WHEN PHYSICIANS TERMINATE PATIENTS:

ASSESSING THE EFFECTS OF TERMINATION ON HEALTH DISPARITIES, THE BENEFITS OF CULTURAL COMPETENCY, AND VIABLE SOLUTIONS

A Thesis

Presented to

The Faculty of the Health Law & Policy Institute

of the University of Houston Law Center

and

The Faculty of the Honors College

University of Houston

In Partial Fulfillment

of the Requirements for Senior Honors Thesis

and the Degree of

Bachelors of Science

By

Peter D. Vu

April, 2017

WHEN PHYSICIANS TERMINATE PATIENTS:

ASSESSING THE EFFECTS OF TERMINATION ON HEALTH DISPARITIES, THE BENEFITS OF CULTURAL COMPETENCY, AND VIABLE SOLUTIONS

_____

Peter Vu

APPROVED:

_____

Jessica L. Roberts, J.D.

Director, Health Law & Policy Institute

_____

Jessica Mantel, J.D.

Co-Director, Health Law & Policy Institute

_____

Helen Valier, Ph.D

Director, Medicine & Society

_____

William Monroe, Ph.D.

Dean, The Honors College

Abstract

Despite efforts to curb health disparities within the United States, the inequalities remain. Consequently, this thesis aims to reduce health disparities by examining patient termination due to a lack of cultural competency within a vaccination framework. This thesis begins by reviewing health disparities and the role of termination within medical care. That section is followed by a discussion of the barriers to cultural competency as a reason for termination using vaccination as a case study. Next, the thesis analyzes the benefits of cultural competency. It concludes with viable solutions and examples to improve health and health care within the United States.

Table of Contents

Introduction

In recent years, there has been a shift in the demographic of the United States toward a minority-majority population (Keating). This shift comes with an equally varied image of health in America. Current literature and substantial research shows health outcomes in the United States are unequally distributed. A report by the Center for American Progress reveals an increasing risk of obesity, diabetes, asthma, and mortality for African Americans, Hispanics, Pacific Islanders, and Native Americans as compared to Asian Americans and Non-Hispanic Whites (Russell). Smoking and alcoholism were also prevalent issues across the board. Additionally, the Center reports the leading causes of death among African Americans and Hispanics as heart disease, cancer, and stroke. Asian Americans and Non-Hispanic Whites were consistently healthier (Russell). Other entities have made similar findings (National Center for Health Statistics (NCHS), The Commonwealth Fund (Mead), and the Centers for Disease Control and Prevention (Meyer)). The prevalence of these disparities is a huge blemish in the United States' health care and in the overall health status of Americans.

Thus, eliminating these disparities is a major goal of the national health agenda set by Congress in the Healthy People 2010 Initiative. As of the writing of this thesis, Healthy People 2020 is now the guiding instrument for the improvement of health in this country. The overarching goals of this initiative include "attaining high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieving health equity, eliminate disparities, and improve the health of all groups; creating social and physical environments that promote good health for all; and promoting quality of life, healthy development, and healthy behaviors across all life stages" (Healthy People 2020,

2010). By eliminating health disparities, we could achieve health equity, subsequently improving health, health care, and quality of life for Americans. Therefore, eliminating health disparities is an important goal.

Despite the increasing public health attention and research on health disparities, there has been little consensus regarding the specific factors that create and maintain them. A search of literature on health disparities shows exponential growth in investment in this field (Brondolo). A midcourse review by Healthy People 2020, however, found limited systematic changes for health disparities related to ethnicity, race, or socioeconomic status despite the increase in research and literature (Healthy People 2020). I argue that health disparities result in part from patient termination due to a lack of cultural competency.

This thesis systematically reviews the literature pertaining to health disparities, physician-patient relationship termination, and cultural competency within medicine. No literature directly links health disparities to cultural competency and termination. Consequently, this method is best because it utilizes a realist synthesis approach, combining qualitative and quantitative research based on explanatory factors (Wong).

This thesis proceeds in three major discussion sections. Section I, in three subsections, introduces the relationship between health disparities, termination, and cultural competency. Subsection A examines health disparities and their relationship to termination. Subsection B builds from subsection A, studying how barriers to cultural competency leads to termination thus generating health disparities. Subsection C introduces vaccination as a case study. Section II analyzes the benefits of cultural competency and how it can influence health and health care while reducing termination

and, as a result, health disparities. Section III follows by introducing solutions to improve cultural competency, diminish termination, and reduce health disparities that result from patient termination. While other literature has examined and proposed a singular approach or aspect of health care to address cultural competency, this thesis will be the first, at the time of writing, to offer an inclusive, unified four-pronged approach to improving cultural competency and reducing health disparities and termination. By being inclusive, Section III provides solutions, including improving communication, cultural competency facilitation, shared decision-making, and medical school curriculum modification, that could improve both medicine and health care.

I. Health Disparities and the Role of Termination

A. Health Disparities and Termination

The relationship between patient and physician is built on the medical knowledge physicians possess, the confidentiality of the relationship, and the mutual trust and respect each party has for each other. Additionally, with a widening demographic within medicine, culture will increasingly influence how relationships in health care are maintained and practiced. Thus, this section will first introduce (and expound upon in later sections) the link between health disparities and termination due to a lack of cultural competency, then examine a physician's duties to patients, and follow with a discussion on the reasons for termination and its effects on patients and health care.

Even with these rules of the physician-patient relationship, termination does occur (Crozer-Keystone Health System). There are multiple reasons why physicians terminate, including for legal protection or because of noncompliance and nonadherence. Termination may result from barriers to communication and bias. Termination leaves

patients less informed about health care and less trusting of their physician (Betancourt), making communication more difficult than it already is (Healthy People 2020). Patients are also less likely to participate in health care and more likely to be nonadherent or noncompliant with future treatments (Chesanow). Physicians' implicit bias towards patients and their needs also leave patients receiving care not catered to their needs, thereby increasing the possibilities of nonadherence or noncompliance. Thus, health disparities may result from termination of the physician-patient relationship.

Cultural competency should help reduce health disparities by having physicians understand patients and their view points better. Using efficient communication and reducing implicit bias can provide patients with care better suited for their needs and lifestyle. This improves patient compliance and adherence to treatments and advice, reducing issues with health disparities and the subsequent need to terminate the physician-patient relationship. Thus, health disparities could result in part from patient termination due to a lack of cultural competency. Increasing cultural competency may improve a patient's outcome.

1. Physician Duties

The modern version of the Hippocratic Oath states physicians "remain a member of society, with special obligations to all my fellow human beings" (Johns Hopkins University). Upon agreement, these obligations begin when the physician-patient relationship forms and continues throughout treatment. An ethical and legal contract forms where the physician has the fiduciary duty to promote the patient's health for his or her benefit. However, the patient must uphold his or her side. Ethically, the physician commits to providing the utmost respect to the patient's welfare and best interests,

putting aside personal interests (American Medical Association (AMA)). Legally, the physician has an obligation to administer care competently, responsibly, respectfully, and compassionately. If, under any circumstances, the physician becomes lax in treating and caring for the patient, the physician becomes liable for medical malpractice (Snyder).

