

Barriers to Optimum End-of-life Care for Minority Patients

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Although major efforts are underway to improve end-of-life care, there is growing evidence that improvements are not being experienced by those at particularly high risk for inadequate care: minority patients. Ethnic disparities in access to end-of-life care have been found that reflect disparities in access to many other kinds of care. Additional barriers to optimum end-of-life care for minority patients include insensitivity to cultural differences in attitudes toward death and end-of-life care and understandable mistrust of the healthcare system due to the history of racism in medicine. These barriers can be categorized as institutional, cultural, and individual. Efforts to better understand and remove each type of barrier are needed. Such efforts should include quality assurance programs to better assess inequalities in access to end-of-life care, political action to address inadequate health insurance and access to medical school for minorities, and undergraduate and continuing medical education in cultural sensitivity. *J Am Geriatr Soc* 50:182–190, 2002.

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The medical literature contains abundant evidence that care for terminally ill patients needs improvement.^{1–4} Numerous barriers to high-quality end-of-life care have been identified.^{1–3,5–19} Although major efforts have been undertaken in the past decade to improve end-of-life care, there is growing evidence that improvements are not reaching those at especially high risk for inadequate end-of-life care: minority patients. This paper explores barriers to optimum end-of-life care that particularly affect minority patients. Current knowledge in several relevant domains is reviewed, including ethnic differences in access to medical services and cultural differences in attitudes to-

ward physicians and end-of-life care. Based on this review, specific types of barriers to optimum end-of-life care for minority patients are identified, and strategies for lowering the barriers are proposed.

BARRIERS TO MEDICAL CARE IN GENERAL FOR MINORITY PATIENTS

Large disparities exist between use of the most varied medical services by minorities and use of the same services by European Americans. At least some of this lower use is due to decreased access.^{20–22} Evidence of disparities is most plentiful for African Americans. Multiple studies document decreased use of cardiac procedures for African Americans with coronary artery disease.^{23–27} Other studies found similar disparities in use of renal dialysis for African Americans with end-stage renal disease.^{28,29} Ayanian et al. found that quality of care was lower for black Medicare beneficiaries than for others hospitalized for congestive heart failure or pneumonia.³⁰ Ayanian's group also found substantially lower access to renal transplantation for black than for white patients.³¹ This finding remained after controlling for patients' preferences and other factors. It also has been found that older African American women receive mammography less often than socioeconomically and demographically matched European American women,^{32,33} and that non-white (mostly African American) pneumonia patients were less frequently admitted to intensive care units than similarly ill and similarly insured European American patients.³⁴ Likewise, ethnic disparities were found in rates of surgery for early-stage non-small-cell lung cancer and glaucoma.^{35,36} Another study found that black Medicare patients hospitalized with heart failure or pneumonia received poorer quality of care than other patients.³⁷ In a large study of Medicare beneficiaries, Kahn et al. showed that "patients who are black or from poor neighborhoods have significantly worse processes of care and greater instability at discharge than other patients."³⁸ A second large study of Medicare beneficiaries by Gornick et al. found that African Americans have fewer visits to physicians for ambulatory care, fewer mammograms, and fewer immunizations against influenza than European Americans. African Americans are also hospitalized more often, have higher rates of lower-limb amputation for peripheral vascular disease and bilateral orchiectomy for prostate cancer, and have higher mortality rates. These differences remained after controlling for income.³⁹

It is clear that lack of insurance is a major barrier to receiving health care and that minority Americans are at

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least twice as likely to be uninsured as European Americans.⁴⁰ Other causes for these ethnic disparities in access and outcomes are less clear and have not been empirically proven. The search for causes is complex. Studies that use different methods, populations, or variables or that define variables differently are not easily comparable. Although many studies of such disparities may control for “race” or socioeconomic status, or even for more specific variables such as income or insurance, the meanings of these terms are not standardized and sometimes remain unclear. Possible causes or associations include unmeasured socioeconomic factors such as differences in insurance type, availability of transportation, and job and familial obligations; cultural differences in attitudes toward or preferences for health care; and actual and perceived racial bias at individual and institutional levels.^{41,42} Further clarification of these possible social, economic, institutional, cultural, and psychological barriers to optimum care for minority patients is particularly important because of poorer overall health among African Americans and Latinos as measured by various parameters.^{40,43} These include higher infant and maternal mortality rates,^{44,45} shorter life expectancy (for African Americans),⁴⁶ and higher incidence of many diseases associated with high morbidity and mortality, such as diabetes mellitus, hypertension, end-stage renal disease, cardiovascular disease, stroke, some cancers, tuberculosis, and acquired immunodeficiency syndrome (AIDS).^{43,47–50}

Decreased access to care for minorities is reflected in decreased access to medical school for the same groups. Minorities continue to be underrepresented in medical schools, in the medical profession, and on medical school faculties at all levels.^{51–54} The recent assault on affirmative action is already making this underrepresentation worse, especially in the states that dropped affirmative action first: California, Texas, Louisiana, and Mississippi.^{55–57} More states plan to follow suit. Minority physicians are known to care disproportionately for underserved, poor, and minority patients.^{58,59} Therefore, barriers to medical education are likely to heighten barriers to care and worsen overall health for these populations.⁶⁰

BARRIERS TO OPTIMUM END-OF-LIFE CARE FOR MINORITY PATIENTS

Disparities in Provision of Analgesia and Other Care

Ethnic disparities also have been found in access to end-of-life care. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) investigators demonstrated that, in five major medical centers, fewer resources were used in caring for seriously ill African Americans than for other patients with similar illness severity and sociodemographics.^{61,62} Several studies reveal lower use of analgesia for minority cancer patients with pain. When Bernabei et al. analyzed data obtained with the Minimum Data Set instrument from 14,000 older cancer patients in over 1,400 nursing homes, they found that African American and minority patients were significantly more likely to receive no pain medication.⁶³ Cleeland et al. studied 281 minority (mostly black and Hispanic) patients and 627 majority patients with cancer. They found that minority patients were significantly less likely to receive guideline-recommended analgesia.⁶⁴ Engle et al. used

a qualitative ethnographic approach to evaluate the needs and concerns of black and white nursing home residents with terminal cancer. They concluded that pain relief was inadequate for the black residents.⁶⁵

A study of analgesia use in a large Los Angeles emergency department found that Hispanic trauma patients were twice as likely to receive no pain medication as non-Hispanic white patients with similar injuries despite the fact that physician assessment of pain severity did not differ between the two groups.^{66,67} In a similar study of black and white patients in an Atlanta emergency department, blacks were significantly less likely than whites to receive analgesics.⁶⁸ In a survey of pharmacies in New York City, Morrison et al. found that pharmacies in predominantly non-white neighborhoods do not stock sufficient medications to treat patients with severe pain.⁶⁹ Although these studies did not focus on analgesia for terminally ill patients, they too indicate that undertreatment of pain disproportionately affects minorities.

