

# OREGON MEDICAL BOARD

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## CULTURAL COMPETENCY

A Practical Guide for  
Medical Professionals





## *Dear Healthcare Professional:*

Thank you for dedicating your career to the health and well being of Oregonians. The care and compassion you collectively provide to patients is appreciated by millions of people in our state each year. And while the practice of medicine is gratifying, the Board recognizes that your work is also highly demanding. This booklet is intended to be a practical guide, including new perspectives and resources to assist you in providing the very best care to each of your uniquely individual patients.

The modern physician's oath promises to not allow "considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor" to interfere with the patient relationship. At the same time, it is known that disparities in health and access to care exist among population groups. As a healthcare provider, you have the power to effect significant change for these Oregonians.

We hope that this booklet allows you to provide care that is increasingly culturally responsive. While this handbook cannot be exhaustive or all-inclusive, it is meant to provide a starting place for additional research and conversation.

Thank you for taking the time to read the following materials and for helping the Board achieve its mission of ensuring patient safety and access to quality care for all Oregonians.

Sincerely,



Kathleen Haley  
*Executive Director*



# INFORMATION ON DIVERSITY IN OREGON

Oregon is growing more racially and ethnically diverse:

**2015 Estimated Total Population:** 3,831,100

**White:** 3,204,600

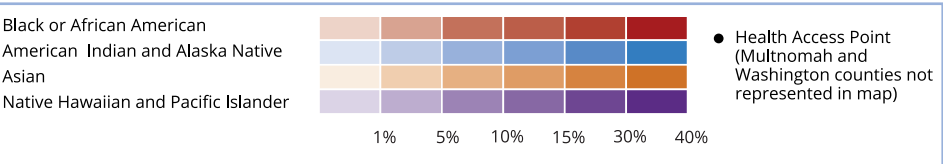
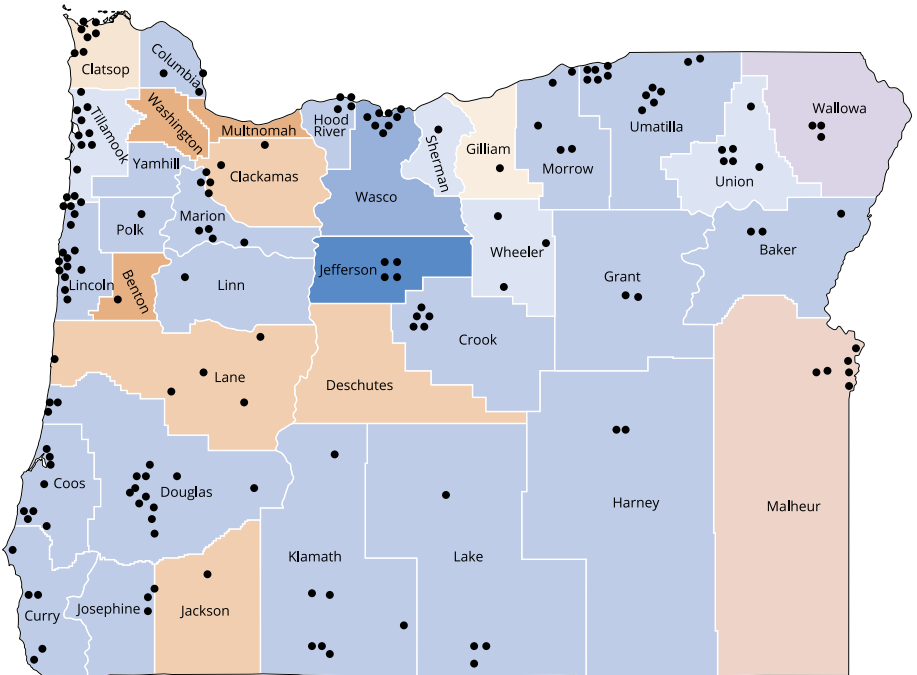
**Latino:** 450,100

**Asian:** 141,300

**American Indian/Alaska Native/  
Pacific Islander:** 66,600

**African American:** 69,200<sup>1</sup>

**Predominant racial groupings in Oregon counties (non-White, non-Latino) 2010 US Census, April 1, 2010**

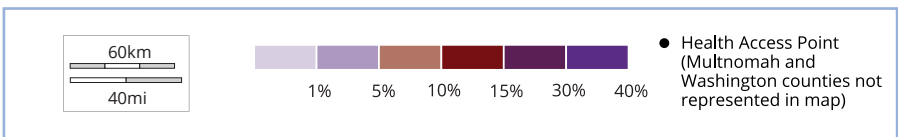
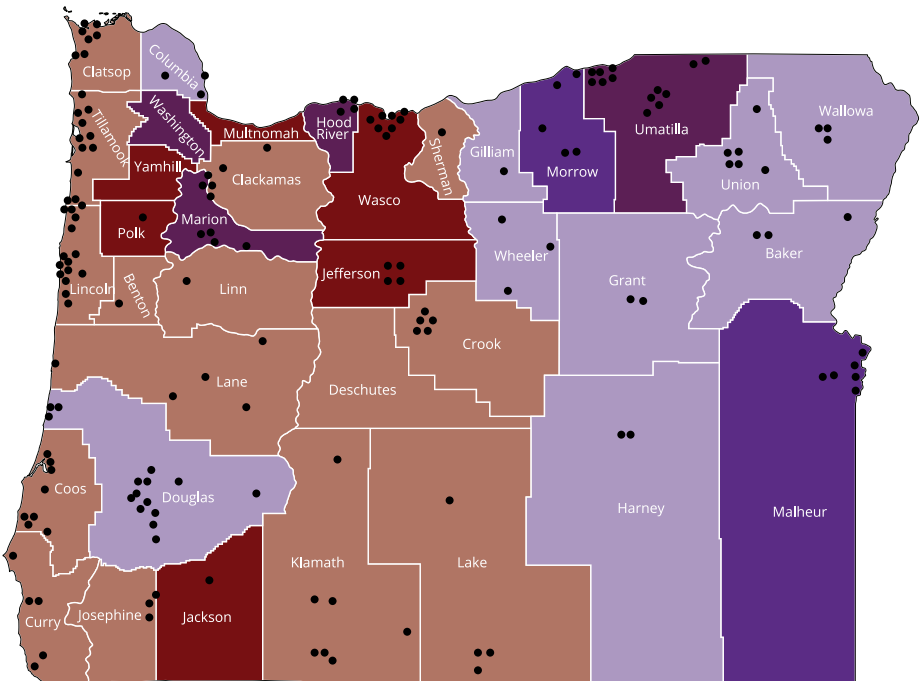