While physicians have duties to their patients, they can also legally terminate a physician-patient relationship. Terminating a patient requires physicians to follow a set of rules. For termination to occur, in the simplest of cases, physicians must notify the patient in certified writing that care will be terminated, giving the patient ample and reasonable time to secure new services. Once the patient secures a new physician or provider, the current physician should send the patient's medical records (including a medical record release form and the termination letter) to the new provider. From the initiation of termination, every interaction and transaction, or lack thereof, should be recorded (Crozer-Keystone Health System, Texas Medical Association (TMA)). Once termination occurs, any treatment or medical advice given after this period may reestablish the physician-patient relationship. Any subsequent termination must follow the same procedural steps. Sample letters have been compiled and can be found in the appendix.

Although the practice of terminating the physician-patient relationship is legal under most conditions there are a few exceptions. Physicians looking to terminate should delay for an acute care patient, especially if the physician is the only practitioner within a reasonable distance. This includes patients with certain diseases who have certain treatment plans. The same is true for patients who are pregnant, especially for those in their second and third trimesters. These guidelines allow physicians to walk the fine line between termination and abandonment (Shepard).

2. Reasons for Termination and its Effects

The impact of the physician-patient relationship is profound. Patients are vulnerable, trusting the physician to heal them. A healthy physician-patient relationship is paramount to improved health outcomes and reduced medical cost (Chipidza, Weiss). Termination results in the opposite effects, representing an unhealthy physician-patient relationship. Termination affects health disparities because it can result in patients' mistrust and disregard of physicians (Chipidza), leading to lower levels of patient satisfaction and compliance in future medical interactions. The decrease in satisfaction and compliance will diminish the quality of health care, potentially increasing health disparities. Thus, reasons for terminating the physician-patient relationship and its effects could shed light on health disparities.

To properly address health disparities that may result from termination, we must understand the situation. Medical associations have a common list of grounds for terminating the physician-patient relationship. Termination criteria includes: treatment nonadherence (reported 23.6% of the time) (the patient fails to follow treatment plans or chronically abuse themselves), follow-up nonadherence (63.4%) (the patient repeatedly fails to show or cancel follow ups and appointments), office policy nonadherence (2.4%) (the patient continuously visits other health care providers for prescriptions and refills against advice from the primary physician, are drug-seeking, or are dissatisfied with treatment or care provided), verbal abuse (10.6%) (the patient or guardian of the patient is rude to physician and office personnel, uses improper language, is difficult and disruptive or violent, threatens themselves or staff, is seductive, and overall noncompliant), nonpayment (the patient owes payment and refuses to work with the office to fix the

situation), and falsification of medical history (the patient purposely falsifies symptoms and history) (Beck, Lippman, Shepard, Santoso). These criteria pertain to noncompliant, nonadherent, and difficult patients.

With noncompliant, nonadherent, and difficult patients, a survey by *Consumer Report* in 2011 reported that the number one physician concern was that patients do not take their advice or follow their treatments (Chesanow). This lack of compliance greatly reduces the efficiency of physicians in promoting health. Complicating matters, physicians and patients may not share the same goal, patients may not fully trust the physician's advice (and may relate more to medical knowledge from unreliable sources), regimens may be too complicated or are unsuccessfully explained, or care may be fragmented and difficult (Chesanow). These factors reduce the quality of care that patients can receive and increase the prevalence of health disparities, especially in minority patients. Termination of these noncompliant, nonadherent, and difficult patients could potentially leave many individuals without proper or sufficient health care, perpetuating health disparities.

Physicians also terminate patients for legal reasons. If the patient has not taken steps to improve his or her health after countless interventions by the physician, the physician does have grounds to terminate the relationship (Texas Medical Association). Physicians do not want to be labeled negligent. A physician is negligent if the physician fails in his or her duty to the patient, or if the physician has violated the professional code of ethics set by his or her regulatory body (Halperin). While patient negligence would beat a professional liability action (Eoff v Hal and Charlie Peterson Foundation),

physicians would rather protect themselves from litigation and damages. Thus, physicians may terminate the physician-patient relationship to avoid legal action.

B. Barriers to Cultural Competency as a Reason for Termination

The increasing racial, ethnic, and socioeconomic demographic shift of the United States calls for a health care system of providers equipped to approach patients' beliefs and their understanding of health. Failing to address this issue will deepen disparities within health care for minority groups (Betancourt). The population of the United States cannot be divided among specific health lines; the variation between and within cultures and subcultures could potentially influence treatment and care. Although many aspects of human physiology are similar across cultures, there is a large enough difference in cultural influences on health to require an increase in cultural competency for minority groups. Similar symptoms among patients do not warrant similar treatment plans; different patients do not always fit the same treatments. Current health care methodology and practices have been slowly moving away from a one-size-fits-all approach to treating patients. To respond to the increasing disparities, the field of medicine should increase cultural competency. This subsection defines and explains cultural competency and assesses the barriers to cultural competency.

1. Definition

While there is no universal definition of *cultural competency*, this section defines cultural competency as used in this thesis and explains the reason for using this definition. Some have defined cultural competency as a method to "balance quality, improve equity, and reduce disparities by specifically improving care for people of color and other disadvantaged populations" (Saha). Others have defined cultural competency as

the ability of health care "to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter" (Johnson, R.). The common ground between differing definitions requires that health care professionals comprehend their own culture, from their ethnic culture to their professional culture, so that they can relate and adjust accordingly to a patient's culture (USDHHS). This thesis defines cultural competency as the ability of a health care system to provide proper and tailored care to patients from a wide range of cultural, social, and ethnic needs, including, but not limited to, values, beliefs, and behaviors regarding health (Betancourt). Culture is a collective pattern of learned beliefs and behaviors, such as thoughts, values, customs, communications, interactions, roles, relationships, and practices of a group. A *group* is defined and influenced by ethnicity, gender, socioeconomic status, occupation, nationality, physical and mental ability, etc. (Lenhoff, Robins).

This definition of culture is intentionally broad. A group of people cannot just be defined by ethnicity, race, or nationality alone. Culture is beyond physical attributes. It encompasses psychological, social, and personal attributes as well. Cultural competency reflects a movement away from one-size-fits-all medicine; it represents the possession of cultural knowledge, respect for cultural differences, and the ability to utilize skills efficiently and effectively in cross-cultural situations. Equivalently, it has shown improvements in understanding and treating culturally and linguistically different patients by reducing organizational, structural, and clinical barriers that may impede care (Betancourt, USDHHS). It also institutionalizes appropriate practices for an increasingly shifting demographic (Brach).

2. Barriers to Cultural Competency

Patients and physicians experience significant barriers to cultural competency. This section aims to understand those barriers. While this thesis does not discuss all barriers to cultural competency, it does identify two key barriers: communication and implicit bias. By addressing these barriers, the potential to improve cultural competency and reduce health disparities significantly increases.

a. Communication Barriers

The act of communication, both verbal and nonverbal, is a key pillar in developing and maintaining a physician-patient relationship. In an extremely diverse population, clear and effective communication can be slightly strained and lacking; the differences in culture cannot be downplayed. Barriers relate to building rapport, language, and sociocultural differences.

