

**An Essay on Cultural Diversity, Healthcare
Disparities, and Cultural Competence
In American Medicine**

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It is both a privilege and a pleasure to address the J. Robert Gladden Orthopaedic Society in Lausanne, Switzerland at the invitation of Augustus White, M.D. I have been called upon to provide a presentation of the status of health care for African Americans and other minorities, and I welcome this task. My credentials for being placed in this position of honor span my medical and academic career, which began when I was an undergraduate pre-medical student at Harvard in the early 1950's and continued through my training in Cardiology at Harvard Medical School and what is now Brigham and Women's Hospital in Boston.

My exposure to the realities of the medical system as it relates to blacks and other minorities continued through my experiences at the Dr. Martin Luther King, Jr. Hospital in Watts, California and subsequently at my current home base at the UCLA School of Medicine, where I have been on faculty for 32 years. During that time span from my undergraduate years to the present, I have not only witnessed some dramatic events and developments regarding the delivery of health care to the nation's medically neediest populations, I have also been privileged to play a role in them. Examples are my founding of three organizations which have had an impact on healthcare delivery and medical education for minorities. The first one was the Central Recruitment Council of Boston Hospitals in 1968, which was successful in changing the paradigm of medical education in those institutions from a history of virtually never having had any African American postgraduate trainees, e.g., interns, residents, and fellows, to a situation where hundreds have now been educated. The second one was the founding in 1974 of the Association of Black Cardiologists, which I started as an attempt to address the special needs of the black community with respect to cardiovascular health. It has had a

tremendous impact on the way in which black patients with heart disease are managed, and 32 years later, it operates out of a new multi-million dollar International Library, Research, and Conference Center in Atlanta, Georgia; it is generally regarded as the best small medical organization in the country. The third organization that I founded is the Minority Health Institute which was initiated in 1985. It is dedicated to decreasing healthcare disparities by educating healthcare professionals about cultural competency and the need for cultural sensitivity in treating a diverse population. It regularly sponsors seminars, symposia, and forums on the unique health problems of blacks and other minorities.

As I developed interest in the provision of a more humane type of healthcare delivery and the elimination of healthcare disparities, I took the opportunity to write and edit a number of publications dealing with these issues. Included are the *Textbook of Black-related Diseases*, an 800-page book which was published in 1975 and is a compendium of diseases peculiar to African Americans;¹ *Humane Medicine, volumes I and II*, which offer a new paradigm in medical education and healthcare delivery, published in 1998 and 2001;^{2,3} and my most recent work, *Eliminating Healthcare Disparities in America: Beyond the IOM Report*, which is now in press and will be available in early 2007. The latest book is an edited compilation of evidence and wisdom on the subject by many of the best experts in the nation.

All of the information above serves as background from a personal perspective for our consideration of the theme of this essay, which has to do with how cultural diversity and cultural competency are interlinked with the reduction and elimination of disparities in healthcare and health status, and how racial and ethnic bias impact on the health and welfare of those most in need of our best medical efforts. I will now offer a discourse on that theme.

Definitions of Key Terms

The Concept of Race

The word *race* is derived from the Latin *generatio* (a begetting) and is a complex of semantic ambiguities, according to anthropologist Elizabeth S. Watts.⁴ It is a controversial expression of taxonomic interest that is useful for classification because it uses phenotypical similarities to subdivide the human species (*Homo sapiens*) into artificial and superficial categories based on skin and eye color, body proportions and facial features or physiognomy, and color and texture of the hair. It

also distinguishes populations by the frequency of certain genes.⁵ From an anthropological standpoint, three primary categories of race are accepted by most authorities: Caucasian (white), Negroid (black), and Mongoloid (Asian, yellow), but other classifications have been offered by various authorities down through the centuries.⁶ The attempt to organize humankind into different groups based on phenotypical characteristics originated with the Swedish taxonomist Linnaeus (Karl von Linne') in his epochal work, *Systema Naturae (A General System of Nature)*, written in 1735, in which he invented the binomial classification that allows all entities in nature to be described as a member of a species and a genus. In the typological classification constructed by Linnaeus, Caucasians, whom he called Europeans, are held in the highest regard, while the Negroid types, whom he designated as Africans, are held in the lowest.

