

CultureCard

A Guide to Build
Cultural Awareness

A stylized, light-colored human figure with its arms raised in a 'V' shape, set against a dark brown background. The figure is composed of simple geometric shapes, including a circle for the head and a triangle for the torso. The background also features faint, overlapping geometric patterns.

**American Indian
and Alaska Native**

About this Guide

The purpose of this guide is to provide basic information for Federal disaster responders and other service providers who may be deployed or otherwise assigned to provide or coordinate services in American Indian/Alaska Native (AI/AN) communities.

This guide is intended to **serve as a general briefing to enhance cultural competence** while providing services to AI/AN communities. (Cultural competence is defined as the ability to function effectively in the context of cultural differences.) A more specific orientation or training should be provided by a member of the particular AI/AN community.

Service providers should use this guide to ensure the following Five Elements of Cultural Competence* are being addressed:

1. Awareness, acceptance and valuing of cultural differences
2. Awareness of one's own culture and values
3. Understanding the range of dynamics that result from the interaction between people of different cultures
4. Developing cultural knowledge of the particular community served or to access cultural brokers who may have that knowledge
5. Ability to adapt individual interventions, programs, and policies to fit the cultural context of the individual, family, or community

*Adapted from Cross, T., Bazron, B., Dennis, K., and Isaacs, M. (1989). Towards A Culturally Competent System of Care Volume I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Myths and Facts

Myth: AI/AN people are spiritual and live in harmony with nature.

Fact: The idea of all AI/ANs having a mystical spirituality is a broad generalization. This romantic stereotype can be just as damaging as other more negative stereotypes and impairs one's ability to provide services to AI/ANs as real people.

Myth: AI/AN people have distinguishing physical characteristics, and you can identify them by how they look.

Fact: Due to Tribal diversity, as well as hundreds of years of inter-Tribal and inter-racial marriages, there is no single distinguishing "look" for AI/ANs.

Myth: Casinos have made AI/ANs rich.

Fact: Out of more than 560 Federally recognized tribes, only 224 operate gaming facilities. About three-fourths of those tribes reinvest revenue in the community. In 2006, only 73 tribes distributed direct payments to individual Tribal members.

Myth: The Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS) are the only agencies responsible for working with tribes.

Fact: The U.S. Constitution, Executive Orders, and Presidential memos outline policy requiring that ALL executive departments have the responsibility to consult with and respect Tribal sovereignty.

Myth: AI/ANs have the highest rate of alcoholism.

Fact: While many tribes and AI/AN villages do experience the negative effects of alcohol abuse, what is less known is that AI/ANs also have the highest rate of complete abstinence. When socioeconomic level is accounted for in a comparison group, alcoholism rates are no different for AI/ANs than for other ethnic or racial groups. Most AI/AN-sponsored events ban the use of alcohol and even "social" drinking is often frowned upon.

Myth: AI/AN people all get "Indian money" and don't pay taxes.

Fact: Few Tribal members receive payments from the BIA for land held in trust and most do not get significant "Indian money." AI/ANs pay income tax and sales tax like any other citizen of their State while the U.S. Alaska Natives may get dividend payments from their Native Corporation or the State of Alaska as State citizens.

Tribal Sovereignty

Presently, there are more than 560 Federally recognized AI/AN tribes in the United States. Over half of these are Alaska Native villages. Additionally, there are almost 245 non-Federally recognized tribes. Many of those are recognized by their States and are seeking Federal recognition.

There is a unique legal and political relationship between the Federal government and Indian tribes and a special legal relationship with Alaska Native Corporations.

The U.S. Constitution (Article 1 Section 8, and Article 6), treaties, Supreme Court decisions, Federal laws, and Executive Orders provide authority to the Federal government for Indian affairs with Federally recognized tribes.

As sovereign nations, Tribal governments have the right to hold elections, determine their own citizenship (enrollment), and to consult directly with the U.S. government on policy, regulations, legislation, and funding.

Tribal governments can create and enforce laws that are stricter or more lenient than State laws, but they are not subservient to State law. State laws cannot be applied where they interfere with the right of a tribe to make its own laws protecting the health and welfare of its citizens, or where it would interfere with any Federal interest.

Criminal legal jurisdiction issues are very complex, depend on a variety of factors, and must be assessed based on the specific law as applied to a specific tribe. In general, the Federal law applies.

The Indian Self-Determination Act (Public Law 93-638) gives the authority to Tribal governments to contract programs and services that are carried out by the Federal government, such as services provided by the BIA or IHS.

The Alaska Native Claims Settlement Act was signed into law on December 18, 1971. Settlement benefits would accrue to those with at least one-fourth Native ancestry, and would be administered by the 12 regional corporations within the State.

Regional and Cultural Differences

Prior to European contact, AI/AN communities existed throughout various areas of North America. Federal policies led to voluntary and forced relocation from familiar territory to the current day reservation system.

When the reservation system was formed in the late 1800s, some bands and tribes were forced by the U.S. government to live together. In some instances, these groups were related linguistically and culturally; in others, they were not closely related and may even have been historic enemies.

On reservations where different AI/AN groups were forced to co-exist, repercussions occurred that still can be experienced today in those communities. **Historic rivalries, family or clan conflicts, and "Tribal politics" may present challenges for an outsider unaware of local dynamics who is trying to interact with different groups in the community.**

While there is great diversity across and within tribes, there are within-region similarities based on adaptation to ecology, climate, and geography (including traditional foods); linguistic and cultural affiliations; and sharing of information for long periods of time.

Differences in cultural groups are closely related to regional differences and may be distinguished by their language or spiritual belief systems. They are also a result of the diversity of historic homelands across the Nation and migration patterns of Tribal groups.

Cultures developed in adaptation to their natural environment and the influence of trade and interaction with non-Indians and other AI/AN groups.

Urban Indian communities can be found in most major metropolitan areas. These populations are represented by members of a large number of different tribes and cultures that have different degrees of traditional culture and adaptation to Western culture norms. They form a sense of community through social interaction and activities, but are often "invisible," geographically disbursed, and multi-racial.

Cultural Customs

Cultural customs can be viewed as a particular group or individual's preferred way of meeting their basic human needs and conducting daily activities as passed on through generations.

Specific cultural customs among AI/AN groups may vary significantly, even within a single community.

Customs are influenced by: ethnicity, origin, language, religious/spiritual beliefs, socioeconomic status, gender, sexual orientation, age, marital status, ancestry, history, gender identity, geography, and so on.

Cultural customs are often seen explicitly through material culture such as food, dress, dance, ceremony, drumming, song, stories, symbols, and other visible manifestations.

