pressure control, weight control, cessation of excessive alcohol consumption, and smoking cessation."] and; 6) plans for long-term effectiveness and sustainability based on the community-provider collaboration mode." A key, unique component of this program is its sustainability, existing for fifteen years and "not only continuing, but gaining in strength and impact...The community now 'owns' these programs, and community ownership has created pride...The Johns Hopkins Medical institutions have moved beyond the traditional role of a tertiary center to an expanded role focusing on ambulatory care, community outreach, and health promotion efforts to the population in the catchment area served by the institution.

Ongoing investigation and evaluation guarantee that new knowledge will be disseminated and offer a means of monitoring the impact, benefits and cost of the program and modifying approaches based on those results.”

Lee B. (1995). “Connecting with the community. Implementing Senate Bill 697.” *California Hospitals Fall*: 11-14.

The author describes how California’s SB 697, the Community Benefits Plan, is strengthening the connection between hospitals and their surrounding communities. In exchange for retention of tax- exempt status, SB 697 mandates that all non-profit hospitals: 1) reaffirm their mission statement by July 1995; 2) complete a community needs assessment with substantial input from community groups; and 3) adopt an annual Community Benefits Plan and submit it to the Office of Statewide Health Planning Department, with a report of what the hospital has done in the preceding year. “SB 697 creates an environment for unprecedented community collaboration in addressing the unmet needs identified at the local level by those who are closest to the action.”

Marshall J. (1995). “Violence prevention over the airwaves, a phenomenon.” *Journal of Health Care for the Poor and Underserved* 6: 246-253.

The author, the executive director and one of the co-founders of the Omega Boys Club, describes the rationale for the club’s existence. He offers his perspective on the new challenges faced by youth today, compared to his youth: 1) lack of opportunities for legal youth employment; 2) availability of weapons of destruction; and 3) the crack epidemic, which has been so powerful as to even undermine the enduring institution of Black motherhood. The Omega Boys Club intervenes on at least three levels in the lives of kids: 1) provides kids with appropriate information (i.e. exposing behaviors such as carrying a gun as not protective but putting one at higher risk); 2) addressing the intellectual and emotional experiences of the alienation kids feel today, “the anger, fear and pain” youth feel over broken homes, broken society, racism, etc.; and 3) providing an alternative set of activities and way of life (i.e. Omega Boys Club currently funds over 100 members in college through the donations of foundations and individuals). They spread the word of violence prevention through an early morning (2 AM) call-in radio show simulcast in Los Angeles and the San Francisco Bay Area, broadcasting to an estimated 200,000 people. There have been plans to expand the simulcast to Chicago.

The Omega Boys Club, as a safe place for youth to gather and talk over issues of violence, gangs, poverty, premature death, drug abuse, racism, etc. offered a unique intercultural coalition. Of this highly acclaimed, successful outreach effort, Marshall says, “At a community center where we meet in San Francisco, young people come from all areas of the city. It was fairly treacherous in the early days because of San Francisco’s significant turf problem. San

Francisco does not have gangs—no Crips and Bloods as in Los Angeles—but it has neighborhood rivalries. For all those young people to assemble together in a room was a dramatic achievement. But I think they realized that the Omega Boys Club was making a genuine effort, that we would take whatever steps necessary to create a safe environment.”

McKnight J. (1978). “Politicizing health care.” *Social Policy* 9: 36-39.

McKnight describes the health advocacy activities of a community-based organization in Chicago, a community whose residents are largely poor and African American. He depicts how “effective health action” can strengthen the community organization, can accomplish much through local resources, and can develop tools for people to use under their own control. McKnight warns how community action ideally diminishes resources consumed by the medical system, as residents become less dependent on health care and its institutions to effect health. “Effective health action must convert a professional-technical problem into a political, communal issue.”

McKnight J. (1994). “Hospitals and the health of their communities.” *Hospitals and Health Networks* 68: 40-41.

