**Addressing Cultural & Religious Diversity in Medicine
Group 5:** Matt Lemieszewski, Irma Purisic, Jaspreet Sra, & Sierra Teegarden

As the world we live in continues to diversify and the long-standing inequalities in the health status of people from culturally diverse upbringings become more evident, there has been a challenge issued to health care providers and their organizations as a whole to view cultural diversity as a priority in providing the highest level of patient care. The patients we treat come from an immense range of cultures and religions that each have different needs, health beliefs, and behaviors. Additionally, patients often have different backgrounds than their provider which can lead to incongruent care based on religious differences, gender issues, and cultural practices that influence medical decisions. A lack of both provider diversity and cultural competence has led to health disparities amongst different sociocultural groups, especially those considered to be a minority. By addressing diversity in medicine, we can begin to understand the determinants of those disparities and make equitable care improvements to the patient-centered model.

Although there have been pushes across the healthcare industry to promote higher levels of cultural competence among providers in the past two decades, there has not been much evidence that the influence on patient treatment outcomes have been significantly superior. The Centre for Forensic Behavioural Science out of Swinburne University in Victoria, Australia wanted to explore how professionals perceived their own cultural competence levels in their care, the degree in which they believe their work addresses cultural disparities, and to analyze the level of training these professionals have had concerning cultural awareness.

By delivering surveys to providers across three major health care systems and one university student health center in the United States, this study allowed researchers to understand how providers at different levels differed in their capacity to identify and overcome the obstacles of caring for patients from an array of backgrounds and cultures.

While a majority of the study participants conveyed confidence in their own ability to meet the needs of multicultural patient populations, a majority confessed to not having undergone any previous cultural training in their education or from their employer. This overconfidence may symbolize a misrepresentation between truly addressing the cultural needs and the everyday experiencing of challenges when working with minority patients. One of the most popular answers received via the survey was that providing interpreters was the best way to provide effective cross-cultural care. This shows one of the biggest misconceptions with healthcare disparities, which is that effective culturally competent care was a matter of communication rather than a multifaceted institutional framework.

While communication is an effective first step, both cultural and religious competence in medicine are important to create a trusting, respectful, and collaborative dialogue between providers and patients. By establishing that dialogue, providers can carry out shared decision making and bring quality care to patients. Religious practices may have an influence on patients’ diets, on which medications they can take, on the gender preference of their provider, and much more. Additionally, many patients turn to their faith when making a decision regarding their medical care, or to relieve any anxieties (Swihart et al., 2021). For many individuals, religion and spirituality are central factors in their lives, being an essential part of their identity. Without religious competence, patients are at risk of receiving poor quality of care, having negative health outcomes, being dissatisfied, and losing trust in healthcare. Providers should modify evaluations and treatments in efforts to provide and improve patient-centered care and meet patient’s needs.

Examples of clinically significant views various religions hold include the following: In Islam, handshakes or contact between genders, pork, shellfish, and alcohol are prohibited. A same-sex practitioner is required unless the situation is an emergency. Jehovah’s Witnesses refuse any blood products. In Sikhism, cutting hair on any part of the body is prohibited. Christian Scientists believe that prayers are more effective as a remedy than medicine is (Swihart et al., 2021). There are many more religions and beliefs, along with their respective views that exist. Without knowing such religious values, providers may unintentionally come across as insensitive and display healthcare as an unsafe environment. One study established 80 percent of patients claimed that physicians rarely gave them a chance to discuss religious or spiritual issues (Dillard et al., 2021). Discussion, support, and acknowledging different religious views and giving the patient the opportunity to discuss their beliefs can better the relationship between patients and providers (Swihart et al., 2021). This can further improve the assessments and interventions which ensue.

When possible, by integrating prayer or culture into treatment or management, the patient-provider relationship strengthens, less medical errors are made, and patient-centered care improves (Swihart et al., 2021). Patients have moral rights with respect to their evaluation and treatment. In efforts to build a therapeutic alliance with patients, providers should respect the cultural or religious background which patients identify themselves with and upon which they form their life decisions.

When it is not solely a problem of ineffective communication, providers must look deeper when they aim to understand the vast array of patients that they serve. This idea includes the notion of understanding the long history your patients have within the local community. Racial essentialism is a belief that all individuals in a race are only distinct due to their genes. This belief has lingered into medicine, has shaped certain clinical decisions and is the basis of many studies. However race and culture are very complex, particularly the Native American and Alaskan Indians. The development of their culture is based off of its history which is comprised of relocation, genocide and exploitation, but the current racial and cultural identity of American Indian and Alaskan Indians has developed based on federal policies. This racial and cultural categorization is still used as a biological marker by clinicians to understand increased or decreased risk of illnesses. In order to make clinical decisions providers use research and data; However, the mis-classification of a culture can exacerbate health disparities. This can lead to underreporting of mortality and morbidity in Native American and Alaskan Indians populations and can lead to worsening health disparities.