Such outward cultural customs are a reflection of a much more ingrained and implicit culture that is not easily seen or verbalized. **Deeply held values, general world view, patterns of communication, and interaction are often the differences that affect the helping relationship.**

A common practice of a group or individual that represents thoughts, core values, and beliefs may be described by community members as "the way we do things" in a particular tribe, community, clan, or family. This includes decision-making processes.

Respectful questions about cultural customs are generally welcomed, yet not always answered directly.

Any questions about culture should be for the purpose of improving the service provider's understanding related to the services being provided.

Many AI/AN people have learned to "walk in two worlds" and will observe the cultural practices of their AI/AN traditions when in those settings, and will observe other cultural practices when in dominant culture settings.

Sharing food is a way of welcoming visitors, similar to offering a handshake. Food is usually offered at community meetings and other gatherings as a way to build relationships.

Spirituality

A strong respect for spirituality, whether traditional (prior to European contact), Christian (resulting from European contact), or a combination of both, is common among all AI/AN communities and often forms a sense of group unity.

Many AI/AN communities have a strong church community and organized religion that is integrated within their culture.

Traditional spirituality and practices are integrated into AI/AN cultures and day-to-day living.

Traditional spirituality and/or organized religions are usually community-oriented, rather than individual-oriented.

Spirituality, world view, and the meaning of life are very diverse concepts among regions, tribes, and/or individuals.

Specific practices such as ceremonies, prayers, and religious protocols will vary among AI/AN communities.

A blend of traditions, traditional spiritual practices, and/or mainstream faiths may coexist. It is best to inquire about an individual's faith or beliefs instead of making assumptions, but be aware that many AI/AN spiritual beliefs and practices are considered sacred and are not to be shared publicly or with outsiders.

Until passage of the Indian Religious Freedom Act in 1978, many traditional AI/AN practices were illegal and kept secret.

Social/health problems and their solutions are often seen as spiritually based and as part of a holistic world view of balance between mind, body, spirit, and the environment.

It is a common practice to open and close meetings with a prayer or short ceremony. Elders are often asked to offer such opening and closing words and given a small gift as a sign of respect for sharing this offering.

Communication Styles

Nonverbal Messages

AI/AN people communicate a great deal through non-verbal gestures. Careful observation is necessary to avoid misinterpretation of non-verbal behavior.

AI/AN people may look down to show respect or deference to elders, or ignoring an individual to show disagreement or displeasure.

A gentle handshake is often seen as a sign of respect, not weakness.

Humor

AI/AN people may convey truths or difficult messages through humor, and might cover great pain with smiles or jokes. It is important to listen closely to humor, as it may be seen as invasive to ask for too much direct clarification about sensitive topics.

It is a common conception that "laughter is good medicine" and is a way to cope. The use of humor and teasing to show affection or offer corrective advice is also common.

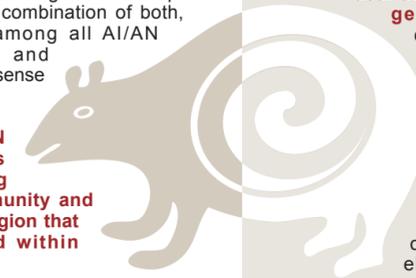
Indirect Communication

It is often considered unacceptable for an AI/AN person to criticize another directly. This is important to understand, especially when children and youth are asked to speak out against or testify against another person. It may be considered disloyal or disrespectful to speak negatively about the other person.

There is a common belief that people who have acted wrongly will pay for their acts in one way or another, although the method may not be through the legal system.

Storytelling

Getting messages across through telling a story (traditional teachings and personal stories) is very common and sometimes in contrast with the "get to the point" frame of mind in non-AI/AN society.



This guide was developed by an ad hoc group of U.S. Public Health Service Commissioned Officers, American Indian/Alaska Native (AI/AN) professionals, and family advocates working together from 2006-2007. The abbreviation AI/AN is used for American Indian/Alaska Native in the interest of space and consistency.

The authors of this guide wish to thank the many AI/AN professionals and community members across the country who contributed their thoughts and comments to this guide. The challenge in developing a basic guide for an incredibly diverse group of people such as AI/ANs cannot be understated. The authors hope the result is accurate, respectful to the communities, and helpful for the users.



Historic Distrust

Establishing trust with members of an AI/AN community may be difficult. Many Tribal communities were destroyed due to the introduction of European infectious illnesses. Similarly, many treaties made by the U.S. government with Tribal nations were broken.

From the 1800s through the 1960s, government military-style boarding schools and church-run boarding schools were used to assimilate AI/AN people. Children were forcibly removed from their families to attend schools far from home where they were punished for speaking their language and practicing spiritual ways in a stated effort to “kill the Indian, save the child.” Many children died from infectious diseases, and in many schools physical and sexual abuse by the staff was rampant. Boarding school survivors were taught that their traditional cultures were inferior or shameful, which still affects many AI/AN communities today.

The Federal “Termination Policy” in the 1950s and 1960s ended the government-to-government relationship with more than 100 Federally recognized tribes. The result was disastrous for those tribes due to discontinued Federal support, loss of land held in trust, and loss of Tribal identity. Most of the tribes terminated during this time were able to re-establish Federal recognition through the Congressional process in the 1980s and 1990s.

The Federal “Relocation Policy” in the 1950s and 1960s sought to move AI/AN families to urban areas, promising jobs, housing, and a “new life.” Those that struggled and stayed formed the core of the growing Urban Indian populations. Ultimately, many families returned home to their reservation or home community. Today, many families and individuals travel between their home community and urban communities for periods of time to pursue education and job opportunities.

Churches and missionaries have a long history of converting AI/AN people to their religions, and in the process often labeled traditional cultural practices such as songs, dances, dress, and artwork as “evil.” Today there is a diverse mix of Christian beliefs and traditional spirituality within each AI/AN community.

Cultural Identity

When interacting with individuals who identify themselves as AI/AN, **it is important to understand that each person has experienced their cultural connection in a unique way.**

An individual’s own personal and family history will determine their cultural identity and practices, which may change throughout their lifespan as they are exposed to different experiences.

The variation of cultural identity in AI/AN people can be viewed as a continuum that ranges between one who views himself or herself as “traditional” and lives their traditional culture daily, to one who views himself or herself as “Indian” or “Native”, but has little knowledge or interest in their traditional cultural practices.

Many AI/AN families are multicultural and adapt to their surrounding culture.