McKnight begins this brief, provocative essay with the notion of the limitations of medical care in improving the public’s health: “While it is true that the environment has always been a primary determinant of health status, modern medicine has been able to offer a remedy without environmental change. It is the truth of our times that that offer is now failing. We are forced to seek improved health in an improved environment, because the medical alternative is steadily decreasing in efficacy.” McKnight argues for health care organizations to reinvest in their communities, thereby building the capacity of communities to take an active part in providing the social change that would lead to improved health status. McKnight describes how medical care’s focus on disease and malady creates a “diagnostic ideology” that in turn creates a community map of needs and deficiencies. This map empowers health care and social and service systems, and creates a powerful resource magnet. It converts citizens to clients and producers to consumers. In direct contrast, the anti-diagnostic ideology creates a map of capacities and assets. This map empowers citizens, associations and enterprises...” He profiles the tensions between the health care systems in major metropolitan areas that currently depend on the “diagnostic ideology” that dictates that public government expenditures go to these revenue-producing institutions, rather than to the poor residents who surround these institutions. “In many low-income areas, hospitals and other health care organizations are recognized as the most affluent, prestigious, and authoritative institutions in their communities. Because of their unique status they have great potential to be community-building assets by using their institutional auspices.

The functions being performed by some local health care organizations include neighborhood and community advocacy; community-directed development activities; direct and indirect financing of development projects; volunteerism among health care professionals in community programs; and the lending out of space to community activities. In all these ways, health care professionals and organizations can invest in their local communities. The potential is clear. There is power to advocate, convene, access external resources and involve personnel and space. This power is a community asset, and one that can be as critical to regenerating health community life as direct patient care.”

Myers A., Pfeiffle P. and Hinsdale K. (1994). “Building a community-based consortium for AIDS patient services.” *Public Health Reports* 109: 555-562.

This article describes the successful efforts of the Denver Department of Health and Hospitals to reduce the cost of AIDS care by formulating an integrative system of care. In the early stages of the AIDS epidemic in Denver, along with a predominantly medical model of management, there were many gaps in the public health system of AIDS care. The article chronicles the learning process of the DHH, by way of unsuccessful grant applications to the Department of Health and Human Services. In the middle of this course of unsuccessful grant applications, the community-based organizations of Denver expressed their frustration with the DHH’s stubborn holding on to of their self-acclaimed expertise and power over the direction of community-wide efforts.

The authors point out, “With months and years of experience, local CBOs had acquired political support, strength of their convictions, and sophistication about the non-medical needs of HIV-infected people. DHH personnel did not yet understand the level of expertise that the CBOs had attained.” In its learning process, the DHH went from prevention and intervention strategies heavily focused on medical management to be provided by them, to a truly collaborative community-wide coalition (including 21 CBOs, including the Black AIDS Project-at-Large, the Latino AIDS Community Network, and the People of Color Consortium Against AIDS). “During the three years DHH learned by trial and error, reinforced by encouragement from HRSA and political pressures in the community, to fully enfranchise CBOs in its plans to serve patients with HIV.”

Rappaport J. (1995). “Empowerment meets narrative: Listening to stories and creating settings.” *American Journal of Community Psychology* 23: 795-807

This is an excellent commentary on the value of integrating empowerment theory with a “narrative” approach. The narrative approach “recognizes that communities, organizations, and individual people have stories, and that there is a mutual influence process between these community, organizational, and personal stories.” In addition to action research and applied

social science approaches that highlight narrative theory (“privileging the voices of the people studied”) Rappaport supports linking this research process to the “clinical” practice of empowerment.