Several other attempts have been made to classify man on a biological basis, and skin color has been the principal criterion used. Ancient Greek mythology related that differences in skin color throughout the world were created when the sun god, Helios, permitted his son Phaeton to drive the sun chariot. Phaeton was an erratic driver who flew too close to certain parts of the Earth, causing the residents of those areas to become burnished, and too far away from other areas, causing people there to have blanched skin and the climate to be cold. However, it was humans themselves, not the gods, who decided how to rank people according to the color of their skin. Insulting treatises have been published by anthropologists such as Carlton Coon⁷ demeaning blacks and other persons of color while exalting whites.

Even before Coon's pronouncements, there were efforts to place blacks in a different species category from whites. The most notorious example was the development of the pseudoscience of phrenology, invented by Franz Josef Gall⁸. Through this thesis, medicine aided and abetted the pro-slavery forces by indicating that measurements of human skulls with calipers, pioneered by Retzius,⁹ demonstrated that whites had larger internal skull capacity and therefore larger brains and more innate intelligence than blacks. The inference was that blacks were lower creatures and were deserving of being subjugated to slavery. Other scientists joined in the denigration of blacks. The pinnacle was reached on February 8, 1848, when the distinguished fellows of the Academy of Natural Sciences of Philadelphia met to hear a lecture by their most revered member, the eminent craniologist Dr. Samuel George Morton. Morton had already written his epic *Crania*

*Americana*¹⁰ in 1839, and at the Philadelphia meeting he presented an 18-year-old Hottentot boy who had been sent to him from South Africa by a craniologist, Samuel Gliddon. Dr. Morton, commenting on the young man's head, described it as completely foreign to the European concept of the ideal physical features for the human species. His theory of racial inferiority were taught in medical schools throughout the country and were endorsed by some of the most respected scientists and physicians of the day, including Dr. Charles Meigs, Dr. John Collins Warren, and Dr. Louis Agassiz of Harvard. Thus, it is clearly seen how the concept of race was distorted and resulted in *racism, bias, and stereotyping*.

The Concept of Ethnicity

To escape the pejorative implications of race, Ashley Montague invented a new term in 1964, *ethnic group*.¹¹ Because *ethnic* implies membership in a socially rather than a biologically defined group, the hope is that the bias and bigotry associated with the use of *race* can be avoided by using the terms *ethnic group* and *ethnicity*. Accordingly, the ethnically relevant term *African American* is more preferred by some to the biologically related expression *black*.

However, simply changing the focus from the biological to the social characteristics of a population group does not eliminate bias. It might be argued that most cases of racial discrimination are actually instances of social discrimination, although this renders the bias no less onerous. The common denominator in racial and ethnic bias is the bigoted perception, developed by one group about another group that differs in some way, that the first, bigoted group is superior in some way. Science and medicine are often used to support these perceptions, as indicated above in the phrenology example. Such examples can serve as catalysts, helping to convince people in the more powerful, controlling group to accept the subjugation of others to the demands, denial of access to care, brutality, enslavement, and other indignities to which racial and ethnic minorities are exposed. The bigot is somehow absolved of guilt if the people who are tortured, murdered, exploited, enslaved, or provided substandard medical treatment are seen as different and inferior, or are *dehumanized*. It is in the nature of prejudice, as described by Harvard sociologist Gordon Allport,¹² to blame the subjugated, powerless group for the trials and tribulations with which it is beset. This might also be called *blaming the victim*. This prejudicial process is seen in the writings of Wilhelm Schallmeyer

(1857-1919) in Germany, who united social Darwinism with the theory of innate degeneracy, which held that mental retardation, shortsightedness, mental illness, and other negative traits were caused by a degenerate constitution. In doing so, he provided the rationale for managing human reproduction that was used by the Nazis against the Jews. This was an early example of *ethnic cleansing*. Similar pronouncements were made by Fritz Lenz, a scientific theorist for Nazi thought, as documented by Proctor, Lifton, and Muller-Hill.^{13,14,15} In more recent years, the *eugenics* theory, which advanced the view that society should be protected against the perpetuation of allegedly inferior people through sterilization and isolation, was propagated by Harvard professor Bernard Davis, the writings of Harvard professors Richard Herrnstein and Joseph Murray in their book, *The Bell Curve*¹⁶, in which they allege that blacks are intellectually inferior to whites, and in the works of Jensen, Eysenck, and others who have assaulted the integrity of black mental health and intellectual capacity.