From the 1950s to the 1970s, the Federal government, adoption agencies, state child welfare programs, and churches adopted out thousands of AI/AN children to non-AI/AN families. The Indian Child Welfare Act was passed in 1978 to end this practice. There are many AI/AN children, as well as adults, who were raised with little awareness or knowledge of their traditional culture; they may now be seeking a connection with their homelands, traditional culture, and unknown relatives.

When asked “Where are you from?” most AI/AN people will identify the name of their tribe/village and/or the location of their traditional or family homeland. This is often a key to self-identity.

It is important to remember that most Alaska Natives do not refer to themselves as “Indians.”

Age is another cultural identity consideration. Elders can be very traditional while younger people can either be multicultural or non-traditional. In many communities, leaders and elders are worried about the loss of the use of the traditional language among children and young adults. Still, in other communities, young people are eagerly practicing the language and other cultural traditions and inspiring older generations who may have felt shame in their identity growing up as AI/AN.

Historical trauma and grief events, such as boarding schools or adoption outside of the tribe, may play a dramatic role in shaping attitudes, sense of identity, and levels of trust.

Role of Veterans and Elders

Elders play a significant role in Tribal communities. The experience and wisdom they have gained throughout their lifetime, along with their historical knowledge of the community, are considered valuable in decision-making processes.

It is customary in many Tribal communities to show respect by allowing elders to speak first, not interrupting, and allowing time for opinions and thoughts to be expressed.

In group settings, people will often ask the elder’s permission to speak publicly, or will first defer to an elder to offer an answer.

Elders often offer their teaching or advice in ways that are indirect, such as through storytelling.

When in a social setting where food is served, elders are generally served first, and in some traditional Alaska Native villages, it is the men who are served first by the women. It is disrespectful to openly argue or disagree with an elder.

AI/AN communities historically have high rates of enlistment in the military service. Often, both the community and the veteran display pride for military service.

Veterans are also given special respect similar to that of elders for having accepted the role of protector and experienced personal sacrifice. AI/AN community members recognize publicly the service of the veteran in formal and informal settings.

AI/AN community members who are veterans are honored at ceremonies and pow wows, and by special songs and dances. They have a special role in the community, so veterans and their families are shown respect by public acknowledgment and inclusion in public events.

The AI/AN community’s view of Uniformed Service members being deployed to an AI/AN community in times of crisis or disaster (such as the U.S. Public Health Service Commissioned Corps or National Guard) will vary greatly. There may be respect for the uniform similar to that shown to a veteran, but there may also be feelings of distrust related to the U.S. government’s and the military’s historical role and presence in AI/AN communities.

Strengths in AI/AN Communities

It is easy to be challenged by the conditions in AI/AN communities and to not see beyond the impact of the problems or crisis.

Recognizing and identifying strengths in the community can provide insight for possible interventions. Since each community is unique, look to the community itself for its own identified strengths, such as:

- **extended family and kinship ties;**
- **long-term natural support systems;**
- **shared sense of collective community responsibility;**
- **physical resources (e.g., food, plants, animals, water, land);**
- **indigenous generational knowledge/wisdom;**
- **historical perspective and strong connection to the past;**
- **survival skills and resiliency in the face of multiple challenges;**
- **retention and reclamation of traditional language and cultural practices;**
- **ability to “walk in two worlds” (mainstream culture and the AI/AN cultures); and**
- **community pride.**

Health and Wellness Challenges

Concepts of health and wellness are broad. The foundations of these concepts are living in a harmonious balance with all elements, as well as balance and harmony of spirit, mind, body, and the environment. Health and wellness may be all encompassing, not just one’s own physical body; it is holistic in nature. AI/ANs define what health and wellness is to them, which may be very different from how Western medicine defines health and wellness.

Many health and wellness issues are not unique to AI/AN communities, but are statistically higher than in the general population. It is important to learn about the key health issues in a particular community.

Among most AI/AN communities, 50 percent or more of the population is under 21 years of age.

Health disparities exist with limited access to culturally appropriate health care in most AI/AN communities.

Only 55 percent of AI/AN people rely on the Federally funded IHS or Tribally operated clinics/hospitals for care.

Suicide is the second leading cause of death among AI/AN people age 10-34. The highest rates are among males between the ages of 24 and 34 and 15 and 24, respectively.

Following a death by suicide in the community, concern about suicide clusters, suicide contagion, and the possibility of suicide pacts may be heightened. A response to a suicide or other traumatic occurrence requires a community-based and culturally competent strategy.

Prevention and intervention efforts must include supporting/enhancing strengths of the community resources as well as individual and family clinical interventions.

Service providers must take great care in the assessment process to consider cultural differences in symptoms and health concepts when making a specific diagnosis or drawing conclusions about the presenting problem or bio-psychological history.

Every effort should be made to consult with local cultural advisors for questions about symptomology and treatment options.

Self-Awareness and Etiquette

Prior to making contact with a community, **examine your own belief system about AI/AN people related to social issues, such as mental health stigma, poverty, teen suicide, and drug or alcohol use.**

You are being observed at all times, so **avoid making assumptions and be conscious that you are laying the groundwork for others to follow.**

Adapt your tone of voice, volume, and speed of speech patterns to that of local community members to fit their manner of communication style.

Preferred body language, posture, and concept of personal space depend on community norms and the nature of the personal relationship. Observe others and allow them to create the space and initiate or ask for any physical contact.

You may experience people expressing their mistrust, frustration, or disappointment from other situations that are outside of your control. **Learn not to take it personally.**

If community members tease you, understand that this can indicate rapport-building and may be a form of guidance or an indirect way of correcting inappropriate behavior. **You will be more easily accepted and forgiven for mistakes if you can learn to laugh at yourself and listen to lessons being brought to you through humor.**

Living accommodations and local resources will vary in each community. Remember that you are a guest. Observe and ask questions humbly when necessary.

Rapport and trust do not come easily in a limited amount of time; however, don’t be surprised if community members speak to you about highly charged issues (e.g., sexual abuse, suicide) as you may be perceived as an objective expert.

Issues around gender roles can vary significantly in various AI/AN communities. Males and females typically have very distinct social rules for behavior in every day interactions and in ceremonies. **Common behaviors for service providers to be aware of as they relate to gender issues are eye contact, style of dress, physical touch, personal space, decision making, and the influence of male and/or female elders.**

Careful observation and seeking guidance from a community member on appropriate gender-specific behavior can help service providers to follow local customs and demonstrate cultural respect.

Etiquette – Do’s

Learn how the community refers to itself as a group of people (e.g., Tribal name).