When physicians feel unable to build rapport with minority-culture patients through lack of proper training, language barriers, or communication issues, it influences the quality of physician-patient communication (Betancourt, Weissman). Physicians have reported diminishing effectiveness in providing care for minority culture patients as compared to providing care for majority-culture patients (Ferguson, Schouten). Unfamiliarity places physicians in a role of uncertainty. In familiar cases, similar factors and symptoms may warrant similar treatments, prescriptions, and medical advice. A patient that does not follow this mold requires different treatments, prescriptions, and medical advice unfamiliar to the physician. Minority status may also play a part. Minority culture patients may be less verbal and assertive in a medical setting than their majority culture counterparts (Schouten). This is due to many minority cultures placing physicians

on a pedestal, taking the physician's words and treatments at face value without any significant input. Physician unfamiliarity and patient passivity leaves both sides of the physician-patient relationship confused on how to properly initiate a relationship. On one hand, the minority culture patient may take a passive role, relaying only the most basic of symptoms and issues and taking the physician's orders at face value without raising concerns that could affect how they handle the treatment. On the other hand, physicians treating minority patients may not be sure how direct or interactive they can be with their patient, affecting how they provide treatment. In either case, this barrier to cultural competency only serves to increase the risks and health disparities for minority cultures.

Language also affects health care outcomes. Language can constitute a barrier because culture encompasses language as its vehicle of expression. Without an understanding of language, or the ability to understand (through interpreters), physicians can be at a loss. Language is especially vital in today's medical field with 27% of patients requiring an interpreter (Zabar). Differences in language may lead to miscommunication and adverse effects because of misunderstandings, frustration, and incapability of shared decision-making (Levin, Krauss-Mars, August, Cave). Logically, understanding the patient's concerns through proper use of language or interpreters, eliciting a patient's health beliefs, and being aware and understanding of cultural barriers is a vital part of a visit (Zabar). Doing so opens the patient's trust and comfort in the physician, leading to higher levels of compliance and health outcomes. From there, communication that involves explanations (through pictures or interpreters), listening, avoiding medical jargon, repeating patient concerns, and checking comprehension (Jensen, Levinson, Harmsen) often lead to higher levels of patient comprehension and improved overall care.

The importance of good physician communication skills should not be undersold (August, Wiking, Fernandez, Hooper). Being able to communicate well and understanding culture competently through communicating could improve health care outcomes across ethnicities. This will only decrease misunderstanding, noncompliance, and diminishing health within minority cultures.

Differing sociocultural viewpoints of illness and disease also create communication breakdown. Misunderstandings are common between individuals who do not share the same religion, norms, and values (Dyregrov, Gerlach, Harmsen, Butow, Suurmond, Villagran). A physician-patient relationship would already be unstable at its initiation if differing cultural viewpoints and understandings exist. The simplest way to resolve that issue is to find common ground and build a relationship from there. Multiple reports state cultural competency and mutual understanding within patient-centered care are important objectives (Cave, Gerlach, Kleinman, Wiking, Harmsen). Moreover, understanding the current health care system, making appointments, or visiting specialized doctors for specific ailments, can be the opposite of a patient-friendly process. Lack of knowledge leads to unsatisfactory communication outcomes and frustration, possibly resulting in misunderstanding and unintentional noncompliance (Cave, Dyregrov, Gerlach, Brugge, Wiking, Suurmond, Villagran, Rosenberg). Recognizing these shortfalls would reduce miscommunications, improve comprehension and compliance, and reduce health disparities.

Physicians should also look to understand that their medical culture, often infused with their own cultural values and beliefs, differs from their patients. For instance, many minority cultures value physicians who also communicate issues and concerns with

family members because many minority culture patients view familial support as important in fighting illness and disease (Cave). However, physicians rarely recognize the value placed on familial communication (Ali). Patients who do not understand the cultural needs of the physician could end up becoming noncompliant and unresponsive to treatment. Physicians who do not understand the cultural needs of the patient may end up with poorly defined treatment plans and execution. This results in diminishing returns on health care outcomes, increasing noncompliance, misunderstandings, and perpetuated health care disparities.

b. Implicit Bias

Bias is another barrier to cultural competency. The values one person holds within his or her private life can easily seep into their professional life and influence their decisions. The same applies to physicians. This subsection will first define bias, followed by a discussion on bias, the effects of bias within medicine, and an examination of stress's influences on bias.

Bias is the negative evaluation of another group, either explicitly or implicitly (Blair). Explicit bias occurs when an individual actively evaluates a group. Implicit bias is unconscious, unaware, and unintentional attitudes or stereotypes that influence and affect an individual's perceptions and decisions, favorable and unfavorable (Staats, Rudman). Implicit bias is an issue because stereotypes, attitudes, and prejudices are difficult to change once ingrained within our unconsciousness. It is more difficult to change when biases are often reinforced and evidence against stereotypes, attitudes, and prejudices are disregarded over time (The Joint Commission (TJC), Gregg). Implicit bias affects the physician's ability to relate to the patient beyond assumptions of the patient

and the patient's culture. Implicit bias could then increase the negative impacts on individual health and health disparities because physicians are less likely to use different solutions to treat patients that fit certain cultures and symptoms.

When given the Implicit Association Test (IAT), many physicians exhibited significant pro-white bias (Green). However, this issue goes beyond race and ethnicity. Studies have recorded bias against other cultures, such as cultures based on health issues. One example includes obesity where obese people were labeled with culturally negative stereotypes ("bad," "stupid," "lazy," "worthless") (Greenwald, Chapman). Other studies considered gender bias where women are often culturally slighted with treatment options compared to men with similar issues (such as knee arthroplasty surgery or hip surgery) because men are stereotypically seen as more likely to utilize these parts of their bodies for activity (Hawker). Implicit bias also targets gender, socioeconomic status, education level, etc. Implicit biases can overtly influence how a physician diagnoses and acts with patients, subsequently affecting how patients perceive their provider's actions and how patients behave and decide on their treatment and overall health care (Ryn, Institute of Medicine (IOM), Chapman).

Stressful conditions, such as time pressure and uncertainty, can perpetuate implicit bias because it allows physicians to be more efficient during inpatient care (Chapman, Tversky, Croskerry). Physicians are trained with information that generalizes about populations. In one study of cognitive and external stressors and their effects on implicit bias, the high risk and demand physicians often experience diminishes high-quality and impartial care (Johnson, T.). These stressors leave physicians relying on heuristics, which include bias and stereotyping, to make quick decisions (Croskerry,

Burgess). Under these stressful conditions, physicians may still implicitly link compliance and preference with white individuals, overtly affecting patient care (Sabin). While implicit bias cannot be entirely removed from the physician-patient relationship, acknowledging it and its effects, even under stressful conditions, can improve treatment and patient compliance while reducing health disparities. If implicit bias is not acknowledged, it will continue to impact health disparities.