Ethnic Differences in Preference for End-of-Life Care

A number of studies reveal differences between ethnic groups in attitudes toward end-of-life care. A difference between African Americans and European Americans in attitudes toward life-sustaining treatment and advance directives is particularly well documented. Multiple studies show that African Americans prefer aggressive life-sustaining treatment more often than European Americans. In their study of African American, Mexican-American, Korean-American, and European American senior citizens in Los Angeles, Blackhall et al. found that African Americans were the most likely to want life-sustaining treatment, whereas European Americans were least likely.⁷⁰ Caralis et al. found that African Americans were less likely than Hispanics or non-Hispanic European Americans to want “physician-assisted death” under any circumstances or to want life-prolonging treatments withheld or withdrawn. Non-Hispanic whites were most likely to agree to both. These results remained after controlling for socioeconomic status.⁷¹ Garrett et al. and Gramelspacher et al. found that African American patients were significantly more likely than white patients to desire aggressive life support in the event of terminal illness.^{72,73} A study of nursing home residents in the Philadelphia area revealed that African Americans were significantly more likely than those classified as “white or other ethnicity” to prefer cardiopulmonary resuscitation (CPR) in the event of cardiac arrest and to prefer tube feeding in the event of inability to eat due to brain damage.^{74,75} The SUPPORT investigators found that, among hospitalized patients with terminal diagnoses, black patients were significantly more likely to want CPR than white patients.⁷⁶ Although adjustment for self-pay or Medicaid coverage eliminated this difference, African Americans were more likely than European Americans to continue to prefer CPR 2 months after hospitalization and were more likely to change a do-not-resuscitate (DNR) order to preferring CPR.⁶² In the same study, African American patients who experienced cardiopulmonary arrest were more likely to receive CPR than “white or other ethnicity” patients.⁷⁷ Among SUPPORT patients who experienced economic hardship, African Americans were more likely than European Americans to prefer life-extending care.⁶² Reese et al. found a

significantly lower interest in hospice care among African Americans than among European Americans.⁷⁸

Multiple studies also show that African Americans are less likely than European Americans to have completed an advance directive or be interested in doing so. Caralis et al. found that African Americans were significantly more likely to feel that they would be treated differently or cared for less if they had a living will. The authors interpreted their results as suggesting a lack of trust by many minority patients of living wills in particular and the health-care system in general.⁷¹ Murphy et al. found that European Americans were more likely to have an advance care directive than Mexican Americans, African Americans, or Korean Americans even after controlling for prior knowledge of advance directives.⁷⁹ In a random sample of U.S. deaths in 1986, Hanson et al. found that use of living wills was lower by blacks than whites even after controlling for socioeconomic factors.⁸⁰ A study of AIDS patients in Boston showed that non-European Americans were significantly less likely to have discussed resuscitation with their physician than European Americans.⁸¹ In two large studies of hospitalized patients in the Cleveland area, the use of DNR orders was substantially lower in African Americans than in whites.^{82,83}

Cultural Difference

The process of dying entails great stress and vulnerability for most patients and families. Patients may feel very removed from the quotidian concerns that preoccupy most people.⁸⁴ This feeling of aloneness and extreme stress suffice to make communication with clinicians difficult. Cultural differences between patients and clinicians make the gap still more difficult to bridge.

Culture—defined as a constellation of shared meanings, values, rituals, and modes of interacting with others that determines how people view and make sense of the world—strongly influences how patients experience health, illness, and medical care.^{85–87} It is especially important in shaping attitudes about death and dying and preferences for end-of-life care.^{70,88–92} Religious and cultural beliefs, practices, and rituals help people cope with the fear, stress, and grief associated with dying by providing a context of meaning and a structure of support. Thus, even patients and families who do not usually follow traditional practices may resort to them in this situation.^{78,93} Clinicians too hold strong culturally determined beliefs about death and dying and resort to particular practices in caring for the dying. Vincent and others have shown that physicians' attitudes toward end-of-life care vary significantly along religious and cultural lines.^{94–96} In addition, modern medicine itself is a culture, and medical education an acculturation process, that helps determine physicians' attitudes.^{97–99} Thus, the process of dying, perhaps more than any other moment in the course of medical care, can accentuate cultural differences between patients, families, and providers.

Several recent studies in the medical literature document cultural differences in attitudes toward medicine and dying. Carrese et al. report that exposing Navajo patients to advanced care planning as required by the Patient Self-determination Act and the principle of autonomy can inadvertently harm them.¹⁰⁰ Paradoxically, the antipaternalistic belief in the patient's right to know, strongly promoted in

the medical ethics literature of the last 30 years, may lead in some instances to a cultural paternalism that can psychologically injure patients from certain cultures.^{101,102}

The study by Blackhall et al. suggests that many Korean Americans and Mexican Americans in southern California may be at risk for such injury.⁸⁸ Blackhall found that Korean Americans and Mexican Americans were more likely than African Americans or European Americans to believe that only the family, and not the patient, should be told the truth about a diagnosis of metastatic cancer or a terminal prognosis and that the family rather than the patient should make decisions about life support. These attitudinal barriers were associated strongly with culture and acculturation, and these associations remained after controlling for socioeconomic status. The investigators also found that Korean Americans had the most positive general attitude about life-sustaining treatment but had a low personal desire to receive it. One subject's explanation for this seeming paradox was that, in spite of her low interest in life support, the decision belonged to her son who was obligated by filial piety to request life support.⁷⁰ The investigators concluded that a family-centered style of medical decision-making is common in some cultures and that physicians ought not, therefore, adhere blindly to the patient autonomy model. Rather, they must take care to learn the beliefs and preferences of each individual patient regarding medical decision-making and to respect those beliefs and preferences.