The shift toward a more diverse Oregon requires that providers learn new skills, and that our health care systems reflect the needs and expectations of all of our patients.<sup>2</sup> Those needs and expectations include flexibility, cultural supports, and the ability to see themselves and their identities reflected in the health care system. These require money, time, training, and culture shifts. Specific examples include:

- Interpreter recruiting and training
- Recruitment and retention of providers from marginalized groups
- Culturally specific patient navigators and clinical support for providers
- Data collection and analysis about outcomes
- Patient and provider feedback mechanisms

### Latino ethnicity in Oregon counties (all races)

2010 US Census, April 1, 2010



Approximately 18% of Oregonians are People of Color. In 2009, only eight of 121 providers who graduated from medical school in Oregon (6%) were not White.<sup>3</sup> This points to the gap between the system as it is in Oregon, and where it could be closer to eliminating those disparities.

The US Office of Minority Health, part of the Department of Health and Human Services, has supported the establishment of Regional Health Equity Coalitions. The National Partnership for Action (NPA) was convened to support and promote efforts to eliminate health disparities across the nation. It was conceived as a collaboration that would be led by the communities affected.<sup>4</sup>

In Oregon, the state Office of Equity and Inclusion oversees the Regional Health Equity Coalitions.<sup>5</sup> There are six in Oregon, covering several intercounty collaborations, both rural and urban. The Oregon Health Equity Alliance covers the most populous four county area<sup>6</sup> and has set policy priority areas including:

- Cultural Competency and Workforce Diversity (including for Healthcare Professionals)
- Improved Data Collection and Analysis
- Access to Health Care<sup>7</sup>

**The goal of providers in general is healthy people thriving in their communities. The goal of a “culturally competent” health system is to eliminate disparities between different cultural groups. The goal of a culturally competent provider is to commit to doing their part, both as a clinician, but also as a system change agent.**

## Cultural Competency

The Oregon Medical Board's mission is *to regulate the practice of medicine in a way to promote access to safe, quality care for all Oregon citizens*. However, Oregonians are growing increasingly diverse, and inequities in access to quality health care are apparent. Racial and ethnic populations, lesbian, gay, bisexual, and transgender communities, low literacy level individuals, and rural Oregonians experience severe health disparities according to the Oregon Health Authority's Office of Equity and Inclusion. Training in cultural competency is one tool to bridge this gap, improve health outcomes and enhance patient safety.

Cultural competency continuing education is a life-long process of examining values and beliefs while developing and applying *an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient interactions and preserves the dignity of individuals, families and communities*.

Continuing education in cultural competency should teach attitudes, knowledge and skills to care effectively for patients from diverse cultures, groups and communities. The Office of Equity and Inclusion states that such training enables health care providers to work effectively in cross-cultural situations.

The Board recommends and encourages licensees to pursue ongoing continuing education opportunities for cultural competency. For purposes of maintenance of licensure, the Board considers continuing medical education (CME) in cultural competency to be relevant to the current practice of all licensees, and licensees may use this type of continuing education toward satisfying the required CME hours for license renewal. The Board will document licensees' voluntary participation in cultural competency CME through the license renewal process beginning in 2015.

In order for Oregon to achieve the triple aim of improving health, improving care, and lowering cost, providers must be responsive to the needs of diverse populations. Cultural competency interventions for health care providers is one method for helping Board licensees adapt to the needs of Oregon's socially and culturally diverse communities.

*Adopted October 2013*

## OVERVIEW OF CULTURAL COMPETENCY

“Cultural Competency” is synonymous with an array of phrases and concepts which are currently in flux and controversial. We can think about this concept on a variety of levels—individual, institutional, cultural, and systemic. There is overlap and dispute here, too.

Oregon defines Cultural Competency as: *A life-long process of examining values and beliefs, of developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient interactions and preserves the dignity of individuals, families and communities.*<sup>8</sup>

Disparities in health outcomes related to various demographics are indisputable. These disparities exist in Oregon, in the US, and throughout the world.<sup>9</sup>

Oregon health care providers frequently do not match the demographics of their marginalized patients. This accounts for miscommunication and discomfort, and perhaps exacerbates health disparities. Because the impacts are happening right now, and demographic changes are constantly evolving, we must take action with limited information and incomplete conceptions. Health care providers have tremendous power to transform patient experience, health, and lives by increasing their own skills in cultural competence.

***Engagement in ongoing professional development around culturally competent practice is therefore essential.***

The aspiration for this handbook is to provide useful information for practitioners in Oregon to avoid basic misunderstandings when working with patients from a variety of backgrounds.



# RATIONALE FOR CULTURAL COMPETENCE INTERVENTIONS

Benefits include:

- Improved patient-provider communication and patient adherence to treatment
- Improved self-reported provider perception and understanding of cultural competency
- Increased ability to provide patient-centered care
- Cost savings due to increased access to appropriate care and higher levels of patient engagement
- Cost savings through improved service delivery and the reduction of costly inpatient and urgent care costs
- Cost savings through the reduction of liability issues<sup>10</sup>

The OMB hopes that this handbook points practitioners towards information they need to give sensitive and respectful care to myriad demographic groups.

## CONTINUING EDUCATION REQUIREMENTS

The State of Oregon began work in 2012 to define Cultural Competency and describe standards for culturally competent practice.<sup>11</sup> In 2013, the Oregon Legislature passed House Bill 2611, becoming ORS 413.450. This law encourages licensed health care professionals to obtain cultural competency education, requires the Oregon Health Authority to provide resources, and requires health licensing boards to report participation to the state.

### ORS 413.450

Continuing education opportunities relating to cultural competency “teach attitudes, knowledge and skills that enable a healthcare professional to care effectively for patients from diverse cultures, groups and communities, including but not limited to: (a) applying linguistic skills to communicate effectively with patients from diverse cultures, groups and communities; (b) using cultural information to establish therapeutic relationships; and (c) eliciting, understanding and applying cultural and ethnic data in the process of clinical care.”<sup>12</sup>

## OAR 847-008-0070 (5)

The Oregon Medical Board encourages but does not require licensees to take cultural competency training. Any hours of cultural competency training may be used to maintain your license.