C. Vaccination as a Case Study

Health disparities encompasses a broad term within the United States' medical agenda. While the United States has progressed the improvement of health, health disparities, economic, racial, ethnic, and social influences, among others, still affect distributions of health. The case of vaccination is similar. This section begins by addressing vaccine disparities and termination because of these disparities, followed by an introduction of anti-vaxxers and other unvaccinated populations. The subsequent subsections discuss vaccine disparities within the barriers of cultural competency and termination because of these disparities.

While the Vaccines for Children (VFC) program has significantly improved immunity, disparities remain (National Adult and Influenza Immunization Summit (NAIIS)). The same issue arises for adults, with disparities for adult immunization persisting, if not widening (NAIIS). Adult immunization consistently miss current immunization targets by Healthy People 2020, with even a larger disparity for minority groups (Lu). Studies by the National Immunization Survey (NIS) have shown immunization gaps to be wider between non-Hispanic Whites and both Hispanics and non-Hispanic Blacks while gaps between non-Hispanic Whites and Asians narrow

(Barker, Chu). What has been said for general health disparities can be said within the context of vaccines. These vaccine disparities go beyond racial and ethnic differences, influenced by also other aspects of culture, such as socioeconomic elements, education, attitudes, gender, sex, and inclination toward health care and vaccination, and care received (Lu). As such, vaccination disparity offers a useful case study.

The current coverage of the anti-vaxxer movement would suggest that the movement is highly influential in the current vaccination disparities. Although this movement has been vocal about reducing, limiting, or removing vaccinations from their children's health care, there are other cultural aspects to consider. As defined in section B, culture is a broad collective in characterizing an individual's understanding of the world. Therefore, other aspects of an individual's life also affect how health care is perceived and practiced, including within a vaccination context.

In using vaccination as a case study, this thesis will delve deeper into understanding cultural competency and how it can help reduce health disparities and termination. The case study will look to the hypothetical and potential effects of cultural competency rather than a definite claim of its effects on health disparities and termination. While the discussions in this section can apply to adult vaccination disparities, the primary focus will be on children vaccination. The following subsections discuss how the barriers to cultural competency affect vaccine disparities and the role of termination.

1. Vaccinations as Influenced by Vaccine Disparities and Termination

Termination can occur in any aspect of medicine, including vaccination. Failing to immunize children could be, controversially, defined as noncompliance, nonadherence,

and difficult in the eyes of the American Academy of Pediatrics (AAP) and physicians overall (Diekema). These noncompliant patients include anti-vaxxers and unvaccinated patients alike. The AAP has been fully supportive of universal immunization and strongly advises parents to opt in (Diekema). Childhood immunization and protection has slowed and reversed progress in some cases, however, with this rise of the anti-vaccine movement and reports of unvaccinated individuals (Wolfe). Interestingly, it has only been recently that physicians and practices have been terminating the physician-patient relationship for failing to vaccinate (Nulty).

According to a study on parental refusal of vaccinations, 39% of pediatricians would terminate a physician-patient relationship if a patient refused all vaccines and another 28% would terminate a physician-patient relation if the patient refused selected vaccines (Flanagan-Kylgis). These numbers indicate termination that occurs even after physicians attempt to educate patients on the importance and necessity of vaccination (Diekema). In many vaccination cases, physicians must consider: 1) whether the parents' decisions constitute medical neglect and should be reported, 2) whether parental decisions put other individuals at risk enough to justify intervention, and 3) how to respond accordingly to parents who refuse vaccination (Diekema). For these reasons alone, many physicians may look to terminate a physician-patient on the grounds of noncompliance, nonadherence, and difficulty in the context of vaccination.

Low vaccination rates can lead to health issues and disparities that leave physicians liable for preventable issues (Halperin). Additionally, the delay and lack of vaccination has been linked to patient neglecting vaccinations (Bakir). Several factors affect whether the parents' decisions will place their children in situations where they can

be harmed and reflect medical neglect. These factors include the probability of contracting the disease, the consequences of morbidity or mortality, and the prevalence of disease within the community (Diekema). While physicians can educate patients on the value and necessity of vaccination, patients can still refuse vaccines for their children. Consequently, practices have now provided refusal-to-vaccinate forms created by the AAP for parents to properly defer vaccines (Diekema, Nulty). The forms protect physicians from liability and negligence lawsuits.

Despite support from the CDC and AAP for universal immunization, termination should not be the primary action if a family refuses or defers immunization. Physicians play a vital role in public health by education and information. Differences of opinion and subsequent termination undermine their role. If anything, termination can lead to more division, no communication with the family in question, and greater risk for the public's health (Healy). While termination of the physician-patient relationship does occur, physicians should reconsider termination of patients if they are noncompliant, nonadherent, or difficult towards vaccinations. Not everything in health care, especially for vaccination disparities, can be taken at face value; patient concerns may differ from physician concerns.

2. Vaccinations as Influenced by Communication Barriers

The uncertainty physicians may face when dealing with unvaccinated or anti-vaccination patients warrants a discussion on communication. The failure to vaccinate may come from differences in the language spoken, especially by a minority culture. English can be hard to translate, especially if English is spoken figuratively. For example, an English-speaking child may translate an idiom, such as "let the cat out of the bag," as

literally letting the cat out of the bag. Likewise, a message of vaccination from the child's parents can accidently be translated to a message of anti-vaccination or incorrectly translate vaccination schedules, leading to patient frustration and continued disparities. Failing to understand complex medications (i.e. type of vaccinations and their effects) and regimes (amount of vaccines and when to get them) are reasons for patients to ignore physicians and vaccination schedules (Jimmy et. al.). From the patient's side, maybe the child poorly translates the family's concerns, wishes, cultural beliefs, and socioeconomic issues, leading to inadequate information for the physician to consider before treatment. Most nonconformity from medical standards comes from the omission of certain orders (or vaccines) (Jimmy). Additionally, some patients may not be versed in the workings of the health care system. The same is plausible for the uses and effects of vaccinations. Maybe the family does not understand the properties of vaccination or how vaccination works. Maybe physicians are not clear in communicating the effects of and reasons for the specific vaccine (Bakir). Studies have shown that 40-60% of all patients were unable to recount their physician's orders and information 10-80 minutes after given that information (Meichenbaum, Ley). Attempts to educate the family without proper communication could result in a difficult transfer of information and retention.

Dealing with anti-vaxxers also requires open and proper lines of communication. Although the reasons for anti-vaccination may vary among individuals within the movement, attempts to understand their stance and to implement educational dialogue can also assist in reducing health disparities. Whatever the case, the effects of inadequate communication can lead to noncompliance and nonadherence to vaccination schedules, resulting in perpetuated vaccine disparities.