It is obvious, therefore, that merely substituting terms (e.g., *ethnicity* for *race*) does not eliminate *racism*. As medical professionals, we must develop a sensitivity regarding these issues that will help us to manage our patients according to the special needs and considerations that they require as members of discrete racial or ethnic groups.

The Concept of Culture

According to Fabrega, the term *culture* involves a group's system of social symbols and the meanings of those symbols.¹⁷ Culture looks beyond what Fabrega calls the *biomedical portrait of disease* and involves the mores, traditions, customs, rituals, language, and patterns that are peculiar to a distinct group of people. It may have tremendous effects on the view of health care held by people in a given culture, and it can affect their understanding, trust, acceptance, and use of the healthcare system presented to them. Cultural factors may also determine the extent to which an ill person understands his or her disease; as physicians, we tend to explain illness on an organic basis (e.g., in terms of some infectious or other process affecting the skeletal, nervous, cardiovascular, gastrointestinal system, etc.). However, a patient from the Maya Indian town of Zinacantan in the highlands of Chiapas, Mexico, may not be able to understand illness in the context of Western orthodox medicine, thinking instead of disease as a foreign process or spirit entering the body.¹⁸ A patient from Haiti who believes in voodoo medicine and has been treated with kerosene-soaked sugar

cubes for a cold by a voodoo practitioner may not understand that he or she has developed serious renal disease because of this treatment and needs urgent medical attention to reverse it. There are many considerations surrounding the complex nature of culture and its impact on health care. Clinicians should be thoroughly educated about the cultural norms that their patients observe and should work with their system of cultural values rather than against it or entirely outside of it.

The Concept of Religion

Religious beliefs are frequently involved in patients' understanding of illness and compliance with prescribed treatment. It is the most delicate of the concepts explored here. The subtlety of its nature derives from the very meaning of *religion*, which may be defined as a system of beliefs based on a group's faith in the power of a supreme being or beings. The impact of religion has sometimes been obstructive in the past to the advancement of science and medicine on the basis of allegedly heretical practice which seemed to contradict religious dogma; practitioners such as Avicenna were burned at the stake, tortured, or ostracized for views that were out of step with prevailing religious doctrine. For instance, vivisection or dissection of the human body was forbidden for centuries in Europe, and it was not until Andreas Vesalius published *De Humanis Corporis Fabrica* (Structure of the Human Body) in 1543 that human anatomy was studied in a thorough manner.¹⁹ Religion still has a pervasive influence on medicine today. The most noteworthy example is the rejection of blood transfusions by Jehovah's Witnesses, which has led to the development of techniques for bloodless surgery and to the wider use of blood substitutes to accommodate patients who are subject to these religious restrictions. The technique of bloodless or transfusion-free surgery is even used in heart surgery, for instance, at institutions such as the University of Pennsylvania Hospital under Charles R. Bridges, Jr., M.D., Chief of Cardiothoracic Surgery.

The Concept of Class

The idea that people in American society are separated by their membership in a certain class is not new; we often speak of lower, middle, and upper-class categories, which are based upon financial status, and there is even an extension of this primary grouping schema in that many now consider that there is an underclass of extreme poverty and homelessness. There is no doubt that the financial means

available to a group helps to determine the type of healthcare it receives. Tudor Hart²⁰ (Hart JT. The inverse care law. 1971, *Lancet*; 1: 405-412.) has described what he calls the “inverse care law”: those who are most in need of medical care receive the least amount of it, and, we might add, the poorest quality. Because the type of care one receives may be determined largely by the ability to pay for that care, this renders our system one of “wealth care” instead of health care. The interrelationship between disease, health, race, and social class has been firmly established.²¹ (Krieger N, Bassett M. The health of black folk. *Disease, class, and ideology in science. Monthly Rev* 1986; 38, 74-85.) It is important to recognize that looking at the intersection of class, race, and healthcare delivery, race is the most predominant factor in determining access to care and quality of care received. This means that healthcare disparities occur more commonly in blacks than in whites even when individuals analyzed from each group have the same class, educational, and health insurance status.

Health insurance coverage is one of the determinants of class. It is recognized that more than 46 million Americans, or about 16 percent of the population, are uninsured or underinsured. Most of these individuals are poor minorities, particularly Hispanics and African Americans. Correcting this problem must be at the top of any agenda to remedy the healthcare crisis.