Lack of sensitivity to, and respect for, cultural difference may compromise end-of-life care for minority patients. As the country becomes culturally more diverse, the risk to minorities of poor end-of-life care due to cultural misunderstanding is likely to grow. Thus, many have called for training in cultural sensitivity for medical students and residents and in continuing medical education (CME) courses.^{103–106}

A small study by Cykert et al. suggests a cultural difference between older African Americans and European Americans in attitudes toward debility and death. When asked about preferences for remaining in a severely debilitated state rather than undergoing a potentially lethal attempt at cure, Cykert et al. found that African Americans had much higher health utility scores: a greater preference to remain alive in spite of severe disability.¹⁰⁷ Another study showed that differences between African American and European American women in cultural beliefs about cancer partially explain differences in breast cancer stage at diagnosis.¹⁰⁸ The question arises as to whether the reported "ethnic" (or "racial") differences in preferences for end-of-life care summarized in the preceding section are better described as cultural differences. Although the definitions of "ethnicity" and "culture" overlap, "ethnicity" denotes, at least in part, a shared genetic or geographical origin. It may be useful for medical purposes to distinguish between diseases particularly prevalent in certain ethnic groups—diseases whose manifestations are primarily genetically rather than culturally determined, such as Tay-Sachs disease or sickle cell anemia—and diseases or conditions related primarily to cultural beliefs or practices. "Race" has always denoted a linkage between physical features such as skin color on the one hand and intellect or behavior on the other.¹⁰⁹ It is widely accepted that this specious con-

cept is not scientifically applicable to anything in reality and has little value in medical research or practice.^{110–112} The documented greater preference among African Americans than among European Americans for aggressive life-sustaining treatment and *against* use of advance directives is due neither to population-specific genetic differences nor to “racial” differences in intellect or behavior. It is due rather to differences in shared meanings and values formed by shared historical and social experience. It is due to differences in culture.

The question now arises as to what might determine this cultural preference in African Americans. Might it be due, as Caralis and others have suggested, to a lack of trust in physicians or the healthcare system on the part of African American and other minority patients?^{71,113–115} Do minority patients sometimes suspect that they may be experimented upon surreptitiously or that physicians may wish to save money or effort by withholding treatment from them? If this were the case, mistrust might constitute a major barrier to optimum care for minority patients. It may compromise patient-physician communication or dissuade patients from seeking needed medical attention and following physicians’ recommendations. Care of terminally ill patients would be compromised for the same reasons. In addition, mistrust may make patients hesitant to complete advance directives and motivate them to insist on aggressive and often painful life-sustaining treatment rather than comfort care.^{116–118} Thus, mistrust may be an especially important barrier to optimum care of terminally ill minority patients.

Mistrust

There now are some data documenting cultural differentials in trust. When Kao et al. surveyed over 2,000 patients to try to discern any relationship between method of physician payment and patients’ trust of their physicians, they found that whites trusted their physicians more than non-whites regardless of the method of physician payment.¹¹⁹ Among patients with end-stage renal disease on dialysis in four geographic regions, Ayanian et al. found that blacks were less likely than whites to report trust in their primary nephrologist’s judgment.³¹ Davidson et al. studied mistrust as a possible barrier to organ donation by African Americans and concluded that “distrust of the medical community is a powerful deterrent to organ donation.”¹²⁰ In addition, three recent studies using focus-group methodologies revealed mistrust of physicians and the healthcare system by African American patients.^{121–123}

Clear data linking culturally based mistrust to specific preferences for end-of-life care are scant. The best evidence linking mistrust of physicians to a preference by African Americans for aggressive life-sustaining treatment comes from Blackhall et al., who followed up their quantitative study with ethnographic interviews. There emerged in interviews with African Americans the prominent theme that “doctors could not be entirely trusted to know when, and if, to stop life support because their motives might be tainted by economic considerations.”⁷⁰ Morrison et al. found that older Hispanics reported less trust in physicians and in the healthcare system than did African Americans or whites.¹²⁴ They also found significant differences be-

tween Hispanics, African Americans, and whites in completion rates of healthcare proxies. However, these latter differences resolved with multivariable analysis that controlled not for trust but for reversible barriers to completing a proxy such as knowledge of proxies and availability of a healthcare agent. In a small study using a focus group methodology, Hauser et al. did find that mistrust and suspicion about the healthcare system influenced attitudes of African Americans toward advance directives.¹²⁵ Similarly, when Reese et al. conducted qualitative interviews with six African American pastors to explore reasons for low use of hospice by African Americans, lack of trust in the healthcare system emerged as a major theme.⁷⁸ These findings have yet to be confirmed in larger or quantitative studies.

Using quantitative methods, McKinley et al. specifically sought to test the hypothesis that African Americans prefer more live-sustaining treatment and use fewer advance directives than whites because African Americans mistrust the healthcare system.¹¹⁸ Although they confirmed these differences in preference for end-of-life care and in use of advance directives, they found no difference between cultural groups in trust. They speculated that this inability to document mistrust may have been due to an inadequate study design that was not conducive to maximizing patients’ forthrightness about a very sensitive issue: trust in their physicians.

Given the evidence that many African American and other minority patients mistrust the healthcare system and the possibility that this mistrust may compromise care, it is important to try to understand mistrust more fully. What has produced mistrust? Is there a historical and social context to which mistrust is an adaptive and reasonable response and within which it makes sense?

Medical Racism

We have seen that widespread disparities exist today in access to many medical services for minority patients. Although precise reasons for these disparities remain unclear, it would not be unreasonable to suspect that racism of various kinds may play a role—individual or institutional, conscious or unconscious.⁴¹ Thus, these widespread disparities are reason enough for minority patients to mistrust the healthcare system. The history of American medicine provides further reasons.

Regrettably, American physicians were among those who supported and profited professionally from slavery. Williams notes that in 19th century United States, “medical research was used to justify racial domination and support the prevailing ideology of racial inferiority.”¹²⁶ Gamble writes, “Antebellum physicians contended that black people possessed peculiar physiological and anatomical features” that made them “not only inferior but inherently suited for slavery.”^{113,127} Such features included thicker skin, better tolerance of heat and sun, less sensitivity to pain, and less susceptibility to diseases such as yellow fever and malaria, than white people.¹²⁸ This belief in a racial difference in pain sensation served as a justification for physicians to perform agonizing experiments on slaves and to use them brutally as teaching material.^{113,114,127,128} Given recent evidence of decreased use of analgesia for African American and other minority cancer patients, the question arises as

to whether a racist belief in differential pain sensation continues to unconsciously—or even consciously—afflict contemporary physicians.