3. Vaccinations as Influenced by Implicit Bias

As suggested by The Joint Commission, understanding a patient's culture and treating them as individuals can help a physician differentiate and respect the differences that can occur through implicit biases, leading to improved health care (TJC). Consider the case of a recently immigrated first-generation minority family consisting of two working parents with less than a high school education speaking broken English. After some time in America, the family finally comes into a majority culture physician's office for an emergency, and the physician notices the family does not have a complete vaccine schedule for their children or themselves. The physician may blame the immigrants for ignoring public health decrees, intentionally opting out of vaccinations, or being part of the anti-vaccination movement. Looking beyond the implicit bias that the physician resorted to, there are possible reasons for the family's disregard. First, consider the parent's broken English. As discussed in earlier sections, this language barrier could result in children having to translate conversations for their parents and, in some cases, have literal translations when figurative language is used. What if the children cannot translate? This leaves the parents as the primary communicators. With broken English, the patient's comprehension and discussion of issues and concerns is limited. Considering the level of education of the parents, maybe they are just not aware of the importance and value of vaccinations, potentially even fearing vaccinations. It is possible that this family came from a country that does not place as high a value on vaccination as the United States does and their lifestyle reflects that culture. What they know of vaccination and medicine is potentially limited, especially with the education they have. It is also possible

that with such education levels they are easily swayed by incorrect sources of medical information, leading to higher rates of unvaccinated family members. Studies have connected the lack of knowledge of immunization schedules and misinterpretations of vaccination effects to vaccine disparities, especially in minority cultures (Larson). Combine that with the inefficient communication, and the rates of vaccination disparities increases. What about beyond communication and education? What if the family is not intentionally disregarding vaccination but instead does not have the resources to get vaccinations? First, the family visited this physician because of an emergency after a long period. It is plausible that the family does not regularly see the physician, especially for things like vaccines (which require regular visits), limiting their exposure to only emergencies. The possibilities behind that can vary, especially socioeconomically. For one, both parents work and the possibility of taking off work to get their children or themselves vaccinated is slim, especially when taking off work may mean choosing between rent, utilities, and food. Maybe this family cannot receive vaccinations because their jobs do not offer insurance coverage for vaccination, or maybe they lack insurance in the first place. Maybe this family just cannot afford to vaccinate over keeping the family housed, clothed, and fed.

Anti-vaxxers, on the other hand, may not have the same cultural issues as this hypothetical family. In their case, their culture of disregarding vaccines comes more from issues with education on vaccines, not being convinced of the importance and effects of vaccines, fear of the adverse effects of vaccines, upholding religious and cultural beliefs, or complex and multiple exposures to vaccines (Jimmy et. al). Physicians should still look to have common ground and avenues to speak from for both kinds of patients who

are not vaccinated. Whatever the case, it is more likely that minority families lack vaccinations for other cultural issues than for intentionally disregarding vaccines, as some would suspect.

***

Health disparities could result in part from patient termination due to a lack of cultural competency. Two key barriers to cultural competency are communication barriers and implicit bias. Vaccination offers a useful case study.

II. Benefits of Cultural Competency

Health care experts swear by the beneficial relationship between cultural competency and its positive effects on quality of care and eliminating disparities (Betancourt). The value placed on cultural competency has led to a call for integrating cultural competency into medical education, systemic practices, and clinical methodology (Betancourt). There is a lack of literature explicitly connecting cultural competency and health disparities. This section argues that cultural competency can reduce health disparities. It discusses the parallels between race-concordant physician-patient relationships (where physicians and patients share the same race) and culturally-sensitive physician-patient relationships, language, and patient outcomes.

Illness itself and how it is understood, experienced, explained, and treated is culturally dependent (Kleinman). Thus, cultural competency is appealing because it can influence how patients react to diagnoses, manage emotions, and negotiate treatments (Descours). That interpersonal relationship that arises from two parties understanding each other's values and beliefs provides substantial ground of being one a major component of a patient's health care (Manning-Walsh). By being able to build that

cultural connection, patients and physicians can share information and knowledge, determine a diagnosis, develop the necessary treatment plan, and provide resources to execute that plan together (Beach). Misunderstandings can occur because of varying beliefs, values, and viewpoints of illness in the physician-patient relationship. Understandably, differences in culture can explain difficulties in a physician-patient relationship and the communication that occurs within that relationship. Simply, cultural competency can influence a patient's compliance to treatment and care.

Additionally, cultural competency advocates a patient-centered care model. Patient-centered care provides patients with an active role in consultations, discussions, and shared decision-making. Differing cultures can be melded together through shared-decision making, allowing for care and cultural competency to be elevated (Descours). Patient-centered care facilitates communication and allows understanding from both parties, improving rapport and health outcomes. Patient-centered communication is equally important in dealing with differing cultural beliefs on illness and disease because it needs physicians and patients to act together on shared decisions. Having an open attitude, empathy (Hooper, Meeuwesen, Seijo, Shapiro), trust (Ge), and respect also provides leaps and bounds in communication and comprehension of differing cultures. At the same time, patient-centered care allows physicians to understand the patient's cultural viewpoints, beliefs, and values to reach a solution and plan for treatment (Descours). In many cases, patient-centered care is successful when physicians see patients as equal partners in maintaining patient health and building stronger and healthier relationships (Epstein). Finding common ground through shared decisions allow physicians and patients to develop understanding and improve healing and health care (Epstein, Engel).

The more a patient understands the choices and treatments suggested and has the power to implement those treatments through shared decisions, the greater the chance of patient compliance and treatment retention. In the case of cultural competency, by framing comprehension and action within the patient's culture and beliefs, patients are more likely to comply with treatments, reducing health disparities.

Another aspect to cultural competency is the role of physicians in minority cultures and how they interact within their culture. Many studies have shown that patients within a minority group prefer to consult physicians from within the same minority group. Race-concordant physician-patient relationships allow understanding between physicians and patients. Additionally, the case for a culturally competent medical force has been consistently compared to a race-concordant physician-patient relationship (where both physician and patient are the same race), especially with the higher ratings of patient participation and overall rating of care (Cooper, Komaromy). As such, if health care can consistently improve interactions with patients, it is possible to improve the health care provided.

However, very little literature reports on the number of these minority physicians and whether they focus caregiving to those within their own communities (Komaromy). A study by Dr. Miriam Komaromy examined the role of minority physicians within their communities, particularly the role of African American and Hispanic physicians. The study showed a huge disparity in care for minorities. Black physicians, in communities that were controlled for racial and ethnic makeup, cared for 25% more black patients than other doctors. In similarly controlled environments, Hispanic physicians cared for 21% more Hispanic patients than other physicians. We must consider the number of minority

physicians and race concordant visits. Countless studies have shown that the physician workforce is lacking diversity (Betancourt, Komaromy, Wear). Thus, with the current number of physicians and the amount of minority patients requiring care, having a workforce that is competent in cultural differences, regardless if a physician is the same ethnicity or cultural practice as the patient, would improve patient access to competent care. Increasing the number of culturally competent physicians would correspondingly increase the number of doctors that could effectively treat minority patients, increase patient turnout rates, and reduce health disparities that plague these minority cultures.