Healthcare Disparities

In 2003, the Institute of Medicine of the National Academy of Science released the results of a long investigation commissioned by Congress on racial and ethnic differences in healthcare delivery, access to care, outcomes of treatment, and other parameters. These results were published in the book, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*.²² I was fortunate to be a reviewer for the book. The study committee defined *disparities* in healthcare as “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention”. In other words, these differences are due to discrimination, bias, and prejudice. The IOM Report, as it is popularly called, identified several areas in which disparities are found, including differences in amputation rates, with blacks having a 3.6 percent higher rate than their white Medicare peers, according to Gornick (1996). The IOM report also emphasized that there is a range of patient-level, provider-level, and system-level factors that may be

involved in racial and ethnic healthcare disparities, beyond access-related factors. Over 100 citations of healthcare disparities covering virtually all fields of medicine were exemplified in the IOM Report. No attempt will be made in this presentation to detail the numerous problems which exist. The book may be accessed online at www.nap.edu.

In terms of its practical importance, how significant are healthcare disparities? Former Surgeon General Dr. David Satcher estimates that *these disparities account for over 100,000 excess deaths of blacks alone each year*. He suggests that if we were truly equal, these excess deaths would disappear.

Cultural Competence in Medicine

Cultural competence is a set of academic, interpersonal, and clinical skills that allows individuals to increase their understanding of differences and similarities within, among, and between groups. A health care provider is said to have achieved cultural competence when the *patient* is satisfied that a collaborative partnership has been established between doctor and patient that facilitates the successful and satisfactory delivery of medical care. This is accomplished when the doctor makes efforts to overcome language barriers in limited English proficiency (LEP) patients, learns to appreciate cultural differences between himself and the patient, and develops a sense of *trust*. Given the fact the most minority patients are treated by physicians from the majority group, these principles are extremely important. The Office of Minority Health of the Federal Government has developed a set of 14 principles called the CLAS Standards (Culturally and Linguistically Appropriate Services) which are primarily directed at healthcare organizations, and are mandated for all organizations receiving Federal funds. The concentration is on the provision of linguistic services and attempts to provide information to patients in their own language through availability of brochures, interpreters, and other means. More information can be obtained by contacting the Office of Minority Health at info@omhrc.gov.

State and local governments have also taken an interest in ensuring cultural competence among healthcare providers. The states of New Jersey, California, and Washington have passed legislation requiring doctors to pass tests of cultural competence as a requirement

of medical license renewal, and several other states are considering such legislation.

The Diverse Patient Universe in America

Cultural diversity is defined as the spectrum of customs, mores, traditions, patterns, habits, and lifestyles exhibited or possessed by the totality of distinct cultural groups within a society. Within the context of medicine, cultural diversity is used to indicate the fact that considerable variation exists between such groups with regard to manifestations of disease, understanding of the health care delivery process, expression of illness, acceptance of and compliance with treatment, and differential response to therapy.

The current U.S. population of 300 million people is a mixture of a multitude of races, ethnicities, languages, cultures, religions, and classes. It is not quite an even blend yet, and it may never be; homogenization does not come easily and perhaps should not be attempted at all. Population subgroups want to maintain their individual identities rather than being forced to become part of a monolithic society that lacks the special characteristics of any one group.

According to the U.S. Census of 2000, the most recent census, minorities occupy about one-third of the population, with Hispanics being the largest subgroup of the minorities at 12.5 percent, African Americans at 12.3 percent, and Asian Americans at 3.6 percent. It is estimated that by 2050, more than half of the population will be minorities, establishing what might be called the “minority majority” society for the first time in the nation’s history. This is already affecting the nature of practice in all fields of medicine, and it will have an increasingly intense impact as time goes by. Learning cultural competence and eliminating healthcare disparities have become issues that must now be viewed as urgent rather than elective on all levels including the federal government, state and local government, and in the private medical sector. In that regard, it is important for all practitioners to have an understanding of the demographics of minorities *vis a vis* the current majority, e.g., white population.