Be honest and clear about your role and expectations and be willing to adapt to meet the needs of the community. Show respect by being open to other ways of thinking and behaving.

Listen and observe more than you speak. Learn to be comfortable with silence or long pauses in conversation by observing community members’ typical length of time between turns at talking.

Casual conversation is important to establish rapport, so be genuine and use self-disclosure (e.g., where you are from, general information about children or spouse, personal interests).

Avoid jargon. An AI/AN community member may nod their head politely, but not understand what you are saying.

It is acceptable to admit limited knowledge of AI/AN cultures, and invite people to educate you about specific cultural protocols in their community.

Etiquette – Don’ts

Avoid stereotyping based on looks, language, dress, and other outward appearances.

Avoid intrusive questions early in conversation.

Do not interrupt others during conversation or interject during pauses or long silences.

Do not stand too close to others and/or talk too loud or fast.

Be careful not to impose your personal values, morals, or beliefs.

Be careful about telling stories of distant AI/AN relatives in your genealogy as an attempt to establish rapport unless you have maintained a connection with that AI/AN community.

Be careful about pointing with your finger, which may be interpreted as rude behavior in many tribes.

If you are visiting the home of an AI/AN family, you may be offered a beverage and/or food, and it is important to accept it as a sign of respect.

Explain what you are writing when making clinical documentation or charting in the presence of the individual and family.

During formal interviews, it may be best to offer general invitations to speak, then remain quiet, sit back, and listen. Allow the person to tell their story before engaging in a specific line of questioning.

Be open to allow things to proceed according to the idea that “things happen when they are supposed to happen.”

Respect confidentiality and the right of the tribe to control information, data, and public information about services provided to the tribe.

Be open to allow things to proceed according to the idea that “things happen when they are supposed to happen.”

Respect confidentiality and the right of the tribe to control information, data, and public information about services provided to the tribe.

This publication may be
downloaded or ordered at
www.SAMHSA.gov/shin.
Or, call SAMHSA's Health
Information Network at
1-877-SAMHSA-7
(1-877-726-4727)
(English and Español).
DHHS Publication No.
(SMA) 08-4354



January 2009

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/8019816>

Cultural Diversity at the End of Life: Issues and Guidelines for Family Physicians

Article in *American family physician* · March 2005

Source: PubMed

CITATIONS

311

READS

3,804

2 authors, including:



Russell Searight

Lake Superior State University

165 PUBLICATIONS 1,876 CITATIONS

SEE PROFILE

Some of the authors of this publication are also working on these related projects:



textbook--Health and Behavior: A Multisystems Approach [View project](#)

Cultural Diversity at the End of Life: Issues and Guidelines for Family Physicians

H. RUSSELL SEARIGHT, PH.D., M.P.H., and JENNIFER GAFFORD, PH.D.
Forest Park Hospital Family Medicine Residency Program, St. Louis, Missouri

Ethnic minorities currently compose approximately one third of the population of the United States. The U.S. model of health care, which values autonomy in medical decision making, is not easily applied to members of some racial or ethnic groups. Cultural factors strongly influence patients' reactions to serious illness and decisions about end-of-life care. Research has identified three basic dimensions in end-of-life treatment that vary culturally: communication of "bad news"; locus of decision making; and attitudes toward advance directives and end-of-life care. In contrast to the emphasis on "truth telling" in the United States, it is not uncommon for health care professionals outside the United States to conceal serious diagnoses from patients, because disclosure of serious illness may be viewed as disrespectful, impolite, or even harmful to the patient. Similarly, with regard to decision making, the U.S. emphasis on patient autonomy may contrast with preferences for more family-based, physician-based, or shared physician- and family-based decision making among some cultures. Finally, survey data suggest lower rates of advance directive completion among patients of specific ethnic backgrounds, which may reflect distrust of the U.S. health care system, current health care disparities, cultural perspectives on death and suffering, and family dynamics. By paying attention to the patient's values, spirituality, and relationship dynamics, the family physician can elicit and follow cultural preferences. (*Am Fam Physician* 2005;71:515-22. Copyright© 2005 American Academy of Family Physicians.)

► See editorial on page 429.

See page 409 for strength-of-recommendation labels.

Ethnic minorities compose an increasingly large proportion of the population of the United States. In the 2000 census, about 65 percent of the U.S. population identified themselves as white, with the remaining percentage representing the following ethnic groups: black (13 percent); Hispanic (13 percent); Asian-Pacific Islander (4.5 percent); and American-Indian/Alaskan native (1.5 percent). About 2.5 percent of the population identify themselves as bi-ethnic, and this figure is likely to continue to grow.¹

The challenge for family physicians in an increasingly diverse society is to learn how cultural factors influence patients' responses to medical issues such as healing and suffering, as well as the physician-patient relationship. The American Academy of Family Physicians (AAFP) has published cultural proficiency guidelines² and policy and advocacy statements about diversity in AAFP educational activities.³ In addition, sensitivity to cultural diversity is integrated within the AAFP's policy statement on ethi-

cal principles for end-of-life care.⁴ Specifically, principle 5 states: "Care at the end of life should recognize, assess, and address the psychological, social, spiritual/religious issues, and cultural taboos realizing that different cultures may require significantly different approaches."

Although cultural proficiency guidelines exist,⁵ few resources are available to family physicians regarding ways to apply these guidelines to direct patient care. Many physicians are unfamiliar with common cultural variations regarding physician-patient communication, medical decision making, and attitudes about formal documents such as code status guidelines and advance directives. End-of-life discussions are particularly challenging because of their emotional and interpersonal intensity.

Physicians also are challenged by the tremendous diversity within specific ethnic minority groups (*Table 1*).^{6,7} In fact, research suggests that when compared with whites of European descent, ethnic minorities exhibit greater variability in their preferences.⁸ There-

Strength of Recommendations

Key clinical recommendation	Label	References
Many ethnic groups prefer not to be directly informed of a life-threatening diagnosis.	C	6
In cultural groups in which patients are not directly informed about a serious prognosis, family members may want the physician to discuss the patient's condition with family members only.	C	6, 34
When considering therapeutic options, physicians should consider that members of many cultural groups prefer that family members, rather than patients, make treatment decisions.	C	6, 34
Direct discussion of advance directives and therapeutic support levels may be undesirable in situations in which they are viewed as potentially harmful to patients' well being.	C	14
When physician-patient communication occurs through a translator, trained health care translators make fewer errors than untrained translators.	C	35

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, opinion, or case series. See page 409 for more information.

fore, while certain styles of communication and decision making may be more common in some cultures, stereotyping should be avoided. Generalizations about specific cultures are not always applicable to specific patients.