In the late 19th and early 20th centuries, many medical and public health journal articles discussed the intrinsic “racial” characteristics of African Americans that supposedly produced high rates of syphilis.¹¹³ These racist attitudes served as a background for the most infamous American medical research project of the 20th century: the Tuskegee Syphilis Study.¹²⁹ It is estimated that between 28 and 100 of the 399 poor African American sharecroppers who were deceived into serving as subjects died of untreated syphilis. James Jones, author of the definitive book on the Tuskegee Study, notes that for many African Americans the Study is a symbol of mistreatment and deceit by the medical establishment.¹³⁰ Several small studies performed in different locations have documented the pervasiveness and power of this symbol in the black community.^{122,123,131}

Even after the Tuskegee Study was shut down, potentially harmful medical experimentation without informed consent continued on prisoners in the Philadelphia prison system who were disproportionately African American and minority. When news of the experiments became public in 1980 and 1981, it was reported particularly thoroughly in minority newspapers.¹³² Major public health projects in recent decades also have proven injurious to minorities. “Voluntary” sterilization initiatives in poor communities in the 1960s disproportionately subjected minority women to coerced sterilization.^{114,133} Federal and state efforts to address sickle cell disease in the 1970s included conflation of sickle cell disease and trait in education materials and senseless mass screening programs. The result was job and insurance discrimination against African Americans.^{133,134}

The history of American medicine includes torturous exploitation, deception, withholding of needed treatment, experimentation without consent, coerced treatment, and stigmatization, perpetrated by healthcare institutions and physicians upon African American and other minority patients. Given this history of medical racism, and given widespread inequalities in access to health care today, mistrust is not surprising.¹¹⁵

Whose problem is mistrust? The literature often construes mistrust as a characteristic of minority patients and populations. This implies that mistrust is a problem of minorities that minorities must overcome. It blames the victims of discrimination and racism for a normal response to being victimized. The basic problem is that physicians and healthcare institutions have not always been trustworthy.¹³⁵ The onus should be on physicians and on the healthcare system to consistently demonstrate trustworthiness, not simply on mistrustful minority patients to try to overcome their misgivings.

CONCLUSION: TOWARD CULTURALLY SENSITIVE END-OF-LIFE CARE AND RESEARCH

Many barriers exist to optimum end-of-life care for minority patients. First, there are large-scale *structural* or *institutional* barriers. These include the economic barrier of inadequate health insurance that disproportionately affects minorities,¹³⁶ social barriers to equal access unrelated to insurance, underrepresentation of minorities in medicine, and

the dismantling of affirmative action programs designed to remedy this underrepresentation. These institutional barriers are forms of institutional racism.^{41,50} Second, there are *cultural* barriers arising from cultural differences between patients or families and healthcare providers and the insensitivity of providers to these differences. Part of this problem is the confusion of cultural difference with genetic or ethnic difference. Third, there are *individual* barriers. These include racially discriminatory practices by individual physicians⁴¹ and the psychological barrier of mistrust generated by individual and institutional discrimination and by cultural insensitivity. Fourth, the highly stressful process of dying, perhaps more than any other moment in the course of medical care, can heighten each of these barriers. It can make manifest latent cultural differences, latent racism—individual or institutional, conscious or unconscious—and latent mistrust due to a legacy of racism. Thus, provision of compassionate and individualized end-of-life care for minority patients can be complicated and challenging and requires special knowledge, communication skills, and sensitivity.

How can these barriers be lowered? Institutional barriers must be addressed at institutional or societal levels. A national, single-payor health insurance program could end the national disgrace of 40 million Americans—disproportionately minority—being without health insurance. The likelihood that this alone would reduce barriers to optimum care and improve outcomes for minorities is suggested by research done in Veterans Affairs Medical Centers where insurance is not an issue.^{137–139} Yet even in this setting disparities in access and outcome remain.^{25,140,141} We believe that a national health insurance program is necessary but not sufficient to eliminate these disparities, because lack of insurance is not the only barrier.

Institutional barriers to equal access also can be addressed in other ways. Legally mandated quality assurance protocols for hospitals and managed care organizations (MCOs) have been proposed to assess differences between social groups in use of services and health outcomes.^{41,142,143} Hospices could make similar assessments. This would require scrupulous collection of data on the ethnicity and socioeconomic status of patients by all such organizations. If ethnic differences are found, further research should explore the cause. Studies of ethnic disparities in access must take care to avoid exaggeration that might needlessly exacerbate mistrust.¹⁴⁴ Reimbursement policies should provide incentives rather than disincentives to hospitals, MCOs, and hospices to serve minorities, the poor, and the chronically and terminally ill.¹⁴² In addition, debt repayment programs and a revitalized National Health Service Corps could provide incentives to young physicians to practice in underserved areas. Affirmative action programs should be protected and strengthened to improve access to medical school for minority students and make the medical profession ethnically more representative of society.

How can physicians learn to provide culturally sensitive end-of-life care? There are no easy answers. No medical algorithm or decision tree will be adequate to this task. Physicians first must recognize that the basic values, principles, and assumptions of western medicine and bioethics are themselves historically situated and culturally determined.^{98,145} They are the values and assumptions of a dominant, but no less particular, culture: the culture consti-

tuted by European and American philosophical and legal traditions.¹⁴⁶ When we physicians recognize our own culture *as a culture*, as but one of a limitless variety of possible cultures, we begin to open ourselves to others. Second, funding agencies and journal editors should require greater discipline and specificity in identifying study populations in medical research. In particular, the concepts of culture and ethnicity should be carefully defined and distinguished, and racial categories should not be used unless needed to study or combat racism or unless chosen as self-identifiers by study subjects.