OMB licensees must obtain continuing medical education to maintain licensure. Educational hours must be relevant to the licensee's current medical practice. No matter the licensee's practice area, "CME in cultural competency is considered relevant CME for the current practice of all licensees and may be used toward satisfying the required CME hours."<sup>13</sup>

## OAR 943-090-0020 (7) & (8)

The Oregon Medical Board, along with other Oregon health care licensing agencies, will begin reporting on the participation of professionals in cultural competency continuing education in 2017. This information will be collected and reported to the Oregon Legislature.<sup>14</sup>

# GUIDELINES FOR CLINICAL APPLICATIONS OF CULTURAL COMPETENCY

The information in this section is broken into 6 primary headings: **Language, Ethnicity, Race, Religion, Gender Minorities, and Rural Oregon.** Under each section, we will briefly explore definitions and suggestions for specific tips and resources. These distinctions are necessarily overlapping and problematic. They also provoke reactivity: Health care practitioners are not immune to stereotypes and assumptions. Providers, particularly those who carry multiple dimensions of social power, are urged to carefully examine their reactions to situations, information, and analysis provided herein. Culturally competent practice requires engagement in a continuous process of self-awareness and self-assessment, and this carries more urgency the more social power a provider holds.

## Self-Awareness and Self-Assessment

The "Implicit Association Test" is an online educational tool and "virtual laboratory." These free online tests take about 20 minutes and aim to reveal subconscious biases. <https://implicit.harvard.edu/implicit>

## General Guidelines to Working Across Difference in Clinical Settings

Patients and their families want more quality time with their doctors. Unfortunately, current healthcare systems don't allow for that, despite the desire of providers and patients. To that extent, our health care system has not achieved "cultural competency." But providers can advocate for system change that would result in better care for all patients.

Note that people and their bodies exist at the confluence of multiple identities, communities, and historical narratives. This handbook is not a diagnostic tool—in fact, to use it in such a way would run precisely counter to its purpose. Better to think of the suggestions herein with respect to specific identities as population snapshots, allowing us to make better guesses and start looking in the right direction—but they do not define the patient and their experience.

Members of some demographic groups experience psychological trauma related to their identity which can impact their interactions with the health care system as well as health outcomes. Providers can facilitate healing by adopting the 6 principles of a Trauma Informed Approach, one of which is "Cultural, Historical, and Gender Issues."<sup>15</sup> A particular area of trauma-informed practice pertains to Adverse Childhood Experiences (ACEs), such as child abuse and neglect. Research shows these experiences have a predictable impact on health outcomes. Providers can learn more about causes, symptoms, and responses to various kinds of psychological trauma to avoid re-traumatizing patients.<sup>16</sup>

### Good Practices

- For some people from certain backgrounds, a personal relationship with the doctor is part of what healthcare means—you can acknowledge this limitation in the US system directly to the patient
- Advocate for hiring cultural specialists and patient navigators who can help patients understand the system and help you understand the patient
- When your identity or background—race, age, gender, etc—doesn't match the patient's, look for extra support within your staff, institution, or beyond
- Develop accountability systems to check your conclusions and assumptions before, during, and after treatment
- Participate in a clinical intercultural collaboration to advocate and stay accountable together

# LANGUAGE

The communication of health information is the primary way that providers can collaborate with patients to improve health outcomes. Communication breakdowns and missteps are common in any communicative endeavor; but within healthcare, precision is key, and the stakes are high. Any method of clarifying communication will improve outcomes. There are two focal points: provider communication, and patient communication. Providers should eliminate jargon, focus on what patients need to do, and check to see that the message has been delivered. When there is a language barrier—when the patient doesn't speak the same language as the provider—language supports must be employed to ensure messages are communicated accurately.

## HEALTH LITERACY

Health literacy is the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.<sup>17</sup>

Providers can better deliver health information by exploring resources for health literacy within and without their facility and adopting the best practices below.

### Good Practices

- Slow down the delivery of information
- Ask patients to repeat back to you their directions (teach-back)
- Remove jargon from oral communication
- Use 70% pictures to 30% text in written communications
- Foreground the most important information; focus on the patient's action steps and schedule; define specialized terms
- Look at the signage and health literature in your facility—does it prioritize images or words?
- Look at the way medication dosages are recorded on prescriptions in your facility—dosages should show clearly the exact time of day and quantity, rather than ambiguous or complex instructions like “take two tablets biweekly”

**KEY RESOURCE:** Centers for Disease Control and Prevention:  
<https://www.cdc.gov/healthliteracy/learn/>

## INTERPRETERS AND TRANSLATORS

Working with interpreters is a particular skill and an essential element of clinical cultural competence. Even calling the correct interpreter requires skill in cultural identification, a complex task. Interpreters are a regular member of the health care team. Determine if your facility trains you to work with interpreters, and learn about the kind of training that interpreters receive to work with you.

There are two basic types of interpretation. *Simultaneous Interpretation* occurs when the interpreter speaks and listens at the same time. It can be very demanding, but when done well it's also very efficient, and can be done over remote transceivers. This mode is more common when the communication is one-way, such as a lecture. *Consecutive Interpretation* occurs when the interpreter speaks after listening to the message being communicated. It's less demanding, and frequently used with two-way or multiparty conversation. *Written Translation* consists of creating a written document in the target language from a written document in the source language. *Sight Translation* is when the interpreter reads a written document in the source language and delivers the message by speaking in the target language.

### Good Practices

- As soon as possible, establish the patient's language and attempt to contact an appropriate interpreter
- Speak directly to the patient, not to the interpreter
- Interpreters are required by law in clinical settings, but interpreters are scarce for some languages—use secondary language interpreters when necessary
- Family members, especially children, should not be relied on to interpret for patients
- Work with interpreters, not around them— it is unethical for a provider with no interpretation training to attempt to communicate without an interpreter

- Despite the ethical, legal, and clinical requirements to communicate only through trained interpreters, health care settings present many pressures to take short cuts, which can result in unfavorable outcomes<sup>18</sup>—advocate for more interpretation resources
- Let interpreters introduce themselves to you and the patient and explain their role—they will speak in third person
- Follow their lead in communication—their job is to direct communication traffic
- Aim for a normal rate of speech; deliver information in digestible chunks; watch the patient/receiver for indications of clarity or confusion
- Speak in plain language; define terms and explain what they mean
- Have the patient or receiver “teach-back,” through the interpreter, any instructions you give; clarify misunderstandings and support with literature where appropriate
- Training and quality of interpretation vary widely, and cultural elements exist; be flexible and open, but give interpreters feedback, including to their supervisor, if you don’t think messages are clearly and accurately communicated
- If possible, have a quick feedback session with the interpreter—ask them what they think went well, and what was challenging