The Federal Government Perspective on Minorities

On October 30, 1997, the Office of Management and Budget of the United States (OMB) issued what is now considered the official categorization of race and ethnicity in this country.²³ Called OMB-15,

the directive does not use the old anthropological criteria, but rather redefines races and ethnicities from a federal view based on a management and budget perspective, and utilizes statistics on health and other matters collected by the National Center for Health Statistics (NCHS). OMB-15 recognizes five races and two ethnic groups. The five races are:

- **American Indian and Alaska Native**
- **Asian**
- **Black of African American**
- **Native Hawaiian or other Pacific Islander**
- **White**

The two ethnicity categories are:

- **Hispanic or Latino**
- **Not Hispanic or Latino**

All races and ethnicities except Asians and whites are considered disadvantaged minorities, although segments of all groups are disadvantaged. In this brief overview, only the two largest minority groups, Hispanics and African Americans, will be briefly discussed regarding their particular health problems and the health disparities that affect them.

Hispanic Americans

This group is very heterogeneous, consisting of many racial, ethnic, and cultural entities, most of whom utilize a common language, Spanish. Sometimes also referred to as Latinos, there are five subgroups in the United States, based on country of origin: Mexican (the largest subgroup), Puerto Rican, Cuban, Central or South American, and “other” Hispanics.

Hispanic Americans (HA) are the most populous minority group in the country. In the 1990 Census they constituted 9 percent of the population and have risen to 12.5 percent at present.

HA are at particular risk for several diseases, such as diabetes mellitus, tuberculosis, hypertension, HIV/AIDS, alcoholism, cirrhosis, cancer and death from violence.²⁴ Only recently has there been a focus on health of the HA community. The Hispanic Health and Nutrition

Survey (Hispanic HANES or HHANES) investigated hypertension prevalence in this group and found it to be lower than in comparable groups of whites and blacks.²⁵ Cardiovascular disease has been found to have a surprisingly low prevalence in HA despite the relatively high prevalence of risk factors such as obesity and diabetes. This has been called the “Hispanic paradox” by Fuentes.²⁶

Socioeconomic factors are a significant part of healthcare access for HA. For instance, a study of HA attending a city clinic identified the following barriers to adequate medical care: language problems, cultural differences, poverty, lack of health insurance, transportation difficulties, and long waiting times.²⁷ Regarding health insurance, HA have a higher rate of non-coverage than whites and African Americans, regardless of income level. About 35 percent of HA adults are uninsured for medical care compared to 21 percent of African Americans and 14 percent of whites. HA are also less likely to visit a doctor’s office, and the rate of no physician contact is highest for HA. Income is obviously a factor; the National Longitudinal and Mortality Study²⁸ revealed that 24 and 34 percent of HA men and women, respectively, earned less than \$10,000 per year, compared to 12 and 18 percent of white males and females, respectively.

Of the HA subgroups, Mexican Americans tend to use folk remedies more than others as opposed to using conventional medical care;²⁹ a survey of Mexican American families in western Texas revealed that folk medicine was used by half of the families.

To summarize the health status of Hispanic Americans, it must be recognized that not only is this group beset by serious diseases leading to high morbidity and mortality rates, it is also at inordinate risk for developing such disease because of the high penetration of risk factors such as obesity, cigarette smoking, and improper diet. Health status is further affected by poverty, lack of access to healthcare, and the language barrier. Almost all factors cited as health care problems among HA are either preventable or remediable. This is where the major thrust must occur in this new century to eliminate health disparities in this increasingly growing minority group.

African Americans

Once the largest minority group in the United States, African Americans (AA, blacks) are now second in size to HA. They represent 12.3 percent of the population at present. AA have been studied more than any other minority group, and therefore more data are available

regarding their health status. Health statistics regarding morbidity, mortality, and longevity have almost always shown that blacks lag behind whites in virtually every category of disease and illness; e.g., death, incidence, prevalence, and complication rates are higher for AA, and recovery rates tend to be lower. Overall life expectancy improved during the 20th Century for all groups but remains lowest for AA. For example, comparing life expectancy figures for whites and blacks yields the following information: white males, 75.0 years; black males, 68.6.0 years; white females, 80.2 years; black females, 75.5 years.³⁰ This life expectancy discrepancy is one of the most striking disparities in vital statistics and is an example of what I have termed the “death gap”.³¹ (Humane Med., vol. II, p.7) There are numerous other examples, such as the fact that the infant mortality rate for AA is twice as high as that for whites. In fact, when mortality from specific diseases is analyzed, it is seen that blacks have worse statistics than whites in most major categories.³²