Third, studies of different cultures aimed at discovering characteristic attitudes toward death, dying, and health care can be helpful if they are performed and interpreted carefully and respectfully. Investigators and journal editors must recognize that intracultural differences are as great as or greater than intercultural differences. When reporting or teaching information gleaned from such studies, it is crucial to emphasize that all patients must be approached as unique individuals.⁹¹ Similarly, in patient care, physicians must focus primarily on individual patients and families. Only in dialogue with a patient and family can a physician assess the relevance of knowledge about a particular culture to which the patient and family appear to belong. As Koenig et al. put it, “efforts to use racial or ethnic background as simplistic, straightforward predictors of beliefs or behaviors will lead to harmful stereotyping of patients and culturally insensitive care of the dying. . . . Culture is only meaningful when interpreted in the context of a patient’s unique history, family constellation, and socioeconomic status.”⁹¹

Attending to the singularity of the other can be accomplished using ethnographic approaches as described, for example, by Kleinman, Carrese, and Carrillo et al.^{106,147–149} Kleinman has described a method for eliciting a brief ethnography. This provides insight into the patient’s understanding of her illness, causes of her suffering, and her values and goals. It serves as a basis for determining her preferences for end-of-life care and for negotiating a strategy to attain her goals that is agreeable to both patient and physician and that does not impose on minority patients the values and goals of the dominant culture.⁸⁶ This method can be adapted for research purposes to provide a deeper understanding of cultural difference than that obtainable with quantitative, epidemiological studies alone.¹⁵⁰ Several groups have used this approach in developing cultural sensitivity training curricula for medical education at various levels, and tools for assessing the effectiveness of such training have been proposed.^{106,151–153} There is early evidence that training of this type can be effective in promoting cultural sensitivity.^{106,154} We believe that culturally sensitive care should routinely be taught and assessed in introduction to clinical medicine courses in medical school; in courses on death, dying, and end-of-life care; and in continuing medical education and risk-management courses.

Similarly, the problem of individual racial bias and discriminatory practices can and should be attacked with education.¹⁵⁵ Instruction on racism as a public health problem should be required in all medical schools receiving public funding. This instruction should include the history of racism in American medicine and the ongoing problem of ethnic inequalities in access to care.

When mistrust is discovered or suspected in interactions with minority patients or families, physicians should gently explore concerns that patients or families might have about experimentation without informed consent, advance directives, or racially discriminatory withholding of medical resources.¹¹⁷ Physicians must be prepared to resist any incentives created by MCOs or insurance companies to limit care.¹⁵⁶ They will then be able to reassure patients and families that all options are available to them, that neither information nor resources will be withheld from them, and that treatment plans will be worked out in dialogue with them. This reassurance may be particularly important in end-of-life care. Particular care must be taken to “promise only what can be delivered and to deliver everything promised.”¹⁵⁷ On occasion, it may be helpful to acknowledge that American medicine has not been immune to racism. At the same time, physicians should be prepared to affirm that they do not tolerate discrimination in their practices and that they treat all patients fairly and equally.

Finally, further research is needed on mistrust that takes into account the complexity of this phenomenon.¹⁵⁸ It would be useful, for example, to determine exactly what aspects of physicians, medical care, or the healthcare system evoke the most mistrust and any association between mistrust and cultural differences in preferences for end-of-life care. The answers could guide educational interventions and institutional and policy changes to promote trust.

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REFERENCES

1. Institute of Medicine, Committee on Care at the End of Life. *Approaching Death: Improving Care at the End of Life*. Washington, DC: National Academy Press, 1997.
2. The SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients. *JAMA* 1995;274:1591–1598.
3. Lynn J, Teno JM, Phillips RS et al., for the SUPPORT Investigators. Perceptions by family members of the dying experience of older and seriously ill patients. *Ann Intern Med* 1997;126:97–106.
4. Cohen LM, McCue JD, Germain M et al. Dialysis discontinuation: A ‘good’ death. *Arch Intern Med* 1995;155:42–47.
5. Billings JA, Block S. Palliative care in undergraduate medical education. *JAMA* 1997;278:733–738.
6. Meier DE, Morrison RS, Cassel CK. Improving palliative care. *Ann Intern Med* 1997;127:225–230.
7. Hill CS. When will adequate pain treatment be the norm? *JAMA* 1995; 274:1881–1882.
8. Angell M. The quality of mercy. *N Engl J Med* 1982;306:98–99.
9. Levy MH. Pharmacologic treatment of cancer pain. *N Engl J Med* 1996; 335:1124–1132.
10. Jaccox A, Carr DB, Payne R et al. Management of Cancer Pain: Clinical Practice Guideline No. 9 (AHCPR publication no. 94-0592). Rockville, MD: Agency for Health Care Policy and Research, 1994.
11. Halevy A, Neal RC, Brody BA. The low frequency of futility in an adult intensive care unit setting. *Arch Intern Med* 1996;156:100–104.
12. Emanuel EJ, Fairclough DL, Slutsman J et al. Understanding economic and other burdens of terminal illness: The experience of patients and their caregivers. *Ann Intern Med* 2000;132:451–459.
13. Covinsky KE, Goldman L, Cook EF et al. The impact of serious illness on patients’ families. *JAMA* 1994;272:1839–1844.
14. Block SD, Billings JA. Patient requests to hasten death. *Arch Intern Med* 1994;154:2039–2047.
15. Chochinov HM, Wilson KG, Enns M et al. Desire for death in the terminally ill. *Am J Psychiatry* 1995;152:1185–1191.
16. Angell M. Caring for the dying—congressional mischief. *N Engl J Med* 2000;341:1923–1925.