**KEY RESOURCE: Oregon Health Care Interpreters Association:**  
<http://ohcia.org/>



# ETHNICITY

In the US, ethnicity and race are distinct categories. The distinction is useful, though often confusing. This section examines Latino/Hispanic ethnicity and the category of Immigrants/Refugees. Oregon clinicians interact frequently with Latino/Hispanic persons in urban and rural areas. The US Census recognizes ethnicity as a binary (Latino/Hispanic, or not Latino/Hispanic), largely from a desire to capture information about Spanish speakers. Despite the simplified racialization of (very often Indigenous) Spanish speaking immigrants from Mexico and Central America, Latino/Hispanic identity can accompany any racial category. As immigration from other parts of the world increases, so too must the categories of ethnicity. It's a difficult problem, but one with which we must grapple. People's visibility within a system requires they be counted.

## LATINO/HISPANIC/CHICANO

As with many groups, simply referring to people in a way that they want can be complex. "Hispanic" was originally intended to include all Spanish speakers or those deriving from a culture that originated in Spain. "Latino/a" became common in the US in the 1980s and 1990s as a way to distinguish people from Mexico, Central, and South America from Europeans—but it includes speakers of Brazilian Portuguese and excludes Spanish speakers from the Philippines. "Chicano/a" was a term used to refer to Mexican descendants living within the US. Latino is used here for simplicity.

An estimated 433,000 people self-identified as Latino in Oregon in the 2015 American Community Survey from the US Census Bureau's American Fact Finder. Of those, 31% report speaking English less than "very well,"<sup>19</sup> a common marker of "Limited English Proficiency" or LEP. Precise numbers don't exist, but a 2014 study estimates about 116,000 undocumented Latinos in Oregon.<sup>20</sup> Latino people across citizenship statuses likely know someone with documentation issues.

About 17,600 undocumented children under the age of 19 live in Oregon.<sup>21</sup> People without documentation are excluded from many health care access options and therefore may seek care at safety net clinics or at the emergency room. Providers working in communities with high numbers of undocumented persons contend with fear around engaging with systems, and health conditions may go untreated. Even for those with insurance, a culture of stress and avoidance around clinical interactions is common.

Oregon health care systems must provide emergency and other care (including interpreters) regardless of the patient's language, nationality, or immigration status. To give satisfactory care, providers should remain knowledgeable about immigration policy.

Many Latinos in the US have a dual last name, with or without a middle name. Generally, one will be the father's last name and the other the mother's maiden name. Often the wife doesn't take the husband's name. People may use their father's last name as the "real" last name, or both names. In the clinical setting, this can result in confusion or error if consistency is not maintained. When possible, confirm with backup documentation and with help of interpreters.<sup>22</sup>

## Good Practices

- Ask your Latino patients what they need and how they would like you to refer to them
- Be aware of the complex histories in the terms "Latino" and "Hispanic"
- Continue to explore and educate yourself about the different Latino stories in your community
- Find out what language your patient speaks—don't assume that Spanish is their first language, or that they don't speak English
- Check assumptions around observed behaviors: certain indigenous groups show respect by refusing eye contact and shaking hands very lightly and softly
- If the patient speaks an indigenous language, try to find an interpreter for their first language; if one is not available, look for evidence that communication is flowing freely and accurately
- Commit to ongoing professional development around ethnic disparities for Latino patients as you would for any professional dimension

### **KEY RESOURCE:** Coalition of Communities of Color: The Latino Community in Multnomah County—An Unsettling Profile:

<http://www.coalitioncommunitiescolor.org/research-data-tools/the-latino-community-in-multnomah-county-an-unsettling-profile>



## IMMIGRANTS & REFUGEES

All refugees are immigrants, but not all immigrants are refugees. For many immigrants, language barriers are present. The breadth of individuals' experience is tremendous, physical and emotional trauma are givens, and the challenges of navigating systems are protracted. Creating a generalized approach is difficult. In Federal Fiscal Year 2016, Oregon admitted 1,780 refugees.<sup>23</sup>

Clinical barriers are vast, complex, and virtually impossible to summarize, from proscriptions around cross-gendered interactions, to folk beliefs about medicine, to inter-ethnic conflict between people who are from the same country or who speak the same language. Extensive, localized, ongoing training for providers in settings of high immigrant/refugee contact will produce the best outcomes for patients.

### Good Practices

- As soon as possible, establish the language and ethnicity of the person and attempt to contact an appropriate interpreter
- Interpreters are required by law in clinical settings, but it's impossible to keep every language interpreter available—use secondary language interpreters when necessary
- Family members should not be relied on to interpret for patients
- Above all, stay flexible with your immigrant/refugee patients—they may not have a context for certain rules (such as a HIPAA form) and other rules may not fit their case
- If you will have an ongoing relationship with an immigrant/refugee, do research on that community as soon as possible
- Commit to ongoing professional development around health disparities for newcomer populations as you would for any professional dimension
- Apply principles of Trauma-Informed Care:
  - Recognize culture shock, learned helplessness, avoidance, dissociation, and other responses to traumatic events
  - Provide supports that promote patient agency

**KEY RESOURCE:** Grantmakers Concerned with Immigrants and Refugees, "Immigrants in Oregon and Washington: Creating an Inclusive Future for All" (2014): <https://www.gcir.org/resources/immigrants-oregon-and-washington-creating-inclusive-and-dynamic-future-all>

# RACE

This handbook recognizes race as a confluence of social phenomena that categorizes, silences, or dehumanizes people based on how they look. Contemporary racial categories (mongoloid, negroid, and caucasoid) began with 18th century English Anthropology to justify the presumed intellectual superiority of European colonists based on observable differences such as skin color.<sup>24</sup>

This sense of race exists for people in many different ways, but it is also encoded in institutions, systems, and culture. The Oregon Constitution specifically excluded Black people as a way to sidestep answering the question ‘Slave State or Free State.’<sup>25</sup> The federal Chinese Exclusion Act<sup>26</sup> and Japanese Internment<sup>27</sup> have also impacted Oregon’s racial landscape.