Improving quality of care is always a goal of health care. One way to improve care through cultural competency is to extend physician language abilities outside of their own language. The benefit of being able to be culturally competent to the point of understanding and speaking another language is momentous. Greater fluency of a language is strongly associated with higher ratings of care and patient health improvements and satisfaction (Fernandez). The use of language allows for clearer communication and understanding for physicians to diagnose and communicate instructions and for patients to relay symptoms and communicate concerns. Even having some common phrases of greetings and basic conversation starters in a patient's mother tongue provides patients a greater sense of ease and comfort (Brugge, O' Leary). This sense of ease facilitates trust and respect between physician and patients, improving patient compliance and comprehension of health care and health, ultimately reducing health disparities.

Understanding language can also reduce cultural assumptions and expectations that may arise as barriers to those who do not speak the language. Studies have shown a

lack of language proficiency between either party leaves patients with lower ratings and satisfaction of care (Baker). By being able to communicate effectively, quality of care improves significantly. Because culture also includes language, cultural competency should enable increased dialogue between physicians and patients. These dialogues can put physicians and patients on common ground and provide clear avenues of discussions. Comprehensible communication between increasingly diverse cultures, whether ethnic or professional, is key in maintaining effective health care. Without proper communication, cultural competency would not be achievable, much less effective. The benefit of culturally competent communication would improve health care across-the-board. Effective cross-cultural communication provides positive energy toward emotional and physical health, reducing anxiety and pain (Stewart). By improving communication through cultural competencies, we can improve health care and reduce disparities.

If health experts swear by the impact of cultural competency on health disparities (Betancourt), the same consequences should be visible for disparities in vaccination. Concordant relationships influence community vaccination, with parents who visit community health centers more likely to vaccinate their children (69 vs. 20%) than parents who visit hospitals (Bakir). Patients who visit community health centers may be treated by physicians who understand the family's issues, may prefer being near the community for comfort (for access to translator and family), or may require more financial assistance in treatments (including vaccines) provided by the center. Patients who visit hospitals may be treated by a diverse physician population that cannot easily relate to patient concerns, may not have a community to turn to for health issues, or have turned to the hospital as a last resort. This difference suggests that culturally sensitive

and relevant education and relationship plays a huge role in vaccination (Bakir). A family who connects to a physician who understands the family's culture, values, socioeconomic issues, and comprehension of medicine is more likely to adhere to vaccination advice than a family whose culture and beliefs are disregarded. Physicians often facilitate discussions on vaccinations with studies showing vaccination coverage highly associated with physician recommendations (Lu). Therefore, having a physician who acts on behalf of the patient, as opposed to a physician who acts on behalf of medical agendas alone, speaks volume to the patient. A shared language allows physicians and patients to express concerns and advice in the same manner, resulting in better retention of information. Vaccination is no different. What if the same family speaks English as a second language and relies on a child or broken English to translate. Along those lines, this family is bound to mistranslate or misunderstand instruction and advice. The family may translate the message that a vaccine is not needed right now to mean it is not necessary ever. Or maybe the family is trying to explain why they want a certain vaccine or opt out of a certain vaccine until a later time but instead receive the opposite results, infringing on patient autonomy. The act of shared communication can reduce such issues and improve upon vaccine disparities. Additionally, studies on the healthy immigrant effect (immigrants are more likely to be healthier than their native population) have shown that these families, especially if recently immigrated, are often healthier and more conscious in maintain their health (Kennedy). Collectively, framing comprehension and knowledge of cultural differences and communication within this case in a patient's culture allows for increased compliance and adherence to vaccinations and vaccine schedules on common grounds, reducing vaccine disparities.

***

Cultural competency advocates patient-centered care to provide patients an active role in the physician-patient relationship. The ratings of patient participation and patient care from cultural competency is comparable to the high ratings seen in race-concordant physician-patient relationships. Cultural competency can also extend physician language abilities, resulting in higher quality of care.

III. Solutions

While many physicians would consider patient termination as a last resort issue, termination occurs for a several reasons, including a lack of cultural competency, which reduces patient exposure to medical advice. How can physicians and others in the medical profession reduce termination and improve medical care? Earlier sections described the benefits and consequences of cultural competency, especially in the efforts to reduce and eliminate disparities in health care. These efforts still need to pinpoint effective strategies and methods to increase cultural competency. Legislators have asked what policies to implement. Administrators have asked what changes to managed health care organizations and hospitals to make. Academicians have asked whether to alter the medical school curriculum. Providers have asked what practices to adopt. Every single aspect of medicine is asking. The next step is to figure out the answer.

This section will first examine improvements in communication followed by a discussion on improved facilitations. It explores increasing shared decision-making third. Rounding out the four-pronged approach is the modification of medical school curriculum. Each subsection will end by applying its solution to vaccination. This approach provides the medical field with multiple avenues to address cultural

competency, reduce health disparities (especially for minority cultures), and minimize termination.

A. Improve Communication

Communication is a broad term describing the transfer of information, including methods of expression that go beyond conversations. This section explains communication improvement within medicine through use of narratives and basic strategies to improve and enhance the physician-patient relationship.

1. Narratives

One way to effectively improve communication and empower patients in both majority and minority populations is through storytelling narratives (Murphy). Narratives are patient's unique stories and expressions, filled with implicit and explicit messages used to understand events, relationships, locations, and experiences (Goddu). Narratives allow novel information to be processed by individuals (Hinyard, Rappaport), especially for those who often have lower health literacy (Kreuter), because it allows individuals to explain medical information in their own words. They are then more likely to understand and comply with treatments. Narratives also develop trust and rapport (Williams, L.); patients can be vulnerable with physicians, allowing physicians an opportunity to see into the patient's life, understand the patient's concerns, and implement treatments accordingly. Narratives are not limited to patient storytelling alone; narratives also include patient's expressions through acting, role-playing, performances, testimonials, television, film, books, essays, memoirs, dance, and music (Goddu).

Minority patients have used narrative story-telling to empower themselves throughout diabetes treatment and regimen and to improve self-care and shared decision-

making between physicians and patients (Goddu). Current literature reports significant diabetes intervention improvements in minority communities such as the Hispanic community with novellas (Millan-Ferro) and the African-American community through story telling (Peek). Narratives improve self-care because they create an environment where diabetes patients can learn information and practices, explore regimen and schedules, build rapport with other individuals experiencing similar health issues, and communicate with their physicians (Goddu). Other minority cultures are expected to have similar improvements with other symptoms and medical issues.

Narratives allow patients to interact at the sociocultural level and result in a more culturally representative understanding of an individual's health and his or her role in health care (Larkey). Without narratives patients may resist instructions and messages. Narrative approaches incorporate patient's stories, promoting similarities within the narrative and the patient's actual experiences. This connection leads to empathy and relatability between the narrative and the patient, promoting the patient's willingness to learn and adopt treatments (Goddu). Because patients are able to tell their story and their perspective, the use of narratives can reduce health disparities by improving cultural competency between physicians and patients, minimizing termination.