17. Orentlicher D, Caplan A. The Pain Relief Promotion Act of 1999: A serious threat to palliative care. *JAMA* 2000;283:255–258.
18. Council on Scientific Affairs, American Medical Association. Good care of the dying patient. *JAMA* 1996;275:474–478.
19. Krakauer EL, Penson RT, Truog RD et al. Sedation for intractable distress of a dying patient: Acute palliative care and the principle of double effect. *Oncologist* 2000;5:53–62.
20. Blendon RJ, Aiken LH, Freeman HE et al. Access to medical care for black and white Americans: A matter of continuing concern. *JAMA* 1989;261:278–281.
21. Council on Ethical and Judicial Affairs, American Medical Association. Black-white disparities in health care. *JAMA* 1990;263:2344–2346.
22. Hogue CJR, Hargraves MA, Collins KS et al. *Minority Health in America: Findings and Policy Implications from the Commonwealth Fund Minority Health Survey*. Baltimore, MD: Johns Hopkins University Press, 2000.
23. Wencker MB, Epstein AM. Racial inequalities in the use of procedures for patients with ischemic heart disease in Massachusetts. *JAMA* 1989;261:253–257.
24. Johnson PA, Lee TH, Cook EF et al. Effect of race on the presentation and management of patients with acute chest pain. *Ann Intern Med* 1993;118:593–601.
25. Peterson ED, Wright SM, Daley J et al. Racial variation in cardiac procedure use and survival following acute myocardial infarction in the department of Veterans Affairs. *JAMA* 1994;271:1175–1180.
26. Peterson ED, Shaw LK, DeLong ER et al. Racial variation in the use of coronary-revascularization procedures. *N Engl J Med* 1997;336:480–486.
27. Gillum RF, Mussolino ME, Madans JH. Coronary heart disease incidence and survival in African-American men and women. *Ann Intern Med* 1997;127:111–118.
28. Barker-Cummings C, McClellan W et al. Ethnic differences in the use of peritoneal dialysis as initial treatment for end-stage renal disease. *JAMA* 1995;274:1858–1862.
29. Kjellstrand CM, Logan GM. Racial, sexual and age inequalities in chronic dialysis. *Nephron* 1987;45:257–263.
30. Ayanian JZ, Weissman JS, Chasan-Taber S et al. Quality of care by race and gender for congestive heart failure and pneumonia. *Med Care* 1999;37:1260–1269.
31. Ayanian JZ, Cleary PD, Weissman JS et al. The effect of patients' preferences on racial differences in access to renal transplantation. *N Engl J Med* 1999;341:1661–1669.
32. Burns RB, McCarthy EP, Freund KM et al. Black women receive less mammography even with similar use of primary care. *Ann Intern Med* 1996;125:173–182.
33. McCarthy EP, Burns RB, Coughlin SS et al. Mammography use helps to explain differences in breast cancer stage at diagnosis between older black and white women. *Ann Intern Med* 1998;128:729–736.
34. Yergan J, Flood AB, LoGerfo JP et al. Relationship between patient race and the intensity of hospital services. *Med Care* 1987;25:592–603.
35. Bach PB, Cramer LD, Warren JL et al. Racial differences in the treatment of early-stage lung cancer. *N Engl J Med* 1999;341:1198–1205.
36. Devgan U, Yu F, Kim E et al. Surgical undertreatment of glaucoma in black beneficiaries of medicare. *Arch Ophthalmol* 2000;118:253–256.
37. Ayanian J. Quality of care by race and gender for congestive heart failure and pneumonia. *Med Care* 1999;37:1260–1269.
38. Kahn KL, Pearson ML, Harrison ER et al. Health care for black and poor hospitalized Medicare patients. *JAMA* 1994;271:1169–1174.
39. Gornick ME, Eggers PW, Reilly TW et al. Effects of race and income on mortality and use of services among Medicare beneficiaries. *N Engl J Med* 1996;335:791–799.
40. The Henry J. Kaiser Family Foundation. Key facts: Race ethnicity and medical care. Menlo Park, CA: The Henry J. Kaiser Family Foundation, 1999.
41. Geiger HJ. Race and health care—an American dilemma. *N Engl J Med* 1996;335:815–816.
42. Schulman KA, Berlin JA, Harless W et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med* 1999;340:618–626.
43. Jaynes GD, Williams RM, eds. *A Common Destiny—Blacks and American Society*. Washington, DC: National Academy Press, 1989.
44. Polednak AP. Black-white differences in infant mortality in 38 standard metropolitan statistical areas. *Am J Public Health* 1991;81:1480–1482.
45. Healthier mothers and babies. *MMWR Morb Mortal Wkly Rep* 1999;48:849–858.
46. Geronimus AT, Bound J, Waidmann TA et al. Excess mortality among blacks and whites in the United States. *N Engl J Med* 1996;335:1552–1558.
47. Stone VE. Disparities in health status and health care quality by race: Where do we go from here? *SGIM Forum* 1997;20:1,7–8.
48. National Center for Health Statistics. *Health, United States, 1999 with Health and Aging Chartbook*. Hyattsville, MD: National Center for Health Statistics, 1999.
49. Willis DP, ed. *Health Policies and Black Americans*. New Brunswick, NJ: Transaction, 1989.
50. Shinagawa SM. The excess burden of breast carcinoma in minority and medically underserved communities. *Cancer* 2000;88:1217–1223.
51. Barzansky B, Jonas HS, Etzel SI. Educational programs in U.S. medical schools, 1998–1999. *JAMA* 1999;282:840–846.
52. Palepu A, Carr PL, Friedman RH et al. Minority faculty and academic rank in medicine. *JAMA* 1998;280:767–771.
53. Minorities continue to be underrepresented in medicine. *Am Med News*, 1998;Sept. 14:19.
54. Bigby JA. Declining enrollment of minorities in medical school. *SGIM Forum* 1998;21:2,8.
55. Affirmative action. *Lancet* 1999;353:1.
56. Greene J. AAMC: Affirmative action has clear effect on med school applications. *Am Med News* 1998;Nov. 23/30:10,13,16.
57. Geiger HJ. Comment: Ethnic cleansing in the groves of academe. *Am J Public Health* 1998;88:1299–1300.
58. Komaromy M, Grumbach K, Drake M et al. The role of black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med* 1996;334:1305–1310.
59. Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. *JAMA* 1995;273:1515–1520.
60. Thurmond VB, Kirch DG. Impact of minority physicians on health care. *South Med J* 1998;91:1009–1013.
61. Phillips RS, Hamel MB, Teno JM et al. Race, resource use, and survival in seriously ill hospitalized adults. *J Gen Intern Med* 1996;11:387–396.
62. Borum ML, Lynn J, Zhong Z. The effects of patient race on outcomes in seriously ill patients in SUPPORT: An overview of economic impact, medical intervention, and end-of-life decisions. *J Am Geriatr Soc* 2000;48:S194–S198.
63. Bernabei R, Gambassi G, Lapane K et al. Management of pain in elderly patients with cancer. *JAMA* 1998;279:1877–1882.
64. Cleeland CS, Gonin R, Baez L et al. Pain and treatment of pain in minority patients with cancer. *Ann Intern Med* 1997;127:813–816.
65. Engle VF, Fox-Hill E, Graney MJ. The experience of living-dying in a nursing home: Self-reports of black and white older adults. *J Am Geriatr Soc* 1998;46:1091–1096.
66. Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. *JAMA* 1993;269:1537–1539.
67. Todd KH, Lee T, Hoffman JR. The effect of ethnicity on physician estimates of pain severity in patients with isolated extremity trauma. *JAMA* 1994;271:925–928.
68. Todd KH, Deaton C, D'Adamo AP et al. Ethnicity and analgesic practice. *Ann Emerg Med* 2000;35:11–16.
69. Morrison RS, Wallenstein S, Natale DK et al. "We don't carry that"—failure of pharmacies in predominantly nonwhite neighborhoods to stock opioid analgesics. *N Engl J Med* 2000;342:1023–1026.
70. Blackhall LJ, Frank G, Murphy ST et al. Ethnicity and attitudes towards life sustaining technology. *Soc Sci Med* 1999;48:1779–1789.
71. Caralis PV, Davis B, Wright K et al. The influence of ethnicity and race on attitudes toward advance directives, life-prolonging treatments, and euthanasia. *J Clin Ethics* 1993;4:155–165.
72. Garrett JM, Harris RP, Norburn JK et al. Life-sustaining treatments during terminal illness: Who wants what? *J Gen Intern Med* 1993;8:361–368.
73. Gramelspacher GP, Zhou XH, Hanna MP et al. Preferences of physicians and their patients for end-of-life care. *J Gen Intern Med* 1997;12:346–351.
74. O'Brien LA, Grisso JA, Maislin G et al. Nursing home residents' preferences for life-sustaining treatments. *JAMA* 1995;274:1775–1779.
75. O'Brien LA, Siegert EA, Grisso JA et al. Tube feeding preferences among nursing home residents. *J Gen Intern Med* 1997;12:364–371.
76. Phillips RS, Wenger NS, Teno J et al. Choices of seriously ill patients about cardiopulmonary resuscitation: Correlates and outcomes. *Am J Med* 1996;100:128–137.
77. Goodlin SJ, Zhong Z, Lynn J et al. Factors associated with use of cardiopulmonary resuscitation in seriously ill hospitalized adults. *JAMA* 1999;282:2333–2339.
78. Reese DJ, Ahern RE, Nair S et al. Hospice access and use by African Americans: Addressing cultural and institutional barriers through participatory action research. *Soc Work* 1999;44:549–559.
79. Murphy ST, Palmer JM, Azen S et al. Ethnicity and advance directives. *J Law Med Ethics* 1996;24:5–14.
80. Hanson LC, Rodgman E. The use of living wills at the end of life. *Arch Intern Med* 1996;156:1018–1022.