Providers must enter every interaction with patients of color aware that racial bias is in operation. This applies even—and sometimes especially—when the provider has significant experience with particular communities, or is a member of a marginalized group themselves. Even when a provider is committed to neutralizing their bias, the patient will likely have had many negative past experiences that may influence the clinical interaction.

Racism is not purely about individual intentions, but is structured into systems. “Color Blindness” is a framework that treats racial differences as simply a matter of individual perception and attitude. If we want better outcomes for patients of color, providers must advocate with and for marginalized patients always—both as individuals, and as professionals within the medical system.

## ASIAN & PACIFIC ISLANDER

Though the word “Asian” is globally understood to span immense geographic and cultural space, most Americans limit the term to Japanese, Chinese, Korean, Vietnamese, or Pacific Islanders. Though perceived as a single category, these groups have significant cultural differences; it is outside the scope of this handbook to provide comprehensive culturally specific suggestions. If language and refugee status are at issue, please look for more details in those sections.

The conception of Asians and Pacific Islanders as the “perpetual foreigner,” and persistent “microaggressions” (interactions of seemingly minor severity that appear in every aspect of life, including health care) can impact health outcomes. Additionally, the “Model Minority” stereotype suggests Asians are the “good” minority, adapting well to White society and cultural patterns, and even “exceeding” them.<sup>28</sup> Though the latter belief is often considered a flattering racial interpretation, it is detrimental to patients. Such beliefs can erase the wide variation in experience for Asians and pathologize those who don’t fit stereotypes.

### Good Practices

- Ask your Asian & Pacific Islander patients what they need and how they would like you to refer to them
- Question “Model Minority” assumptions
- Continue to explore and educate yourself about the variety of Asian & Pacific Islander people in your community
- Commit to ongoing professional development around working with Asian & Pacific Islanders as you would for any professional dimension

**KEY RESOURCE:** Asian Americans Advancing Justice: A Community of Contrasts: Asian Americans, Native Hawaiians, and Pacific Islanders in the West (2015): [http://advancingjustice-aaajc.org/sites/default/files/2016-09/AAAJ\\_Western\\_Dem\\_2015.pdf](http://advancingjustice-aaajc.org/sites/default/files/2016-09/AAAJ_Western_Dem_2015.pdf)

## PEOPLE OF AFRICAN DESCENT/BLACK

“Black” describes people who are descended from groups across Africa. In this section, we will use “people of African descent” as the most neutral and encompassing term, which applies both to people born in the US, and those who have recently immigrated from Africa. Insight in working specifically with African immigrants can be found in the sections in Ethnicity, Language, and Religion.

Providers must remember that racism is encoded into US culture and continues to the current day. People of African descent, US-born or not, live with relentless negation of their experience, compounded by persistent “microaggressions,” interactions of seemingly minor severity that appear in every aspect of life, including health care, that can impact health outcomes. Health care professionals must recognize implicit bias in order to provide culturally competent care for their Black patients. Evidence has shown that such implicit bias can lead to differences in diagnosis and resulting treatment. For example, a 2016 University of Virginia study showed that 50% of White medical students held at least one false belief about Black people and pain. As the number of false beliefs increased, the more likely that the respondent would rate a fictional Black patient’s pain as lower than a fictional White patient’s pain, suggesting that implicit bias can influence diagnostic judgment.<sup>29</sup>

### Good Practices

- Ask your patients of African descent what they need
- Question assumptions that preclude vulnerability and fragility
- Develop trusting relationships with people of African descent, both US and foreign born, as a matter of professional and ethical development
- Commit to ongoing professional development around working with people of African descent as you would for any professional dimension

**KEY RESOURCE:** The Urban League of Portland: The State of Black Oregon (2015): [https://ulpdx.org/programs/advocacy-and-civic-engagement/advocacy-and-public-policy/publication\\_archive/state-of-black-oregon-2015/](https://ulpdx.org/programs/advocacy-and-civic-engagement/advocacy-and-public-policy/publication_archive/state-of-black-oregon-2015/)

## PEOPLE OF EUROPEAN DESCENT/WHITE

“White” describes people who are descended from groups across Europe. Some people currently considered White in the US (Italians, Irish) would not have been considered so 100 years ago.<sup>30</sup> This section will address European descended people, regardless of whether they were born in the US or abroad. The prevalence and dominance of this demographic allows marginalized intersections to be overlooked; for example, white immigrants from across Europe and Central Asia may be assumed to be “American” or speak English because they are “American looking.”

White patients generally do not see themselves as recipients of power greater than those of other races. A critical racial misconception in the US is the naming of White people as “Caucasian,” rather than “European.” This practice flows from the original anthropological racial categories mentioned in the main heading under “Race.” This designation persists in the US (though not elsewhere) as a pseudo-scientific term for people of European descent.<sup>31</sup> There are non-European immigrants who are truly Caucasian, including Georgians, Azerbaijanis, and Armenians.<sup>32</sup> More accurate representation of patients is essential for more accurate reporting of demographic outcomes and is a necessary part of systemic transformation.

### Good Practices

- Although White patients do not experience racial marginalization, they may experience other forms of discrimination—examine assumptions of native language and home country
- Encourage use of “White” or “of European descent” in speech and on demographic forms
- Commit to ongoing professional development around disparities as you would for any professional dimension

**KEY RESOURCE:** Portland Community College: Whiteness History Month, 2016: <https://www.pcc.edu/about/diversity/cascade/whiteness-history-month/whiteness.html>

# INDIGENOUS/NATIVE AMERICAN PEOPLE

Indigeneity is incredibly varied in the US. There are 562 distinct cultural groups and nations recognized by the US government, from Native Hawaiʻian to the Lakota, from Ojibway to Tohono O’odham. Reservations are not US territory and are not bound by most US laws—they inhabit distinct sovereign nations. There are nine federally recognized tribes in Oregon.

Indigenous people may hold multiple identities alongside their Nativeness. Some North American Native people look White, but assuming they are “American” could be disrespectful. Native people may speak languages alongside of, or instead of, English. Poverty is ubiquitous in reservation life and common for urban Native people, too.<sup>33</sup>

Much of the current dialogue around diversity and inclusion may not pertain to Native patients. For example, rather than working towards legal citizenship (immigrants) or pushing for the rights and protections already guaranteed them (African Americans), many Native people inside US borders want sovereignty or liberty *from* the US, not inclusion.