He extols the “clinical” benefits of providing an opportunity and a place for the stories of community members to be told: “People who seek either personal or community change often find that it is very difficult to sustain change without the support of a collective that provides a new communal narrative around which they can sustain changes in their own personal story. Associated with such narratives are cognitive, emotional, and behavioral consequences that involve social support, role opportunities, new identities, and possible selves. The goals of empowerment are enhanced when people discover, or create and give voice to, a collective narrative that sustains their own personal life story in positive ways. This process is reciprocal, such that many individuals, in turn, create, change, and sustain the group narrative...The practice implications of this approach lead us to listen to, amplify and give value to the stories of the people we serve. We are led to help people to discover their own stories, create new ones, and develop settings that make such activities possible—all activities consistent with the goals of empowerment.” Rappaport goes on to describe the many different implications this process of integrating narrative theory with empowerment might have for the activities of the researcher/practitioner: “Many [researchers]...share a desire to collaborate, as both researcher and practitioner, in long-term community relationships that respect and advance the viewpoints and interests of the people with whom they work. Sometimes these viewpoints and interests are held individually but remain unexpressed in the absence of a coherent collective and public forum. Sometimes they are small voices with limited access to the public legitimation that amplifies certain interest group voices over others. Sometimes, when we do our community work, the viewpoints and interest of the community members are neither obvious nor easily expressed because there is no place for them to be expressed. In such circumstances those of us who claim empowerment as our point of view may find ourselves working with either existing community organizations (to help amplify their voice) or for the creation of new settings that may serve a legitimation function for people to tell their own stories.” This is an important article reflecting an apparently very young area of applied research and public health practice that has implications for individual and community health.

Voorhees C., Stillman F., Swank R., Heagerty P., Leaven D. and Becker D. (1996). “Heart, body, and soul: impact of church-based smoking cessation interventions on readiness to quit.” *Preventive Medicine* 25: 277-85.

Given the relatively low spontaneous quit rates and poor treatment outcomes among African American smokers, this study was designed to evaluate the effects of a multi-modal, culturally relevant intervention for smoking behavior change compared with a self-help strategy among urban African Americans in Baltimore churches. This randomized controlled trial in urban

African American churches used the stages of change model to compare the effectiveness of two interventions in moving smokers along a continuum toward smoking cessation. Twenty-two churches were randomly assigned to either an intensive culturally specific intervention or a minimal self-help intervention. Smokers were interviewed at baseline church health fairs and at a one-year follow-up. Self-reported quitters at follow-up were evaluated using saliva cotinine and exhaled carbon monoxide levels (CO). Stages of change were measured by applying a standardized stages of change instrument to individual interview response sequences. Analysis compared the two intervention groups at one-year follow-up with baseline stages. Outcomes included quit rates and positive progress along the stages of change.

The results of multiple logistic regression analyses showed that the multi-modal cultural intervention group was more likely to make positive progress along the stages of change continuum, compared with the self-help intervention group (OR = 1.68; P = 0.04). Church denomination and intervention status interacted in the multivariate model. Baptists in the intensive intervention were three times (OR = 3.23; P = 0.010) more likely to make progress than all the other denomination groups. It is notable that a spiritually based model focusing on environmental sanctions was more likely than a standard church disseminated self-help intervention to positively influence smoking behavior in an urban African American population.

B. Lifestyle and Self-Care Approaches for Multicultural Health

DiPasquale-Davis J. and Hopkins S. (1997). "Health beliefs of an elderly Filipino group." *Public Health Nursing 14*: 118-122.

Following a brief but very useful review of the literature on the significance of cultural variation in self-care practices (defined by these authors as including nutrition, exercise, stress management, environmental awareness, and self-responsibility) among the elderly, the authors present results of their survey of a convenience sample of fifty-two Filipino men and women in South Florida. Seventy-nine percent of the sample included foods from their own culture in their diet; 77 percent reported eating fried foods. Approximately 20 percent of the sample had gained between sixteen and twenty pounds in the last two years, secondary to eating too much (their self-reports). There was very low use of tobacco and alcohol (<20 percent), and over half reported exercising daily. Many participants stated health is a gift from God to be protected as their rationale for valuing self-care/health promotion activities. Authors conclude that such findings indicate that this subgroup of the population would not only benefit from, but would be receptive to a health promotion program that was culturally-specific.