81. Haas JS, Weissman JS, Cleary PD et al. Discussion of preferences for life-sustaining care by persons with AIDS. *Arch Intern Med* 1993;153:1241–1248.
82. Shepardson LB, Youngner SJ, Speroff T et al. Variation in the use of do-not-resuscitate orders in patients with stroke. *Arch Intern Med* 1997;157:1841–1847.
83. Shepardson LB, Gordon HS, Ibrahim SA et al. Racial variation in the use of do-not-resuscitate orders. *J Gen Intern Med* 1999;14:15–20.
84. Heidegger M. *Being and Time*. Albany, NY: State University of New York Press, 1997.
85. Galanti GA. *Caring for Patients from Different Cultures*. Philadelphia, PA: University of Pennsylvania Press, 1991.
86. Jecker NS, Carrese JA, Pearlman RA. Caring for patients in cross-cultural settings. *Hastings Cent Rep* 1995;25:6–14.
87. Fox K. Cultural issues in pediatric care. In: Behrman RE, Kliegman R, Jenson HB, eds. *Nelson Textbook of Pediatrics*, 16th edition. Philadelphia, PA: Saunders, 1999, pp 9–10.
88. Blackhall LJ, Murphy ST, Frank G et al. Ethnicity and attitudes toward patient autonomy. *JAMA* 1995;274:820–825.
89. Kagawa-Singer M. Diverse cultural beliefs and practices about death and dying in the elderly. In: Wieland D, ed. *Cultural Diversity and Geriatric Care*. New York: Haworth Press, 1994, pp 110–116.
90. Klessig J. The effect of values and culture on life-support decisions. *West J Med* 1992;157:316–322.
91. Koenig BA, Gates-Williams J. Understanding cultural differences in caring for dying patients. *West J Med* 1995;163:244–249.
92. Orona CJ, Keonig BA, Davis AJ. Cultural aspects of nondisclosure. *Camb Q Healthcare Ethics* 1994;3:338–346.
93. Harwood A, ed. *Ethnicity and Medical Care*. Cambridge, MA: Harvard University Press, 1981.
94. Vincent JL. Cultural differences in end-of-life care. *Crit Care Med* 2001;29:N52–N55.
95. Vincent JL. Forgoing life support in western European intensive care units: The results of an ethical questionnaire. *Crit Care Med* 1999;27:1626–1633.
96. Bruera E, Neumann CM, Mazzocato C et al. Attitudes and beliefs of palliative care physicians regarding communication with terminally ill cancer patients. *Palliative Med* 2000;14:287–298.
97. Berger JT. Culture and ethnicity in clinical care. *Arch Intern Med* 1998;158:2085–2090.
98. Kleinman A. *Writing at the Margin*. Berkeley, CA: University of California Press, 1995.
99. Good BJ. *Medicine, Rationality, and Experience*. Cambridge, England: Cambridge University Press, 1994.
100. Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation. *JAMA* 1995;274:826–829.
101. Paltiel O. Atonement. *Ann Intern Med* 1996;125:416–417.
102. Gostin LO. Informed consent, cultural sensitivity, and respect for persons. *JAMA* 1995;274:844–845.
103. Flores G, Gee D, Kastner B. The teaching of cultural issues in U.S. and Canadian medical schools. *Acad Med* 2000;75:451–455.
104. Loudon RF, Anderson PM, Gill PS et al. Educating medical students for work in culturally diverse societies. *JAMA* 1999;282:875–880.
105. American Academy of Pediatrics. Culturally effective pediatric care: Education and training issues. *Pediatrics* 1999;103:167–170.
106. Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: A patient-based approach. *Ann Intern Med* 1999;130:829–834.
107. Cykert S, Joines JD, Kissling G et al. Racial differences in patients' perceptions of debilitated health states. *J Gen Intern Med* 1999;14:217–222.
108. Lannin DR, Mathews HF, Mitchell J et al. Influence of socioeconomic and cultural factors on racial differences in late-stage presentation of breast cancer. *JAMA* 1998;279:1801–1807.
109. Eze, EC, ed. *Race and Enlightenment: A Reader*. Oxford, England: Blackwell, 1997.
110. Montagu A. *Man's Most Dangerous Myth: The Fallacy of Race*. Cleveland, OH: World, 1964.
111. Jones JS. How different are human races? *Nature* 1981;293:188–190.
112. Lewontin RC. *Biology as Ideology*. New York, NY: Harper, 1991.
113. Gamble VN. A legacy of distrust: African Americans and medical research. *Am J Prevent Med* 1993;9:35–38.
114. Dula A. African American suspicion of the healthcare system is justified: What do we do about it? *Cambbridge Q Healthcare Ethics* 1994;3:347–357.
115. Thomas SB, Quinn SC. The Tuskegee Syphilis Study, 1932–1972: Implications for HIV education and AIDS risk education programs in the black community. *Am J Public Health* 1991;81:1498–1505.
116. Cherny NI, Coyle N, Foley KM. The treatment of suffering when patients request elective death. *J Palliat Care* 1994;10:71–79.
117. Krakauer EL, Truog RD. Case study: Mistrust, racism, and end-of-life treatment. *Hastings Cent Rep* 1997;27:23–25.
118. McKinley ED, Garrett JM, Evans AT et al. Differences in end-of-life decision-making among black and white ambulatory cancer patients. *J Gen Intern Med* 1996;11:651–656.
119. Kao AC, Green DC, Zaslavsky AM et al. The relationship between method of physician payment and patient trust. *JAMA* 1998;280:1708–1714.
120. Davidson MN, Devney P. Attitudinal barriers to organ donation among black Americans. *Transplant Proc* 1991;23:2531–2532.
121. Ferguson JA, Weinberger M, Westmoreland GR et al. Racial disparity in cardiac decision making. *Arch Intern Med* 1998;158:1450–1453.