Principlism, a well-established ethical framework for medical decisions in the United States and Western Europe, highlights cross-cultural differences that occur along four dimensions: autonomy, beneficence, nonmaleficence, and justice.^{9,10} Although many patients in the United States value autonomy, other cultures emphasize beneficence. In the United States, legal documents such as advance directives and durable powers of attorney are strategies to prolong autonomy in situations in which patients can no longer represent themselves. Other cultures, however, de-emphasize autonomy, perceiving it as isolating rather than empowering. These non-Western cultures believe that communities and families, not individuals alone, are affected by life-threatening illnesses and the accompanying medical decisions.¹¹ Cultures valuing nonmaleficence (doing no harm) protect patients from the emotional and physical harm caused by directly addressing death and end-of-life care. Many Asian and Native American cultures value beneficence (physicians' obligation to promote patient welfare) by encouraging patient hope, even in the face of terminal illness.

Although patients in the United States tend to value autonomy, some cultures value beneficence.

harm caused by directly addressing death and end-of-life care. Many Asian and Native American cultures value beneficence (physicians' obligation to promote patient welfare) by encouraging patient hope, even in the face of terminal illness.

Cultural influences in late-life care became particularly evident with the passing of the 1990 Federal Patient Self Determination Act (PSDA).¹² Case studies appeared that highlighted unforeseen dilemmas in the PSDA's implementation among some ethnic and cultural groups.^{13,14} Subsequent research and case studies identified three basic dimensions in end-of-life treatment that may vary culturally: communication of "bad news," locus of decision making, and attitudes toward advance directives and end-of-life care.

TABLE 1
Points of Cultural Diversity in Health Care

Emphasis on individualism versus collectivism
Definition of family (extended, nuclear, nonblood kinship)
Common views of gender roles, child-rearing practices, and care of older adults
Views of marriage and relationships
Communication patterns (direct versus indirect; relative emphasis on nonverbal communication; meanings of nonverbal gestures)
Common religious and spiritual-belief systems
Views of physicians
Views of suffering
Views of afterlife

Information from references 6 and 7.

Communicating Bad News

The consumer movement, legal requirements, an emphasis on patient informed consent, and reduced physician authority have contributed to health-related “truth telling” in the United States. Outside the United States, health care professionals often conceal serious diagnoses from patients. Physician strategies commonly employed to minimize direct disclosure include using terminology that obscures the seriousness of a condition or communicating diagnostic and treatment information only to the patient’s family members. Many African and Japanese physicians, when discussing cancer with patients or family members, choose terms such as “growth,” “mass,” “blood disease,” or “unclean tissue,”¹⁵ rather than specifically describing a potentially terminal condition. In Hispanic, Chinese, and Pakistani communities, family members actively protect terminally ill patients from knowledge of their condition. In the United States, this protection may include deliberately not translating diagnosis

and treatment information to patients,¹⁶ a situation that is less likely to arise with appropriate use of a translator (*Table 2*).^{17,18}

There are four primary reasons for non-disclosure: (1) certain cultures specifically view discussion of serious illness and death as disrespectful or impolite^{5,19,20}; (2) some cultures believe that open discussion of serious illness may provoke unnecessary depression or anxiety in the patient; (3) some cultures believe that direct disclosure may eliminate hope; and (4) some cultures believe that speaking aloud about a condition, even in a hypothetical sense, makes death or terminal illness real because of the power of the spoken word.

In many Asian cultures, it is perceived as unnecessarily cruel to directly inform a patient of a cancer diagnosis.^{15,21} Even among people of European background, Bosnian-Americans and Italian-Americans perceive direct disclosure of illness as, at minimum, disrespectful, and more significantly, inhumane.^{15,22} Recent immigrants to the United States described Bosnian physicians as “going around” the diagnosis and being indirect about serious illness in contrast to American physicians, whose directness they described as hurtful.²²

Emotional reaction to news of serious illness is also considered directly harmful to health. It is thought that a patient who is already in pain should not have to grapple with feelings of depression as well.²¹ This negative emotional impact on health also appears to be one of the primary reasons that Chinese patients are less likely to sign their own do-not-resuscitate (DNR) orders.²³ This concern, together with Asian values of reverence for aging family members,⁷ may be especially pronounced in elderly patients who, because of their frailty, are perceived as more vulnerable to being upset by bad news. In addition, the special status of the elderly in Asian culture includes a value that they should not be burdened unnecessarily when they are ill.^{11,15,24}

Direct disclosure of bad health news may eliminate patient hope. Bosnian respondents indicated that they expected physicians to maintain patients’ optimism by not revealing terminal diagnoses.²² Among

TABLE 2
Guidelines for Medical Interviews with Translators

Ideally, the translator should not be a family member.

Translators should be trained to respect patient confidentiality.

Physicians should orient the translator to the process of the medical encounter.

Physicians should request a literal, word-for-word translation.

Physicians should request the translator to ask the physician to restate or clarify unfamiliar terms.

After making a complete statement, the physician should pause for translation.

The physician should look directly at the patient, rather than at the translator, when either the physician or patient is speaking.

The physician should speak in the second person. For example, he or she might ask, “Where is your pain?” rather than “Can you ask him where he hurts?”

Information from references 17 and 18.

In some ethnic groups, factors outside medical technology, such as a divine plan and personal coping skills, may be more important for survival than physician intervention.

other ethnic groups emphasizing this perspective of hope, there is the notion that factors outside of medical technology, such as a divine plan and personal coping skills, may be more important for survival than physician intervention.⁵

Filipino patients may not want to discuss end-of-life care because these exchanges demonstrate a lack of respect for the belief that individual fate is determined by God.²⁴ If their hope is shattered, patients are no longer able to enjoy their daily lives and may feel they are "...among the dead while still alive."^{11(p213)}

Finally, Native American, Filipino, and Bosnian cultures emphasize that words should be carefully chosen because once spoken, they may become a reality. For example, a commonly held Navajo belief is that negative words and thoughts about health become self-fulfilling. Carrese and Rhodes¹⁴ noted that Navajo informants place a particularly prominent value on thinking and speaking in a "positive way." About one half of their Navajo informants would not even discuss advance directives or anticipated therapeutic support status with patients because these verbal exchanges were considered potentially injurious. Similarly, the reluctance of Chinese patients and their families to discuss possible death is based on the belief that direct acknowledgement of mortality may be self-fulfilling.²³