Jepson C., Kessler L., Portnoy B. and Gibbs T. (1991). "Black-white differences in cancer prevention knowledge and behavior." *American Journal of Public Health* 81: 501-4.

Authors used data from the 1987 National Health Interview Survey of 22,088 adults, including 3,053 African Americans, to assess the relationship between cancer prevention behavior and respondents' level of knowledge and beliefs about cancer prevention. They found that, compared to Whites, Blacks were less likely to ever have undergone diet changes in the interest of their health (31 percent vs. 37 percent), were less likely to have had mammograms (31 percent vs. 40 percent) and/or stool blood test (31 percent vs. 39 percent). Blacks were also more likely than Whites to smoke (32 percent vs. 29 percent). They also found that Blacks were less likely to believe that cancer is preventable. Blacks scored lower than Whites on 3 prevention knowledge questions. Differences by race in health risk and prevention behavior disappeared when respondents' level of cancer prevention knowledge was controlled for, implying that if Blacks had the prevention knowledge, they would have engaged in health behaviors at least the level of Whites. Authors suggest that "interventions designed to narrow the behavioral discrepancies between Blacks and Whites by reducing knowledge discrepancies" may result in constructive changes in health risk and prevention behavior of Blacks, potentially narrowing the racial disparities in cancer mortality.

Lubell A. (1988). "Can exercise help treat hypertension in Black Americans?" *The Physician and Sportsmedicine* 16: 165-168.

This article begins by making the case for exercise as an effective treatment for hypertension. Possible reasons for why Blacks have not equally participated in "the exercise and fitness boom" are offered. Dr. A. Lasco, who planned the CHAPP program described below states, "The poor tend to be more concerned about acute health care, safety, and crime. Preventing illness through exercise and nutrition programs is a new concept for them." Dr. Frank Douglas, who designed the church-based program described below says, "Special diets and exercise programs can be costly. And many poor patients live in areas where it's not safe to jog. Physicians and other health care providers must give concrete suggestions and prescribe simple exercises they can do at home." The article goes on to describe several novel outreach strategies to encourage Blacks to exercise as a means of reducing blood pressure: 1) the County Health Assessment and Promotion Project (CHAPP) of a neighborhood health clinic in Atlanta offered low admission cost, transportation, and baby-sitting to women in a successful obesity treatment program; 2) the Chicago Heart Association Church Blood Pressure Program, where trained volunteers measured blood pressure after church services; and 3) The Barbershop as High Blood Pressure Control Centers Program, where barbers were taught how to measure customers' blood pressure and to refer those with hypertension to medical care. One of the founders of this program, Dr. B. Wayne King, at the writing of this article, had received a grant to build a model barbershop in Baltimore which will have exercycles in addition to waiting room chairs.

Nebeling L., Forman M., Graubard B. and Snyder R. (1997). "The impact of lifestyle characteristics on carotenoid intake in the United States: The 1987 National Health Interview Survey." *American Journal of Public Health* 87: 268-271.

Dietary carotenoids are thought to prevent cancer through their anti-oxidant effects. Authors used data from food frequency questionnaires administered by phone to 16,317 Black and White respondents. Researchers reported higher carotenoid intake among Blacks, among women, and among the college educated. Higher intake among Blacks was thought to be due to Blacks' higher reported consumption of sweet potatoes and dark leafy greens (mustard, kale and collards).

O'Donnell L., San Doval A., Duran R. and O'Donnell C. (1995). Video-based sexually transmitted disease patient education: Its impact on condom acquisition. *American Journal of Public Health*. 85: 817-822.

Educational videos about safe sex may increase the willingness to purchase condoms. Researchers analyzed the impact of video programs and discussion groups on subsequent change in condom purchasing behavior. A total of 3,257 patients at a sexually transmitted disease clinic agreed to participate. Inner-city adult residents of Hispanic or African American ethnic background either viewed a twenty-minute video or joined a discussion group after viewing the video presentation. Small groups had a leader of the same sex to help overcome cultural barriers against consistent condom use. A third group served as controls. Each participant received coupons for three free condoms redeemable at a nearby pharmacy. Almost 37 percent of the patients with both video and group exposure redeemed their coupons for condoms compared to 27.6 percent of video viewers or 21.2 percent of controls.