2. Strategies to Improve Communication

Of different strategies that can be used to improve communication and enhance the physician-patient relationship, proxemics provides an up-close approach. Proxemics is a method of communication that relies on fully active face-to-face communication. It is an effective tool for the physician to maintain active communication and to gauge the patient for any reaction to a diagnosis or treatment (Descours). It is difficult to imagine

giving health-related information over the phone and needing to gauge the patient for further explanation. Thus, face-to-face communication allows the physician to know if further elaboration or reassurance is needed, shaping the consultation to the patient. As earlier sections have shown, more responsive communication can improve the patient's quality of care. This sort of communication promotes active listening and, in turn, active communication, making sure both parties are on the same page. Proxemics ensures the patient that the physician is actually paying attention to any concerns he or she may have. By showing investment in the patient's health and actively offering comprehensible treatment plans, patient noncompliance substantially decreases, leaving less room for termination to occur and more room for health care improvement (Descours).

Studies have also suggested that active, effective communication not only improves a physician-patient relationship but also improves the emotional health of a patient, symptom resolution, functional and physiological status, and pain control (Stewart). Physicians should also ask questions that range beyond the information that the patient initially provided. These questions include the physical aspects of any health issues, feelings and concerns, comprehension issues, expectations and perceptions of treatment and side effects, and any other issue the patient may have. Again, active participation between both physician and patient is key. It makes patients feel as if their care is the utmost importance to the physician and that the physician understands their problem.

Connection is another strategy that improves the physician-patient relationship (Descours). Establishing rapport, providing support, and encouraging health all make patients feel better connected to physicians. Physicians achieve connection by relating to

the patient through non-medical issues such as sports, music, pop culture, etc. These sorts of attempts to connect with the patient demonstrate to patients a sense of care and humanity. Shared connections show patients that physicians are actively investing into the patient's health. Connection also leads to partnership-building, allowing patients to serve their role in this physician-patient team in working towards a common goal (TJC). As a result, patients feel more obligated to maintain their health, listen to their physicians, and follow through on regimens (Descours). Thus, connection between physicians and patients reduces the potential of noncompliance, nonadherence, and difficulty on the patient's behalf.

The physician-patient relationship is about building and maintaining trust (Descours). Transparency also improves a physician-patient relationship because trust, honesty, and consent all contribute to the patient's willingness to work with the physician. A transparent relationship allows patients to understand their health in detail. By providing all the issues and facts in a physician-patient relationship, physicians can frame health care in a way where patients feel empowered to control their own outcomes, increasing the potential of compliance and overall health care and decreasing the potential of termination. Asking patients to review what they know about their conditions or health issues is one way to improve transparency and to ensure that patients are comfortable speaking on issues. Consent also serves as a medium for patients to grasp control over their own health. The idea of transparency relates back to a united relationship; a trustworthy relationship allows for higher rates of compliance and health care involvement, reducing health disparities and the potential for termination.

Demonstrating empathy and emotions while increasing patient involvement also improves the physician-patient relationship. Seeing countless patients throughout a day can create a sense of cranking out patient after patient, but studies have shown the value of empathizing with each patient (Descours). By having empathy and emotions, physicians relate to patients and are authentic, bringing the patient into the relationship and medical encounter as an equal. In addition, the cognitive component of empathy and seeing an issue from the patient's perspective have been shown to reduce bias, stereotypes, and prejudice. Physician empathy also improves patient satisfaction, increases patient self-efficacy, decreases emotional distress, improves compliance, and, again, improves overall quality of health care that a patient receives (TJC). Physicians who are attuned with their emotions during patient interactions have stronger bonds with patients individually and socially (TJC).

The observations apply with equal force to vaccines. Narratives can improve the physician-patient relationship and empower patients where other mediums, such as fortune tellers, have dismissed their claims as unwarranted. Consider a minority culture family. As seen in earlier discussions, family narratives promote an understanding of their situation and environment, to themselves and to physicians. For many minority cultures, it is plausible that their comprehension of medicine, the cost of medicine, the exposure to medicine, and the access to medicine all play a part in the narratives of being unvaccinated. The same can be said for anti-vaxxers. Their narratives matter as well. Considering what anti-vaxxers have experienced would teach physicians how these families have been affected and would allow some sympathy and understanding. Narratives develop trust, comprehension of issues, and positive health changes that could

ultimately reduce health disparities resulting from lack of vaccination or anti-vaccination. Looking to improve the dialogue between physicians, the unvaccinated, and anti-vaxxers can only lead to better self-care by the patient, complemented by a patient-centered care approach. For the unvaccinated, it may just be a matter of exposure and access to vaccines. For anti-vaxxers, proxemics, connection, and transparency can open dialogue and relationship, especially where anti-vaxxer patients have do not trust the system and the effects of vaccination. In many cases, proxemics, connection, and transparency can only improve health care for these families by opening up avenues of conversations between physicians and patients that can guide these families towards vaccination for their family.

B. Improve Facilitation

The way the medical field operates at the organizational, systemic, and clinical levels influence the health care provided. While there are various recommendations for improving cultural competency, improving the facilitation of these operations require changes at the organizational, systemic, and clinical level.

Organizational cultural competency promotes qualified minorities in both advancements for positions in, and employments into, medicine (Betancourt). Programs should look to advance and to implement leadership programs for qualified, minority health care professionals because of the varied insight applicants may bring. Organizations can also recruit and hire minority health care personnel to promote the organizations' mission and standards (Betancourt). While these individuals are qualified experts, this strategy provides a force of minority professionals that can improve and influence academia, government, and private industry with an understanding of health

care for minority populations. The effects of these individuals on organizational cultural competency is like the effects of race-concordant physician-patient relationships: higher ratings of care and compliance to health care because patient beliefs are understood. The effects of a culturally-sensitive individual should provide similar improvements in health facilitation.

Systemic cultural competency improves health care's ability to monitor and improve quality of care by eliminating systematic and institutional barriers to health care (Betancourt). The goal of improving communication and improving systemic cultural competency is the same: to improve physician-patient communication. Systemic cultural competency differs from improving communication, however, by focusing on providing patients and physicians the ability to communicate, improving communication focuses on the physician-patient's actual communication. Systemic cultural competency requires medical interpreters ranging from on-site interpreters, off-site/remote telephones, or simultaneous interpretations. Health information must reflect the appropriate levels of health literacy by population. Personnel should understand language proficiency and cultural norms and signage, programs of health promotion/education and disease prevention, instructions, etc. (Betancourt). Researchers should also systematically identify tools that can detect medical errors that arise from a lack of cultural competency. These include systemic errors that are caused by language barriers, misunderstanding medical and health educational and instructional efforts, and misinterpreting the risks and benefits of any regimen or procedures. The push for systemic cultural competency requires data collection to maintain proper record. Interpreters that understand medicine and that can translate information for a patient expedite the process of health care. As

seen in earlier sections, communication leads to higher quality of care and compliance by patients. It also provides patients with a better relationship with another medical personnel, improving compliance and health results. The systematic collection of data provides the medical field with the ability to track and record issues that arise from lack of cultural competency. The subsequent use of this data allows health care professionals to examine, evaluate, and execute plans that can reduce lack of cultural competency, decrease health disparities, and minimize the potential of termination.