The greatest killer of AA is cardiovascular disease (CVD), not violence or HIV/AIDS, as some people believe. In fact, CVD is responsible for about 40 percent of AA deaths annually, a percentage that is higher than in whites. According to the National Heart, Lung, and Blood Institute of the National Institutes of Health, the death rate in 1995 from CVD in blacks was 154 per 100,000; for whites, it was 114 per 100,000. The Federal Government has established a goal in its Healthy People 2010 objectives to decrease the rate of CVD deaths in blacks down closer to the rate for whites.

As I indicated above, I founded the Association of Black Cardiologists because of a lack of proper national focus on CVD in blacks. One of the areas that has been focused upon by the ABC is the problem of heart failure in blacks, which was relatively ignored in the past. Through research co-sponsored by the ABC, a novel drug combination of hydralazine and isosorbide dinitrate was developed which has shown amazing efficacy in decreasing mortality in the sickest heart failure patients. Interestingly, it is very effective in African American patients but it does not have a significant impact on mortality in white patients. The Federal Food and Drug Administration (FDA) approved a drug for use in a specific race (blacks) for the first time, based on the very impressive research results in a randomized clinical trial.³³ This has led to some controversy because some observers feel that medicine should be “color blind” and that the BiDil situation represents “racial profiling”. These critics ignore two important facts:

(1) The difference in effectiveness between blacks and whites is a true example of the application of evidence-based medicine rather than some wild theory with little basis; (2) The history of clinical trials reveals that blacks have rarely been included to any significant extent, yet the results of such trials have been applied broadly to blacks as well as whites, as though “one size fits all”. The rationale has been that what is good for whites should certainly be good for blacks. It is unfortunate that the controversy is one reason that has kept many African American patients from receiving this life-saving drug.

Much of the impetus for programs like Healthy People 2010 has come from the ABC. It is clear that this precedent needs to be replicated in other medical fields, hence the rationale for the creation of the J. Robert Gladden Orthopaedic Society, which serves as the diversity arm of the American Association of Orthopedic Surgeons (AAOS).

Quality of Care

Aside from the issues of healthcare disparities and cultural competence, there is a concern about the *quality* of the care delivered rather than just the quantitative aspect. The National Committee on Quality Assurance (NCQA) is an independent, non-profit 501C3 agency that serves the public in a “watchdog” and advisory role which has established a set of performance standards for the healthcare industry and for health plans in particular. These are called HEDIS standards (Health Plan Employee Data and Information Sets). NCQA issues a “report card” to plans based on their achievement of the HEDIS standards. This is an attempt to protect patients, or medical consumers, in general. There has been some concern that there is not enough concentration on minority health issues by NCQA, and therefore, a new group based in Washington, D.C. called the National Minority Quality Forum (NMQF) was formed to correct this deficiency.

Conclusion

Racial discrimination is against the law in the United States, and medical practitioners need to be aware of this fact. This includes unintentional as well as intentional discrimination. The legal basis is contained in Title VI of the Civil Rights Act of 1964. It applies especially to discrimination in public accommodations such as hospitals receiving Federal funds. Private offices and facilities have been apparently

immune to the law, but measures are being planned in state and local governments to overcome the limitations of the Federal law.

A final consideration involves crucial questions which every doctor and minority patient should pose to himself or herself: Am I prejudiced? Am I guilty of discrimination against minorities? Patients need to ask whether discrimination actually exists. In the National Healthcare Disparities Report of 2006,³⁴ only 25 percent of whites surveyed thought that getting quality healthcare is more problematical for minorities than for whites; the comparable percentages for Hispanics and African Americans polled were 56 and 44, respectively. Therefore, Hispanics and blacks perceive much more discrimination than whites.

In a similar survey, only 25 percent of white doctors felt that the healthcare system treats minorities unfairly, compared to 77 percent of African American, 52 percent of Hispanic, and 33 percent of Asian doctors. This dichotomy of views between minorities and the majority group means that much more work need to be done to increase communication and awareness regarding healthcare disparities through education about cultural competence. In this manner, I expect that the quality of medical care delivered to minorities will be enhanced, and more racial and ethnic harmony and understanding will be achieved in medicine.

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