Perez-Stable E., Marin G. and Marin B. (1994). "Behavioral risk factors: A comparison of Latinos and non-Latino Whites in San Francisco." *American Journal of Public Health* 84: 971-6.

Authors conducted telephone surveys of 652 Latinos and 584 Whites, who lived in the same San Francisco census tracts, to assess levels of health risk behaviors. After adjusting for age, gender, education, and employment, compared to Whites, Latinos reported less frequent use of alcohol and less smoking. Compared to Whites, Latinos were also twice as likely as Whites to have a sedentary lifestyle. Latina women were two times as likely to have never had a Pap smear and over three times as likely to have never had a clinical breast exam. Less acculturated Latinos were less likely than more acculturated Latinos to have consumed alcohol in the last month and more likely to be sedentary. Authors conclude, "To effectively promote healthy behaviors among ethnic and racial groups in the United States, programs need to be based on the specific cultural and behavioral characteristics of each group...It is important to con-

duct health promotion campaigns in Spanish, to use easily understood messages that are culturally appropriate, and to base these messages on research that identifies attitudes and values specific to the target audience.”

Skolnick A. (1997). ““Hard to reach” Hispanics get health news via physician’s radio, TV shows.” *Journal of the American Medical Association* 278: 269-272.

Skolnick describes the work of Elmer Huerta, MD, M.P.H., a practicing physician who conducts two-minute radio reports on many areas of health (Cuidando Su Salud/Taking Care of your Health), a one hour health program on cable Saturday mornings, and a one hour radio call-in show from Maryland on Sundays. Cuidando Su Salud broadcasts in eight out of ten of the nation’s largest Hispanic centers (Denver, New York, Miami, Chicago, Dallas, Houston, Tucson, and San Francisco), reaching an estimated 10 to 15 million Latinos. These spots are offered free of charge to radio stations, funded by the Cancer Research Foundation of America (Alexandria, VA). Advertisements for tobacco, alcohol, or unproved health products or medical treatments are not allowed to air with these radio spots. After presenting the National Cancer Institute’s 1-800 phone number on these radio stations, Spanish speaking callers to the public service increased by 700 percent.

Sucher K. and Kittler P. (1991). “Nutrition isn’t colorblind.” *Journal of the American Dietetic Association* 91: 297-299.

This is an excellent, albeit brief discussion of the need to recognize cultural differences in nutrition counseling. The authors present at least five general lines of argument in support of their imperative. 1) Rates of nutrition related diseases often differ by race: Diabetes is several times more prevalent in Native Americans, Latinos and African Americans than in Whites. Celiac sprue is found more often in the Irish than in other populations. And Glucose-phosphate dehydrogenase deficiency is found more often in those of Asian descent and in people from the Mediterranean region. 2) Traditional food habits have been shown to have little adverse impact on diet: The four food groups including dairy products are moot for those who are lactose intolerant, yet, many Asian people prepare their daily soups by soaking bones in acidified broth, releasing calcium, and Latinos prepare tortillas with lime-soaked corn. 3) On occasion, traditional practices, like the culturally desirable obesity among Nigerian women, may conflict with “optimal” nutrition. 4) Most adverse dietary changes are the result of acculturative change, i.e. the higher rates of coronary artery disease among Japanese men who assume diets higher in fats and cholesterol in the U.S. 5) Borderline deficiencies can be seen when people are introduced to a new environment: Asian Indian children who emigrated to Britain who assumed high phytate vegetarian diets in a new cloudy climate were at risk for rickets. Authors close by touting the need for culturally sensitive, specific approaches to nutrition counseling. They also cite the urgent need for more research in “nutritional anthropology: “Despite many seminal studies of food habits, the need for culturally specific research has never been greater.”