Locus of Decision Making

In the past 30 years, the U.S. system of medical ethics has de-emphasized physician beneficence and increasingly emphasized patient autonomy. A patient's capacity for making independent decisions is questioned only if cognitive function or patient judgment appears to be impaired by medical or psychiatric illness. In contrast, many ethnic communities view it as appropriate to withhold potentially distressing information from cognitively intact, competent patients. Therefore, the North American cultural norm of individual decision making about medical care may have to be altered when physicians care for ethnically diverse patients. Alternate models of decision making include family-based, physician-based, and shared physician-family decision making (*Table 3*).^{5,19,25}

Cultures that place a higher value on beneficence and nonmaleficence relative to autonomy have a long tradition of family-centered health care decisions. In this collective decision process, relatives receive information about the patient's diagnosis and prognosis and make treatment choices, often without the patient's input. Compared with persons of black and European descent, Koreans and Mexican-Americans were more likely to consider family members, rather than the patient alone, as holding the decision-making power regarding life support.⁹ With acculturation, Mexican-Americans were more likely to agree that patients should be directly informed of their conditions. However, acculturated Mexican-Americans continued to view decision making as a family-centered process.^{5,8} Blacks may view an overly individualistic focus as disrespectful to their family heritage.^{5,26,27}

Among Asian cultures, family-based medical decisions are a function of filial piety—an orientation toward the extended family as opposed to individual patient self-interest.²⁴ Illness is considered a family event rather than an individual occurrence.¹¹ Interests in Asian families are often bi-directional—there is an equivalent concern about the impact of the elderly person's death on the family.

Many societies attribute a high degree of authority, respect, and deference to physi-

The Authors

H. RUSSELL SEARIGHT, PH.D., M.P.H., is director of behavioral science at the Forest Park Hospital Family Medicine Residency Program in St. Louis. In addition, he is clinical associate professor of community and family medicine at Saint Louis University School of Medicine. Dr. Searight received a doctorate in clinical psychology from Saint Louis University, and a master's degree in public health from Saint Louis University School of Public Health.

JENNIFER GAFFORD, PH.D., is faculty psychologist at the Forest Park Hospital Family Medicine Residency Program. She received her doctorate in clinical psychology from Saint Louis University and completed an internship at the University of Vermont Medical Center.

Address correspondence to H. Russell Searight, Ph.D., M.P.H., Family Medicine Residency Program, 6125 Clayton Ave., Suite 222, St. Louis, MO 63139 (e-mail: russellsearight@msn.com). Reprints are not available from the authors.

cians.²⁸⁻³⁰ Patients and families defer end-of-life decisions to the physician, who is seen as an expert. Eastern European medicine has had a long tradition of physician-centered, paternalistic decision making. In Russian medicine, the physician rather than the patient or patient's family often unilaterally determines a patient's level of life support.²⁹ Recent Bosnian immigrants to the United States reported that they would prefer that physicians, because of their expert knowledge, make independent decisions to reduce the burden on patients and their families.²²

In Asian, Indian, and Pakistani cultures, family members and physicians may share decisional duties. Family care of the terminally ill in Asian and Indian cultures is a shared responsibility for cognitively intact and incapacitated relatives. Physicians in Pakistan may be adopted into the family unit and addressed as parent, aunt, uncle, or sibling.³⁰ This family status provides the physician with a role sanctioning his or her involvement in intimate discussions.³⁰

Advance Directives and End-of-Life Care

Survey data suggest that about 20 percent of the U.S. population has advance directives.^{31,32} Most investigators find significantly

lower rates of advance directive completion among Asians, Hispanics, and blacks.^{31,32} For example, about 40 percent of elderly white patients indicated that they had an advance directive, compared with only 16 percent of elderly blacks.³³ In one study,⁸ none of the Korean respondents had advance directives, and relatively few of the Hispanics had completed these documents. The low rates of advance directive completion among non-whites may reflect distrust of the health care system, health care disparities, cultural perspectives on death and suffering, and family dynamics such as parent-child relationships (Tables 3^{5,19,25} and 4^{34,35}).

Among blacks, nonacceptance of advance directives appears to be part of a much broader pattern of values regarding quality of life, as well as a historical legacy of segregation. DNR orders may be viewed as a way of limiting expensive health care or as cutting costs by ceasing care prematurely.¹¹ Historically, this perspective may stem from a long history of distrust of the white-dominated health care system. The Tuskegee syphilis study,³⁶ in which infected black men were followed for 40 years but were not informed of the availability of penicillin treatment, is well known in the black community.

The reluctance of blacks to formally address

TABLE 3

Cross-Cultural Interview Questions Regarding Serious Illness and End-of-Life Care

"Some people want to know everything about their medical condition, and others do not. What is your preference?"

"Do you prefer to make medical decisions about future tests or treatments for yourself, or would you prefer that someone else make them for you?"

To patients who request that the physician discuss their condition with family members: "Would you be more comfortable if I spoke with your (brother, son, daughter) alone, or would you like to be present?" If the patient chooses not to be present: "If you change your mind at any point and would like more information, please let me know. I will answer any questions you have." (This exchange should be documented in the medical record.)

When discussing medical issues with family members, particularly through a translator, it is often helpful to confirm their understanding: "I want to be sure that I am explaining your mother's treatment options accurately. Could you explain to me what you understand about your mother's condition and the treatment that we are recommending?"

"Is there anything that would be helpful for me to know about how your family/community/religious faith views serious illness and treatment?"

"Sometimes people are uncomfortable discussing these issues with a doctor who is of a different race or cultural background. Are you comfortable with me treating you? Will you please let me know if there is anything about your background that would be helpful for me to know in working with you or your (mother, father, sister, brother)?"

Information from references 5, 19, and 25.