## Good Practices

- Ask your Native patients what they need and how they would like you to refer to them
- Seek out opportunities to understand history from a Native perspective and listen to Native voices
- Volunteer at an organization such as the Native American Rehabilitation Association to better understand the issues facing Native communities off the reservation
- Remember that Native Americans may be distrustful of systems and government—their definition of respect may not be inclusion, but self-determination in a clinical setting
- Ask colleagues with clinical experience in a reservation setting about their experience and realizations
- Commit to ongoing professional development around working with Native people as you would for any professional dimension

**KEY RESOURCE:** Coalition of Communities of Color: The Native Community in Multnomah County—An Unsettling Report:  
<http://www.coalitioncommunitiescolor.org/research-data-tools/the-native-american-community-in-multnomah-county-an-unsettling-report>

# RELIGION

Religion and spirituality overlap with expectations around health care and must be taken into account by providers. End of life care, cross-gender interactions between provider and patient, family planning: these situations and others may involve religious and spiritual concerns that will affect patients' health and well-being, as well as their experience in the clinical setting.

Considering the diversity of religious experience in Oregon and the fact that everyone requires medical care, a culturally responsive provider will practice respectful inquiry into religion and what that means for the patient. Religious beliefs have been at the center of high visibility health care discussions in recent years, including Death with Dignity, vaccination, and other issues.

Religious beliefs or faith traditions may lead a patient to disagree with your medical advice. Oregon law allows competent adult patients to refuse medical care. Laws also allow parents to claim a nonmedical exemption from vaccination requirements. Providers can better counsel patients by learning more about the groups in your service area and asking appropriate questions.

## Good Practices

- Take the extra time to connect with the patient and family, and admit what you don't know about specific faith practices; ask for support and guidance
- Ask "Are you fasting?" and "Do you have any dietary restrictions, including alcohol?"
- Ask "Do you have any religious concerns related to your medical care?"
- "Is there anything else I need to know to give you the best care possible?"
- Commit to ongoing professional development around religious practices

**KEY RESOURCE:** Islamic Social Services of Oregon State Muslim Healthcare Handbook: <http://www.i-sos.org/healthcare.php>

**KEY RESOURCE:** Immunization Law Handbook: <https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/GettingImmunized/Documents/SchLawHandbook.pdf>

# GENDER MINORITIES

Gender is a social construct that impacts how the world and people interact with each other. Our mainstream gender system is strictly binary and unchanging—woman or man, never both, never neither. US constructions of gender and sex are often tied together—we understand women to be those generally physically capable of gestation, and men to be those generally physically capable of insemination.

Shifts in gender conceptualization are cultural and on-going, but what distinguishes those committed to ending gender oppression are these baseline understandings: a person's real gender is what they say it is; and "genitals do not equal gender" (a common saying within the trans-inclusive community).

Those whose gender doesn't match that assigned to them at birth may experience violence and abuse. Culturally competent practice requires empathy for the abuse that trans, intersex, and genderqueer/non-binary people suffer, in addition to ongoing work checking one's assumptions and understandings.

Some useful distinctions:

- **Cis:** describes people for whom the gender assigned to them at birth matches what they know their gender to be
- **Trans:** describes people for whom the gender assigned to them at birth does not match what they know their gender to be
- **Non-binary:** describes people whose gender is not binary: perhaps their gender is both man and woman, or neither
- **Gender Identity:** a person's gender; decided by the person
- **Gender Expression:** the way a person likes to show their identity
- **Gender Assigned at Birth:** based on visible sex organs, this is what is written on the birth certificate
- **Sex:** characteristics of sex organs, commonly understood as Male, Female, or Intersex



The Oregon Health Equity Alliance’s 2015 “Mend the Gap” report succinctly outlines some systemic barriers that transgender patients face. Among these are health insurance forms that require individuals to mark “male” or “female.” These categories can result in refusal of care when the needed care appears incompatible with the person’s gender. A billing code that allows for a gender/procedure mismatch has been endorsed by the Department of Health and Human services, though this may not be widely known.<sup>34</sup>

## Good Practices

- Believe your Trans/Queer/Intersex patients: ask what they need, how they would like you to refer to them, and refer to them as such
- Ask people for their pronouns always, even people you think ‘don’t look’ trans or genderqueer; when in doubt, default to they/their/theirs and inform your staff to do so as well
- Understand that Trans/Queer/Intersex people have accumulated trauma around clinical settings—this will impact their ability to trust providers
- Apply principles of Trauma-Informed Care:
  - Seek out peer supports for the patient
  - Prioritize a collaborative approach to patient agency
  - Transparency can facilitate trust and connection—admit areas of ignorance
- Familiarize yourself with common medications that Trans patients might be using, e.g., testosterone, estradiol, spironolactone, DHT, finasteride, progesterone
- Commit to ongoing professional development around working with Trans/Queer/Intersex patients

**KEY RESOURCE:** World Professional Association for Transgender Health: <http://www.wpath.org/>

# RURAL OREGON

About 16% of Oregonians, approximately 660,000 people, live rurally.<sup>35</sup> Accessing health services is an enormous barrier for many rural dwellers; some people live more than 100 miles from any clinic. The distance comes with isolation and other challenges. Members of rural communities have high incidences of Adverse Childhood Experiences (ACEs), making trauma-informed care essential to better outcomes.

Compounding this is a depressed economic situation stemming from the decline of the timber industry and the ending of federal timber subsidies in 2015. Services are severely limited in many areas, creating a cycle of privation that contributes to poor health outcomes. In rural Oregon, all other types of diversity are represented, but in ways which make generalizing about approaches and solutions difficult.