VII. Research and Evaluation

Borrero M., Schensul J. and Garcia R. (1982). "Research based training for organizational change." *Urban Anthropology 11*: 129-153.

Authors describe the Hispanic Health Council of Hartford, Connecticut, a community-based organization. Members of the Puerto Rican/Hispanic community were trained in qualitative, quantitative and action research approaches. They work in collaboration with anthropologists to collect and analyze data in an ongoing manner on health problems and solutions in the community and gaps in service delivery. They produce health education materials, provide trainings to practitioners, hospital management personnel and other service organizations, and advocate for legislative and funding priorities.

Bushy A. (1995). "Ethnocultural sensitivity and measurement of consumer satisfaction." *Journal of Nursing Care and Quality 9*: 16-25.

An excellent, basic article that lays out a compelling argument for ethnocultural sensitivity in the context of the "new" dialogues of CQI (Continuous Quality Improvement) of health care organizations. The author goes on to present the rationale for going beyond quantitative analyses to incorporate qualitative approaches in consumer satisfaction. She gives several steps to begin the process, expanding on them with conceptual discussions and practical suggestions. For example, Bushy comments on the problematic approach of using impersonal, albeit convenient and relatively inexpensive mail surveys in communities of color to assess consumer satisfaction: "Program evaluators may find it useful to view the community metaphorically—as a theater—having a front and back stage... The information revealed by the front stage generally consists of superficial, controlled, protected, and false responses. The actors (community members) often display protective behaviors such as testing an evaluator's motives, disguising or hiding reality by offering misinformation, and demonstrating ambivalence about revealing truths to a stranger... When feelings of trust, acceptance, and respect replace fear and distrust, the health professional or evaluator is in a position to progress from front to back stage. As one progresses, the information that is revealed has greater depth since the actors are more willing to share intimate secrets and treasured information. In essence, the quantity and quality of backstage data tend to be rich and meaningful compared with the ambiguous and superficial information obtained front stage."

Coles C. and Grant T. (1985). "Curriculum evaluation in medical and health care education." *Medical Education 19*: 405-422.

Though not specifically about multicultural education, the authors present an extensive and important theoretical framework for evaluating medical education curricula. Their model includes acknowledging and addressing the separate and intersecting areas of "the curriculum on paper," "the curriculum in action," and "the curriculum that is the student's experience." As such, issues such as the institutional context in which curriculum innovation is attempted are examined thoroughly. A list of both quantitative evaluation methods (attitude scales, rat-

ing scales, questionnaires, etc.) and qualitative evaluation methods (ethnographic interviews, participant observation, diaries, documentary analyses, etc.) are discussed. Authors offer the following caveat: "Curriculum development is essentially concerned with people's attitudes, assumptions, values and expectations. No change is possible without addressing these areas. And dealing with people's feelings is a delicate as well as slow process... Effective and lasting curriculum development may take years rather than months. Perhaps educational change should be measured in generations rather than anything else."

Delgado M. (1996). "Puerto Rican elders and gerontological research: Avenues for empowerment and participation." *Activities, Adaptation & Aging 21: 77-89.*

The field of gerontology has slowly embraced the influence of ethnicity, race, and culture on help-seeking and service utilization patterns. Increased attention to these factors has highlighted the necessity for gerontological organizations to develop services that take into account an elder's cultural context. This article reports on a series of qualitative-based research activities that were utilized to involve Puerto Rican elders in a large-scale field study. A total of 591 Puerto Rican elders, 368 of whom had a functional disability, and 214 primary caregivers of those disabled elders were interviewed. A multi-pronged approach to obtaining qualitative data maximized elder participation in all phases of the research. A series of recommendations were made to help organizations undertake assessments, program evaluation, and other forms of service-focused research and to open avenues for empowerment in research. (©1998 APA/PsycINFO, all rights reserved.)