TABLE 4

Cross-Cultural Communication for Serious Illnesses and End-of-Life Care

<i>Issue</i>	<i>Potential solution</i>
Ethnic minorities, which compose about one third of the U.S. population, often have distinct norms for physician-patient communication and decision making for seriously ill patients.	Physicians can become knowledgeable about cultural norms in patients they commonly treat. They can describe the dimensions as they apply to specific ethnic groups (see Table 1). Physicians should ask patients directly about cultural issues that may affect communication patterns and treatment.
Up to 17 percent of the U.S. population speaks a primary language other than English.	Physicians must find accessible, trained translators. Untrained translators should be briefly oriented to their role (see Table 2).
Some cultures view directly informing patients of a serious diagnosis as harmful.	Physicians can ask patients if they would like to be directly informed of the results of medical investigations. Physicians can let patients know that they will discuss the patient's condition with the patient at any time. These exchanges should be documented in the medical record (see Table 3).
Patients may prefer that their family members be the recipients of diagnostic and treatment information.	If a patient prefers that family members receive information, find out which family member(s).
Treatment decisions may be made by an informally appointed family member, family-wide consensus, or physician-family collaboration.	Physicians should ask patients how they would like treatment decisions to be made. At this point, the physician can determine the extent to which patients/ family members wish to be involved in treatment decisions.
When compared with whites of Northern European background, patients who belong to other ethnic groups are less likely to complete formal advance directives.	Physicians should inform patients and/or family members about the availability of written advance directives and durable powers-of-attorney. They can ask the patient or family if there is a preferred approach for making decisions on the patient's behalf.
Patients from some cultures, particularly those with histories of health care discrimination, may not trust physicians who are of a different ethnic background.	In this situation, it is good to ask patients directly if they are comfortable working with a physician of a different ethnic background. When appropriate, physicians can acknowledge that members of a particular ethnicity have had histories of less than optimal care. Patients and family members can be encouraged to inform the physician immediately if they have quality-of-care concerns.

Information from references 34 and 35.

end-of-life care also may stem from a history of health care discrimination. Although individual studies vary, the preponderance of evidence indicates that nonwhites, even after controlling for income, insurance status, and age, are less likely to receive a range of common medical interventions such as cardiac catheterization, immunizations, and analgesics for acute pain.^{37,38} Although issues such as geographic patterns of medical care play some role in these disparities,³⁹ mistrust of the health care system is likely to be a factor in the lower rates of organ donation among blacks, as well as a reduced acceptance of hospice care.^{40,41} Blacks with colon cancer were more likely than comparably ill white patients to want artificial nutrition, mechanical ventilation, and cardiopulmonary resuscitation.⁴¹ Similarly, black patients overall are about one half as likely to accept DNR status and are more likely than whites to later change DNR

Black patients overall are about one half as likely as whites to accept DNR status and more likely than whites to later change DNR orders to more aggressive levels of care.

orders to more aggressive levels of care.⁴² These attitudes also carry over to black physicians, who are significantly more likely than their white colleagues to recommend aggressive treatment to patients with brain damage and known terminal illness.⁴³ Similarly, black physicians are less likely to accept physician-assisted suicide as an acceptable intervention.⁴³

In addition to a historical legacy of unequal care, black patients also appear to view suffering somewhat differently than whites of European background. While whites may be concerned about dying patients undergoing needless suffering, black physicians and patients are more likely to think of suffering as spiritually meaningful, and life as always having some value.^{11,44} Survival alone, even if it involves significant pain, may be an important demonstration of religious faith.⁵

Among Hispanics, the lack of acceptance of advance directives may stem from a view of collective family responsibility.⁴⁵ Hispanic patients may be reluctant to formally

appoint a specific family member to be in charge because of concerns about isolating these persons or offending other relatives. Instead, a consensually oriented decision-making approach appears to be more acceptable in this population. Formalization of this process is seen as unnecessary and potentially harmful, because it may lead to increased and extended family conflict.⁴⁵

Finally, among Asians, aggressive treatment for elderly family members is likely to be guided by filial piety. Asian adults feel a responsibility to reverently care for aging parents. This sense of obligation makes it difficult for relatives to request other than extraordinary measures.²⁰ Similarly, elderly Asian parents may experience a reciprocal obligation to continue living for the emotional well-being of their adult children.²⁰

Guidelines for Cross-Cultural Communication

Physicians can actively develop rapport with ethnically diverse patients simply by demonstrating an interest in their cultural heritage. Attention to dimensions such as those listed in *Table 1*^{6,7} should help physicians develop a more detailed understanding of important cultural issues. The power imbalance of physician-patient interaction may make it particularly difficult for ethnic minority patients to directly request culturally sensitive care. Through skillful use of patient-centered questions (*Table 3*)^{5,19,25} and by including interpreters as necessary (*Table 2*),^{17,18} physicians can develop a richer understanding of patients' health care preferences.

Patient preferences for nondisclosure of medical information and family-centered decision making may be disorienting initially to American-trained physicians. When treating patients from cultures with norms of nondisclosure, physicians might describe the dimensions of informed consent and offer to provide diagnostic and treatment information (*Table 4*).^{34,35} By offering autonomy to patients, cultural norms are respected while rights to independent decisions are simultaneously acknowledged.^{46,47} A patient who refuses diagnostic information and prefers family- or physician-centered deci-

sion making has made a clear, voluntary choice. Physicians should also appreciate that, in certain cultures, while communication about serious illness and death may not be overt, information may be conveyed with subtlety. Facial expressions, voice tone, and other nonverbal cues may convey the seriousness of a patient's status without the necessity for explicit statements. In addition, stories about "good" deaths of family and community members may be shared with seriously ill patients.¹⁴

The physician's partnership with his or her patients and their families provides unique insight into their values, spirituality, and relationship dynamics, and may be especially helpful at the end of life. By eliciting and following cultural preferences regarding disclosure, advance planning, and decisional processes that relate to seriously ill patients, family physicians can provide culturally sensitive end-of-life care.

The authors indicate that they do not have any conflicts of interest. Sources of funding: none reported.

REFERENCES

1. United States Census Bureau. U.S. Census, 2000. Washington, D.C.: 2001.
2. American Academy of Family Physicians. Positions and policies: cultural proficiency guidelines (2001, 2003). Accessed online December 16, 2004, at: <http://www.aafp.org/x6701.xml>.
3. American Academy of Family Physicians. Positions and policies: diversity-assuring sensitivity to diversity in AAFP education (2000). Accessed online December 16, 2004, at: <http://www.aafp.org/x6711.xml>.
4. American Academy of Family Physicians. Position and policies: ethics, core principles for end-of-life care, principle 5 (2000, 2002). Accessed online December 16, 2004, at: <http://www.aafp.org/x6791.xml>.
5. Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end of life: "You got to go where he lives." *JAMA* 2001; 286:2993-3001.
6. McGoldrick M, Giordano J, Pearce JK, eds. *Ethnicity and family therapy*. 2d ed. New York: Guilford, 1996.
7. Searight HR. *Family-of-origin therapy and diversity*. Washington, D.C.: Taylor & Francis, 1997.
8. Blackhall LJ, Murphy ST, Frank G, Michel V, Azen S. Ethnicity and attitudes toward patient autonomy. *JAMA* 1995;274:820-5.
9. Beauchamp TL, Childress JF. *Principles of biomedical ethics*. 4th ed. New York: Oxford University Press, 1994.