## Good Practices

- Cultivate trusting relationships with community members
- Apply principles of Trauma-Informed Care:
  - Prioritize a sense of safety which can form a foundation for trust
  - Inquire about Adverse Childhood Experiences, such as child abuse, lack of nutrition, etc
  - Look for ways to interrupt Adverse Childhood Experiences with parents and children
- Participate in a local Regional Health Equity Coalition, if there is one in your area (*see pg. 4*)
- Look for your leverage to improve outcomes in systems: institutions, communities, organizations
- Be wary of the polarizing effects of electoral politics at the local level—community building can make changes that benefit people regardless of ideology
- Advocate for resource sharing networks and use technology to close distance and resource gaps

**KEY RESOURCE: Rural Health Information Hub:**  
<https://www.ruralhealthinfo.org/states/oregon>

## RESOURCES FOR ADVANCING HEALTH EQUITY

Catholic Charities Refugee Resettlement: [http://www.catholiccharitiesoregon.org/services\\_refugee\\_resettlement.asp](http://www.catholiccharitiesoregon.org/services_refugee_resettlement.asp)

Coalition of Communities of Color: Unsettling Profiles: <http://www.coalitioncommunitiescolor.org/cc-c-dataresearch/>

Health Literacy: <https://health.gov/communication/literacy/quickguide/factsbasic.htm>

Immigrant Refugee Community of Oregon: <https://irco.org/>

Islamic Social Services of Oregon State Muslim Healthcare Handbook: <http://www.i-sos.org/healthcare.php>

Lutheran Community Services Northwest: <http://www.lcsnw.org/portland/resettlement.html>

Multnomah County Health Dept: Refugee Health: <https://multco.us/global/refugee-health>

Muslim Educational Trust: <http://www.metpdx.org/>

Native American Rehabilitation Association: <http://naranwdev.redbridgeonline.com/services/>

Open Minded Health: Trans 101 for Trans people: <http://openmindedhealth.com/transgender-101-trans-people/>

Oregon Health Authority Office of Equity and Inclusion: Jackson County Health Equity Final Report, Phase 2: <https://www.oregon.gov/oha/oei/reports/Jackson%20County%20Health%20Equity%20Phase%201%20Report%20-Final.pdf>

Oregon Health Care Interpreters Association: <http://ohcia.org/hub>

Oregon Health Equity Alliance: <http://www.oregonhealthequity.org/resources/5-year-plan/>

Oregon Health Sciences University Transgender Health Program: <https://www.ohsu.edu/xd/health/services/transgender-health/>

Oregon Latino Health Coalition: <http://orlhc.org/>

Oregon Regional Health Equity Coalition 2016 Evaluation Report: <http://www.krhec.org/RHEC%20Evaluation%20Report%20Summer%202016%20w-exec%20sum.pdf>

PCC Transgender Referral Resources: <https://www.pcc.edu/resources/women/cascade/transgender-resources.html>

Regional Health Equity Coalitions: <https://www.oregon.gov/oha/oei/Pages/rhec.aspx>

Trans Student Educational Resource: <http://www.transstudent.org/definitions>

Urban League: State of Black Oregon: [https://ulpdx.org/programs/advocacy-and-civic-engagement/advocacy-and-public-policy/publication\\_archive/state-of-black-oregon-2015/](https://ulpdx.org/programs/advocacy-and-civic-engagement/advocacy-and-public-policy/publication_archive/state-of-black-oregon-2015/)

World Professional Association for Transgender Health: [http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351&pk\\_association\\_webpage=4655](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655)

## REFERENCES

1. Data Access and Dissemination Systems (DADS). (October 5, 2010). 2010 US Census, Table QT-P3, Race and Hispanic or Latino Origin, Oregon. Retrieved May 7, 2017, from <https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t>
2. Oregon Health Authority Cultural Competence Continuing Education Committee. (n.d.). Recommendations for Advancing Cultural Competence Continuing Education for Health Professionals in Oregon (pp. 2-4, Rep.). doi:<http://www.oregon.gov/oha/oei/reports/Cultural%20Competence%20Continuing%20Education%20Report.pdf>
3. Oregon Health Equity Alliance. (n.d.). HOPE Coalition 5-Year Plan Final (p. 21, Rep.). doi:[http://www.oregonhealthequity.org/wp-content/uploads/2012/04/HOPE-COALITION-FIVE-YEAR-PLAN-FINAL\\_-Sept-26.docx](http://www.oregonhealthequity.org/wp-content/uploads/2012/04/HOPE-COALITION-FIVE-YEAR-PLAN-FINAL_-Sept-26.docx)
4. Office of Minority Health. (n.d.). Retrieved May 7, 2017, from <https://minorityhealth.hhs.gov/npa/templates/browse.aspx?vl=1&vlid=34>
5. Regional Health Equity Coalitions. (n.d.). Retrieved May 7, 2017, from <https://www.oregon.gov/oha/oei/Pages/rhec.aspx>
6. Oregon Health Equity Alliance (OHEA). (n.d.). Retrieved May 7, 2017, from <https://www.oregon.gov/oha/oei/Pages/ohea.aspx>
7. Oregon Health Equity Alliance. (n.d.). HOPE Coalition 5-Year Plan Final (p. 9, Rep.). doi:[http://www.oregonhealthequity.org/wp-content/uploads/2012/04/HOPE-COALITION-FIVE-YEAR-PLAN-FINAL\\_-Sept-26.docx](http://www.oregonhealthequity.org/wp-content/uploads/2012/04/HOPE-COALITION-FIVE-YEAR-PLAN-FINAL_-Sept-26.docx)
8. Oregon Health Authority Cultural Competence Continuing Education Committee. (n.d.). Recommendations for Advancing Cultural Competence Continuing Education for Health Professionals in Oregon (p. 2, Rep.). doi: <http://www.oregon.gov/oha/oei/reports/Cultural%20Competence%20Continuing%20Education%20Report.pdf>
9. Oregon Health Equity Alliance. (n.d.). HOPE Coalition 5-Year Plan Final (p. 4, Rep.). doi:[http://www.oregonhealthequity.org/wp-content/uploads/2012/04/HOPE-COALITION-FIVE-YEAR-PLAN-FINAL\\_-Sept-26.docx](http://www.oregonhealthequity.org/wp-content/uploads/2012/04/HOPE-COALITION-FIVE-YEAR-PLAN-FINAL_-Sept-26.docx)
10. Cultural Competence Continuing Education Brief (p. 1, Issue brief). (2014). Portland, OR: Oregon Health Authority. doi:[https://www.oregon.gov/oha/oei/Documents/Cultural%20Competence%20CE%20Brief\\_FINAL.pdf](https://www.oregon.gov/oha/oei/Documents/Cultural%20Competence%20CE%20Brief_FINAL.pdf)
11. Oregon Health Authority Cultural Competence Continuing Education Committee. (n.d.). Recommendations for Advancing Cultural Competence Continuing Education for Health Professionals in Oregon (p. 6, Rep.). doi:<http://www.oregon.gov/oha/oei/reports/Cultural%20Competence%20Continuing%20Education%20Report.pdf>
12. Oregon Revised Statute 413.450(4): Continuing education in cultural competency (2015).
13. Oregon Administrative Rules 847-008-0070(5): Oregon Medical Board – Continuing Medical Competency (2017).