Francisco V., Paine A., and Fawcett S. (1993). "A methodology for monitoring and evaluating community health coalitions." *Health Education Research 8: 403-16.*

Community coalitions are prominent mechanisms for building local capacities to address health and social concerns. Although there are case studies and descriptive reports on coalitions, there is little empirical information about coalition process and outcome. This paper describes a case study using a methodology for monitoring and evaluating community health coalitions. Data are fed back to coalition leaders and members, funding agents, and other relevant audiences as part of the development process. The monitoring system provides data on eight key measures of coalition process and outcome: the number of members, planning products, financial resources generated, dollars obtained, volunteers recruited, services provided, community actions, and community changes. Illustrative data are presented for two different community health coalitions. Finally, challenges and opportunities in evaluating community coalitions are discussed.

Grills C., Bass K.; et al. (1996). Empowerment evaluation: Building upon a tradition of activism in the African American community. In: ***Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability***. Fetterman D., Kaftarian S., Wandersman A., eds. Thousand Oaks, CA, SAGE Publications.

The authors describe their work at the South Central Los Angeles/Community Coalition for Substance Abuse Prevention and Treatment. Evaluation was not solely a way to assess the content and quality of program “ends.” Rather, evaluation activities are seen as a “means” toward the Coalition’s goal of community empowerment: “In typical grassroots organizing settings, there are few resources. Because you are challenging power, you cannot afford to make mistakes with the resources on hand. Consequently, the need to review, critique, and look for ways to improve is an essential component of the organizing effort... The opportunity to evaluate the work in accordance with standard quantitative scientific procedures was an asset these activists never had before... This merger of the community activist tradition and social science evaluation technology promotes the coalition’s goal to enfranchise its disenfranchised communities.” The article is replete with specific and practical examples of how empowerment evaluation is used to achieve the Coalition’s goals of health promotion and community empowerment.

Muller I. and Haase B. (1994). “Managing diversity in health service organizations.” ***Hospital and Health Services Administration* 39: 415-434.**

The authors discuss the concept of “the advantage of diversity” in the workplace and the need for organizations to develop creative and pragmatic ways to manage that diversity. They present an assessment instrument based on their review of the literature. Criteria they use in evaluation are: 1) philosophy and support of organizational leaders, 2) organizational strategies (policies and programs) for managing diversity, 3) the ethnic, racial and gender composition of the organization’s workforce, 4) the extent of structural integration (composition of senior management relative to the overall workforce of the organization), and 5) the organizational type (on a continuum, homogenous vs. pluralistic vs. “diversity friendly” and multicultural). Expanded explanations of each dimension of assessment are offered along with an illustrative case study.

Pumariega A. (1996). “Culturally competent outcome evaluation in systems of care for children’s mental health.” ***Journal of Child and Family Studies* 5: 389-397.**

A good general discussion of the need and of a proposed approach to assessing the cultural competence of a service organization. The author gives very brief guidelines on how to solicit participation of community and staff in evaluation, and on evaluation design and measurement strategies. He considers briefly the cultural appropriateness of qualitative/ethnographic approaches to evaluation. He also introduces important insights such as “the cultural acceptability of answers on the extremes of a Likert-type questions may differ across groups.”

Vega W. (1992). "Theoretical and pragmatic implications of cultural diversity for community research." *American Journal of Community Psychology* 20: 375-391.

This article identifies several important issues commonly encountered, or overlooked in conducting applied research with subgroups from varying cultural backgrounds. The process of creating cultural categories for comparative analyses that complement the research design, have heuristic salience, and extend the explanatory value of findings is reviewed. Other issues discussed include vulnerabilities associated with using cognitive constructs and interpreting their meaning across cultural domains, methods of combining theory for intergroup and intra-group specific tests that facilitate synthesis without partitioning out cultural information, and implications of cultural diversity for designing, implementing, and interpreting results of community intervention trials. Recommendations for recognizing and overcoming common problems are supplied. The need for developing university-community partnerships to facilitate research and for maximizing end use of findings is emphasized.

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