Physicians can actively develop rapport with ethnically diverse patients simply by demonstrating an interest in their cultural heritage.

10. Sugarman J, ed. 20 common problems: ethics in primary care. New York: McGraw-Hill, 2000.
11. Candib LM. Truth telling and advance planning at the end of life: problems with autonomy in a multicultural world. *Fam Syst Health* 2002;20:213-28.
12. Federal patient self-determination act 19090, 42 U.S.C. 1395 cc(a).
13. Braun KL, Nichols R. Cultural issues in death and dying. *Hawaii Med J* 1996;55:260-64.
14. Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation. Benefit or harm? *JAMA* 1995;274:826-9.
15. Holland JL, Geary N, Marchini A, Tross S. An international survey of physician attitudes and practice in regard to revealing the diagnosis of cancer. *Cancer Invest* 1987;5:151-4.
16. Kaufert JM, Putsch RW. Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language, and power. *J Clin Ethics* 1997;8:71-87.
17. Herndon E, Joyce L. Getting the most from language interpreters. *Fam Pract Manag* 2004;11:37-40.
18. Flores G, Abreu M, Schwartz I, Hill M. The importance of language and culture in pediatric care: case studies from the Latino community. *J Pediatr* 2000;137:842-8.
19. Hern HE Jr, Koenig BA, Moore LJ, Marshall PA. The difference that culture can make in end-of-life decision-making. *Camb Q Healthc Ethics* 1998;7:27-40.
20. Frank G, Blackhall LJ, Michel V, Murphy ST, Azen SP, Park K. A discourse of relationships in bioethics: patient autonomy and end-of-life decision making among elderly Korean Americans. *Med Anthropol Q* 1998;12:403-23.
21. Matsumura S, Bito S, Liu H, Kahn K, Fukuhara S, Kagawa-Singer M, et al. Acculturation of attitudes toward end-of-life care: a cross-cultural survey of Japanese Americans and Japanese. *J Gen Intern Med* 2002;17:531-9.
22. Searight HR, Gafford J. "It's like playing with your destiny": Bosnian immigrants' views of advance directives and end-of-life decision-making. *J Immigr Health*. [In press]
23. Liu JM, Lin WC, Chen YM, Wu HW, Yao NS, Chen LT, et al. The status of the do-not-resuscitate order in Chinese clinical trial patients in a cancer centre. *J Med Ethics* 1999;25:309-14.
24. Yeo G, Hikuyeda N. Cultural issues in end-of-life decision making among Asians and Pacific Islanders in the United States. In: Braun K, Pietsch JH, Blanchette PL, eds. *Cultural issues in end-of-life decision making*. Thousand Oaks, Calif: Sage, 2000:101-25.
25. Ersek M, Kagawa-Singer M, Barnes D, Blackhall L, Koenig BA. Multicultural considerations in use of advance directives. *Oncol Nurs Forum* 1998;25:1683-90.
26. Waters CM. Understanding and supporting African Americans' perspectives of end-of-life care planning and decision making. *Qual Health Res* 2001;11:385-98.
27. Berger JT. Cultural discrimination in mechanisms for health decisions: a view from New York. *J Clin Ethics* 1998;9:127-31.
28. Schlesinger M. A loss of faith: the sources of reduced political legitimacy for the American medical profession. *Milbank Q* 2002;80:185-235.
29. Karakuzon M. Russia. In: Crippen D, Kilcullen JK, Kelly DF, eds. *Three patients: international perspectives on intensive care at the end-of-life*. Boston: Kluwer, 2002:67-72.
30. Moazam F. Families, patients, and physicians in medical decisionmaking: a Pakistani perspective. *Hastings Cent Rep* 2000;30:28-37.
31. Pietch JH, Braun KL. Autonomy, advance directives, and the patient self-determination act. In: Braun K, Pietsch JH, Blanchette PL, eds. *Cultural issues in end-of-life decision making*. Thousand Oaks, Calif: Sage, 2000:37-53.
32. Baker ME. Economic, political and ethnic influences on end-of-life decision-making: a decade in review. *J Health Soc Policy* 2002;14:27-39.
33. Hopp FP, Duffy SA. Racial variations in end-of-life care. *J Am Geriatr Soc* 2000;48:658-63.
34. Murphy ST, Palmer JM, Azen S, Frank G, Michel V, Blackhall L. Ethnicity and advance care directives. *J Law Med Ethics* 1996;24:108-17.
35. Flores G, Law MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* 2003;111:6-14.
36. Caplan AL. Twenty years after: the legacy of the Tuskegee syphilis study. In: Teays W, Purdy LM, eds. *Bioethics, justice and health care*. Belmont, Calif.: Wadsworth-Thomson Learning, 2001:231-5.
37. Smedley BD, Stith AY, Nelson AR, eds. *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, D.C.: National Academies Press, 2003.
38. Steinbrook R. Disparities in health care--from politics to policy. *N Engl J Med* 2004;350:1486-8.
39. Lavizzo-Morey R, Knickman JR. Racial disparities--the need for research and action. *N Engl J Med* 2003;349:1379-80.
40. Siminoff LA, Lawrence RH, Arnold RM. Comparison of black and white families' experiences and perceptions regarding organ donation requests. *Crit Care Med* 2003;31:146-51.
41. McKinley ED, Garrett JM, Evans AT, Danis M. Differences in end-of-life decision making among black and white ambulatory cancer patients. *J Gen Intern Med* 1996;11:651-6.
42. Tulsy JA, Cassileth BR, Bennett CL. The effect of ethnicity on ICU use and DNR orders in hospitalized AIDS patients. *J Clin Ethics* 1997;8:150-7.
43. Mebane EW, Oman RF, Kroonen LT, Goldstein MK. The influence of physician race, age, and gender on physician attitudes toward advance care directives and preferences for end-of-life decision-making. *J Am Geriatr Soc* 1999;47:579-91.
44. Orona LJ, Koenig BA, Davis AJ. Cultural aspects of nondisclosure. *Camb Q Healthc Ethics* 1994;3:338-46.
45. Morrison RS, Zayas LH, Mulvihill M, Baskin SA, Meier DE. Barriers to completion of healthcare proxy forms: a qualitative analysis of ethnic differences. *J Clin Ethics* 1998;9:118-26.
46. Moskop JC. Informed consent in the emergency department. *Emerg Med Clin North Am* 1999;17:327-40.
47. Freedman B. Offering truth. One ethical approach to the uninformed cancer patient. *Arch Intern Med* 1993;153:572-6.