Fetal alcohol spectrum disorder (FASD) is claimed to be a genetic condition among Native Americans. However, researchers do not account for particular historical, political, or sociocultural factors that lead to FASD. The use of race and culture as a basis to make clinical decisions poses certain limitations. Data and studies fail to take into account both the complexities of cultures from different tribes and use genes to determine differences against certain illnesses. There are several different tribes within Native American and Alaskan Indian people, yet the data provided classifies these distinct groups as a single racial group. By not being aware of the different tribes and the different values which exist among the tribes, providers fall short of providing culturally competent care and become more inclined to make assumptions. By making these assumptions, clinicians can make errors in diagnosing, treating, or drive patients away from seeking care. Such an assumption is seen with the FASD, linking it as a “Native American” condition. The weak and ambiguous data can cause overestimation or underestimation of the patient's disease risk. The social inequities present between Native Americans and Alaskan Indians are visible in the data that impacts the decision making process of providers.

Native Americans and Alaskan Indians are not the only groups who have felt the negative impact of cultural disparities in healthcare. The culturally centered group known as E-WORTH (Empowering African-American Women on the Road to Health) based out of New York City demonstrated what the impact of good communication can do for an individual’s well-being. In this randomized clinical trial, it was set out to determine the effectiveness of a cultural group-based HIV and STI intervention by comparing findings to a control group.

Black women who had a history of drug use and were enrolled in community supervision programs in New York City were randomly assigned to each group. The control group had a single 30-minute session for HIV testing and information versus the E-WORTH group that had an hour session for HIV testing and orientation followed by four 90-minute group sessions per week for 12 months. The study ran from the years 2015-2019.

Results showed that E-WORTH participants had 54 percent lower odds of testing positive for an STI at the 12-month assessment and reported 38 percent fewer acts of condomless vaginal or anal intercourse with a male partner compared to the HIV streamlined intervention control group.

Limitations of this study include the control group not being in a group-based setting which is needed to determine the effectiveness of group settings alone versus cultural-based group settings. There were other limitations in the statistical analysis such as not accounting for risk-behaviors with participants who had same-sex partners.

Community Supervision Programs include parole, probation, or alternative-to-incarceration programs in the United States, which have an increased number of HIV/STI cases for black women compared to other cultural groups, illustrating the importance of this study. An intention-to-treat approach was used; therefore, the statistical analysis was based on the group that participants were originally assigned and did not consider alternative treatment that may have been received thereafter. Accordingly, results should be interpreted as prospective effects of treatment policy instead of prospective effects of specific treatment.

The results from the E-WORTH study suggest that cultural group-based medical interventions may be more efficacious than non-culture centered individual interventions even after accounting for the limitations of that study. This model should be studied on other cultural or religious groups with specific risk-reduction needs such as those of Native American and Alaskan Natives. If similar results are replicated, it would further demonstrate the benefit of applying culturally targeted risk-reduction as a standard practice in preventative medicine.

It is not questioned that, regardless of a provider's depth of cross-cultural knowledge, the importance of cross-cultural awareness has become universally accepted. However, thematic analysis of the study showed that there was a need for interventions that acknowledge the value of cultural awareness-based approaches, while also investigating the practicality of more thorough competence and safety training for all providers. Providers themselves come from different cultural and religious backgrounds and have different levels of cultural or religious competence. As mentioned, having a majority of providers confess to not having undergone training in education or in the workplace merely indicates the absence of recognition, acknowledgement and exploration of patients’ religiosities which are necessary to address the diversity in medicine and bring about a culturally and religiously sensitive care.

**References**

Dillard, V., Moss, J., Padgett, N., Tan, X., & Kennedy, A. B. (2021, June 15). *Attitudes, beliefs*

*and behaviors of religiosity, spirituality, and cultural competence in the medical profession: A cross-sectional survey study*. PLOS ONE. https://doi.org/10.1371/journal.pone.0252750.

Gampa, V., Bernard, K., & Oldani, M. J. O. J. (2020). Racialization as a Barrier to Achieving
 Health Equity for Native Americans. *AMA Journal of Ethics*, *22*(10).
 https://doi.org/10.1001/amajethics.2020.874.

Gilbert L, Goddard-Eckrich D, Chang M, et al. Effectiveness of a Culturally Tailored HIV and

Sexually Transmitted Infection Prevention Intervention for Black Women in Community Supervision Programs: A Randomized Clinical Trial. *JAMA Netw Open.* 2021;4(4):e215226. doi:10.1001/jamanetworkopen.2021.5226

Jackson, C. S., & Gracia, J. N. (2014). Addressing health and health-care disparities: the role of a

diverse workforce and the social determinants of health. *Public health reports*

*(Washington, D.C. : 1974)*, *129 Suppl 2*(Suppl 2), 57–61.

https://doi.org/10.1177/00333549141291S211

Shepherd, S.M., Willis-Esqueda, C., Newton, D. *et al.* The challenge of cultural

competence in the workplace: perspectives of healthcare providers. *BMC Health Serv Res* 19, 135 (2019). https://doi.org/10.1186/s12913-019-3959-7

Swihart, D. L., Yarrarapu, S., & Martin, R. L. (2021). Cultural Religious Competence In Clinical

Practice. In StatPearls. StatPearls Publishing.