14. Oregon Administrative Rules 943-090-0020: Oregon Health Authority – Cultural Competency Continuing Education for Health Care Professionals (2017).
15. Migration Policy Institute (MPI) analysis of U.S. Census Bureau data from the 2014 American Community Survey (ACS), 2010-2014 ACS pooled, and the 2008 Survey of Income and Program Participation (SIPP) by James Bachmeier of Temple University and Jennifer Van Hook of The Pennsylvania State University, Population Research Institute. doi:<http://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/OR>
16. Oregon Department of Human Services. (2017). Refugees in Oregon Data. Retrieved May 17, 2017, from <https://www.oregon.gov/DHS/ASSISTANCE/REFUGEE/Pages/data.aspx>
17. Centers for Disease Control and Prevention. (December 13, 2016). What is Health Literacy? Retrieved May 7, 2017, from <https://www.cdc.gov/healthliteracy/learn/>
18. Modern Health Care. (August 30, 2014). Hospitals often ignore policy on using qualified medical interpreters, patient safety is endangered. Retrieved May 7, 2017, from <http://www.modernhealthcare.com/article/20140830/MAGAZINE/308309945>
19. Data Access and Dissemination Systems (DADS). (October 5, 2010). Oregon. Retrieved May 7, 2017, from [https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_15\\_5YR\\_B16005I&prodType=tableB16005I](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_5YR_B16005I&prodType=tableB16005I) – Nativity by language spoken at home by ability to speak English for the population 5 years and over (Hispanic or Latino) Universe: Hispanic or Latino population 5 years and over
20. Migration Policy Institute (MPI) analysis of U.S. Census Bureau data from the 2014 American Community Survey (ACS), 2010-2014 ACS pooled, and the 2008 Survey of Income and Program Participation (SIPP) by James Bachmeier of Temple University and Jennifer Van Hook of The Pennsylvania State University, Population Research Institute. doi:<http://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/OR>
21. Mend The Gap: Why Full Coverage Makes Sense for Oregon (p. 5, Publication). (2015). Portland, OR: Oregon Health Equity Alliance. doi:[http://www.oregonhealthequity.org/wp-content/uploads/2015/11/OHEA\\_MendtheGap\\_Web.pdf](http://www.oregonhealthequity.org/wp-content/uploads/2015/11/OHEA_MendtheGap_Web.pdf)
22. Ruiz-Pérez, R., López-Cózar, E. D., & Jiménez-Contreras, E. (2002). Spanish personal name variations in national and international biomedical databases: implications for information retrieval and bibliometric studies. *Journal of the Medical Library Association*, 90(4), 411–430.
23. Oregon Department of Human Services. (2017). Refugees in Oregon Data. Retrieved May 17, 2017, from <https://www.oregon.gov/DHS/ASSISTANCE/REFUGEE/Pages/data.aspx>
24. Marks, Jonathan (2008). “Race: Past, present and future. Chapter 1”. In Koenig, Barbara; Soo-Jin Lee, Sandra; Richardson, Sarah S., *Revisiting Race in a Genomic Age*. Rutgers University Press.

25. Oregon Historical Society. (n.d.). Black Exclusion Laws in Oregon. Retrieved May 7, 2017, from [https://oregonencyclopedia.org/articles/exclusion\\_laws/#.WQ9oivnythH](https://oregonencyclopedia.org/articles/exclusion_laws/#.WQ9oivnythH)
26. Oregon Historical Society. (n.d.). Chinese Americans in Oregon. Retrieved May 7, 2017, from [https://oregonencyclopedia.org/articles/chinese\\_americans\\_in\\_oregon/#.WPPSTrgrK3B](https://oregonencyclopedia.org/articles/chinese_americans_in_oregon/#.WPPSTrgrK3B)
27. Oregon Historical Society. (n.d.). Japanese Americans in Oregon. Retrieved May 7, 2017, from [https://oregonencyclopedia.org/articles/japanese\\_americans\\_in\\_oregon\\_immigrants\\_from\\_the\\_west/#.WQYaxvnythE](https://oregonencyclopedia.org/articles/japanese_americans_in_oregon_immigrants_from_the_west/#.WQYaxvnythE)
28. Chapter 4 Contesting the Model Minority and Perpetual Foreigner Stereotypes: A Critical Review of Literature on Asian Americans in Education Jennifer C. NgSharon S. Lee, Yoon K. Pak Review of Research in Education Vol 31, Issue 1, pp. 95 - 130 First published date: November 15, 2016
29. Hoffman, K.M., Trawalter, S., Axt, J.R, & Oliver, M. N. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites PNAS 2016 113 (16) 4296-4301; published ahead of print April 4, 2016, doi:10.1073/pnas.1516047113
30. Ignatiev, N. (2015). How the Irish Became White. New York: Routledge.
31. Dewan, S. (July 6, 2013). Has Caucasian Lost its Meaning? The New York Times. Retrieved May 7, 2017, from <http://www.nytimes.com/2013/07/07/sunday-review/has-caucasian-lost-its-meaning.html>
32. Caucasian Peoples. (December 7, 2001). Retrieved May 18, 2017, from <https://www.britannica.com/topic/Caucasian-peoples>
33. Schaefer Riley, N. (July 2016). One Way to Help Native Americans: Property Rights. The Atlantic. doi:<https://www.theatlantic.com/politics/archive/2016/07/native-americans-property-rights/492941/>
34. Mend The Gap: Why Full Coverage Makes Sense for Oregon (p. 7, Publication). (2015). Portland, OR: Oregon Health Equity Alliance. doi:[http://www.oregonhealthequity.org/wp-content/uploads/2015/11/OHEA\\_MendtheGap\\_Web.pdf](http://www.oregonhealthequity.org/wp-content/uploads/2015/11/OHEA_MendtheGap_Web.pdf)[http://www.oregonhealthequity.org/wp-content/uploads/2015/11/OHEA\\_MendtheGap\\_Web.pdf](http://www.oregonhealthequity.org/wp-content/uploads/2015/11/OHEA_MendtheGap_Web.pdf)
35. Rural Health Information Hub. (n.d.). Retrieved May 7, 2017, from <https://www.ruralhealthinfo.org/states/oregon>



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