122. Corbie-Smith G, Thomas SB, Williams MV et al. Attitudes and beliefs of African Americans toward participation in medical research. *J Gen Intern Med* 1999;14:537–546.
123. The Henry J. Kaiser Family Foundation. *Perceptions of How Race and Ethnic Background Affect Medical Care: Highlights from Focus Groups*. Menlo Park, CA: Henry J. Kaiser Family Foundation, 1999.
124. Morrison RS, Zayas LH, Mulvihill M et al. Barriers to completion of health care proxies: An examination of ethnic differences. *Arch Intern Med* 1998;158:2493–2497.
125. Hauser JM, Kleeffeld SF, Brennan TA et al. Minority populations and advance directives: Insights from a focus group methodology. *Cambridge Q Healthcare Ethics* 1997;6:58–71.
126. Williams DR. The concept of race in Health Services Research: 1966–1990. *Health Serv Res* 1994;29:261–274.
127. Savitt TL. *Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia*. Urbana, IL: University of Illinois Press, 1978.
128. Pernick MS. *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America*. New York, NY: Columbia University Press, 1985.
129. Brandt AM. Racism and research: The case of the Tuskegee Syphilis Study. *Hastings Cent Rep* 1978;8:21–29.
130. Jones JH. *Bad Blood*. New York, NY: Free Press, 1993.
131. Shavers VL, Lynch CF, Burmeister LF. Factors that influence African-Americans' willingness to participate in medical research studies. *Cancer* 2001;91:233–236.
132. Hornblum AM. *Acres of Skin*. New York, NY: Routledge, 1998.
133. Kevles DJ. *In the Name of Eugenics*. Berkeley, CA: University of California Press, 1985.
134. Duster T. *Backdoor to Eugenics*. New York, NY: Routledge, 1990.
135. Siminoff LA, Arnold R. Increasing organ donation in the African American community: Altruism in the face of an untrustworthy system. *Ann Intern Med* 1999;130:607–609.
136. Joranson DE. Are health-care reimbursement policies a barrier to acute and cancer pain management? *J Pain Symptom Manage* 1994;9:244–253.
137. Dominitz JA, Samsa GP, Landsman P et al. Race, treatment, and survival among colorectal carcinoma patients in an equal-access medical system. *Cancer* 1998;82:2312–2320.
138. Akerley WL, Moritz TE, Ryan LS et al. Racial comparison of outcomes of male Department of Veterans Affairs patients with lung and colon cancer. *Arch Intern Med* 1993;153:1681–1688.
139. Freedland SJ, Jalkut M, Dorey F et al. Race is not an independent predictor of biochemical recurrence after radical prostatectomy in an equal access medical center. *Urology* 2000;56:87–91.
140. Mirvis DM, Burns R, Gaschen L et al. Variation in utilization of cardiac procedures in the Department of Veterans Affairs health care system: Effect of race. *J Am Coll Cardiol* 1994;24:1297–1304.
141. Powell IJ, Schwartz K, Hussain M. Removal of the financial barrier to health care: Does it impact on prostate cancer at presentation and survival? A comparative study between black and white men in a Veterans Affairs system. *Urology* 1995;46:825–830.
142. Fiscella K, Franks P, Gold MR et al. Inequality in quality: Addressing socioeconomic, racial, and ethnic disparities in health care. *JAMA* 2000;283:2579–2584.
143. Satcher D. The initiative to eliminate racial and ethnic health disparities is moving forward. *Public Health Rep* 1999;114:283–287.
144. Schwartz LM, Woloshin S, Welch HG. Misunderstandings about the effects of race and sex on physicians' referrals for cardiac catheterization. *N Engl J Med* 1999;341:279–283.
145. Gould SJ. *The Mismeasure of Man*. New York, NY: Norton, 1981.
146. King PA. The dangers of difference. *Hastings Cent Rep* 1992;22:35–38.
147. Kleinman AR. *The Illness Narratives*. New York, NY: Basic, 1988.
148. Carrese JA, Rhodes LA. Bridging cultural differences in medical practice. *J Gen Intern Med* 2000;15:92–96.
149. Carrese J. Culture, healing, and professional obligations: Commentary. *Hastings Cent Rep* 1993;23:16.
150. Inui TS. The virtue of qualitative and quantitative research. *Ann Intern Med* 1996;125:770–771.
151. Like RC, Steiner RP, Rubel AJ. Recommended core curriculum guidelines

- on culturally sensitive and competent health care. *Fam Med* 1996;27:291–297.
152. Núñez AE. Transforming cultural competence into cross-cultural efficacy in women's health education. *Acad Med* 2000;75:1071–1080.
153. American Medical Association. *Cultural Competence Compendium*. Chicago, IL: American Medical Association, 1999.
154. Majumdar B, Keystone JS, Cuttress LA. Cultural sensitivity training among foreign medical graduates. *Med Educ* 1999;33:177–184.
155. Tatum BD. Talking about race, learning about racism: The application of racial identity development theory in the classroom. *Harvard Educ Rev* 1992;62:1–24.
156. Mechanic D, Schlesinger M. The impact of managed care on patients' trust in medical care and their physicians. *JAMA* 1996;275:1693–1697.
157. Burrs FA. The African American experience: Breaking the barriers to hospices. *Hospice J* 1995;10:15–18.
158. Crawley L, Payne R, Bolden J et al. Palliative and end-of-life care in the African American community. *JAMA* 2000;284:2518–2521.