Clinical cultural competency targets professionals' abilities to notice and be aware of cultural differences of minority cultures and uses that information to best develop a regimen to promote recovery and a healthy patient (Betancourt). One strategy is implementing more cross-cultural training and professional development for personnel. These trainings should incorporate an increased awareness of minority health disparities, impact of minority culture on health decisions, development of strategies to address and assess minority culture health beliefs, and cross-cultural communication (Betancourt). At the baseline, health care providers should have a basic understanding of the different cultures of the community they serve and should avoid stereotyping. Health care providers should also recognize their implicit bias, use techniques to de-bias patient care, and practice evidenced-based medicine (Ryn). The effects of utilizing cultural competency in a clinical setting improves the physician-patient relationship, opening lines of communication that can ultimately improve a patient's rate of care. As discussed earlier, communication and cultural competency improves compliance and adherence, increasing quality of health care (especially for minority culture patients), reducing health disparities, and minimizing the potential of termination.

Another way to develop interventions to improve cultural competency is to understand implicit bias as a habit. Doing so allows physicians to become aware of their habits and, once aware, physicians can reduce their implicit bias (Green). Treating patients as individuals also lessen the impact of implicit bias and stereotypes. Specific information reduces the effects of implicit bias and stereotypes because it forces physicians to actively record patient information rather than relying on generalizations. Instead of giving each patient similar treatments and medications based on a set of shared symptoms, treating the patient as an individual allows medical care to be patient-specific, resulting in improved outcomes. Actively understanding implicit bias as a habit reduces noncompliance and nonadherence, minimizing the need for termination while promoting improvement of health care through cultural competency.

Improving cultural competency at the organizational, systemic, and clinical levels applies to vaccination too. In the case of unvaccinated patients, by promoting diversity within the medical profession, health care systems improve minority culture health by implementing plans and decrees that can provide minority cultures access to vaccination education and care. The use of interpreters improves communication. Interpreters would allow proper vaccine education and assurance in a patient's mother tongue while improving health literacy for vaccinations. Improving data collection of vaccination disparities for minority cultures can identify vaccine deserts, regions where there is a lack of vaccinated population. Training physicians to rely less on implicit bias and to increase awareness of the cultural concerns of unvaccinated patients can improve cultural competency and health care for minority cultures. At the organizational, systematic, and clinical level of cultural competency, anti-vaxxers should not be allowed to influence

medical and scientific knowledge. Anti-vaxxers can be acknowledged and can raise concerns, but, as earlier sections have discussed, implementing anti-vaccination policy at the organizational level can damage the health of United States citizens. Vaccines have eradicated multiple diseases and limited the destructive powers of many others (Healy). Many claims of vaccines causing autism or other degenerative effects have also been disproven (Healy). Having anti-vaxxers influence health care could increase health disparities. Having individuals that can relate to anti-vaxxers can improve the health literacy of these individuals and their claims against vaccinations. Data collection on anti-vaxxer locations can also allow for preparations of an epidemic outbreak. Physicians could increase trainings that incorporate an increased awareness of anti-vaxxer concerns, look to reduce the impact of low health literacy on health decisions, and develop strategies to address and assess health beliefs of anti-vaxxers. In any case, by addressing the various levels of cultural competency within medicine, we can reduce health disparities, improve compliance and adherence, and diminish the potential of termination.

C. Improve Shared Decision-Making

Shared decision-making can also improve quality of care. In terms of solutions directed at the unvaccinated, the anti-vaccination movement, and reducing health disparities, shared decision-making is one of the most significant and influential practices. As a component of patient-centered care, shared decision-making establishes a partnership between physicians and patients that emphasizes the patient's role in his or her own health maintenance as well as respects any wishes the patient may have (IOM). Shared decision-making includes three domains: information and educational sharing between patients and physicians, deliberation and discussion of pros and cons of

treatments, and decision-making that is both agreed upon by physician and patient (Charles). One concern is what constitutes as “shared” from both physician and patient perspectives. Patients often want a shared partnership with their physician, one where the relationship can be defined as “50-50” (Peek). Studies have shown, however, that physicians and patients approach their relationships differently from the definition of shared decision-making. For example, the patient may not share enough information, deliberation and discussion may be forced or dominated by the physician, or decision-making is not truly shared and consented (Peek).

Shared decision-making avoids patient termination by generating positive health outcomes. Shared decision-making creates trust. Understandably, implicit bias, stereotyping, and racism negatively influences the trust a patient will have with a physician, detrimentally influencing shared decision-making and perpetuating health disparities. Studies have shown that facilitating the three domains of shared decision-making increases trust within a physician-patient relationship can improve overall health care (Peek). Trust results in patients adopting more shared decision-making decisions, allowing patients to voice their preferences more freely (Peek). This trust allows physicians to provide more information, such as test results and overall health care notes, and to improve the quality of health care. Trust and its ability to facilitate shared decision-making has seen health care improvements across the board for all patients. These results can greatly influence the continued growth of health care and its quality for patients, increasing patient participation and overall health care while reducing the potential for termination.

Shared decision-making improves vaccination outcomes. Imagine an unvaccinated family coming in for an emergency and the physician brings up vaccination. The physician proceeds to explain the pros and cons of vaccination, making sure the family understands the value of vaccines. Afterwards, the physician asks the family what they would like to do. Based on the effects of shared decision-making, it would seem reasonable that the family would opt in. Educating the family provides the knowledge and ability to make informed decisions. This shows the family the respect the physician has for them. Additionally, providing the pros and cons of vaccines builds the family's trust in the physician and the physician's vaccination suggestions. This trust allows the family and physician to approach vaccinations together, improving patient compliance and vaccination rates. Anti-vaxxers can also participate in shared decision-making. While anti-vaxxers may be unwavering for vaccination education and vaccination choice, physicians actively participating in shared decision-making with them can improve health care. By showing the same level of respect to anti-vaxxers, it is possible to delve into their thought-process and understand their concerns. By educating, listening, and respecting anti-vaxxers similarly, health care (and potentially vaccination) physician-patient relationship can be improved.

D. Modify Medical School Curriculum

Medical school curriculum should also emphasize cultural competency. Through a combination of scientific knowledge and human values, medical education is shifting towards a more humanistic and multicultural approach to medical care. The benefits of

such courses include a significant increase in health care quality improvement, especially with minority cultures (Boutin-Foster).

Cross-cultural education is an important addition to medical curriculum. Cross-cultural education is vital to prepare physicians for treating culturally diverse patients (Zweifler). Cross-cultural education also improves the physician-patient relationship by improving communication and eliminating cultural and racial disparities in medicine (Williams, D.). Accreditation bodies of medical schools also back cross-cultural education as the future of medical training with standards placed to ensure growth and success (Liaison Committee on Medical Education Accreditation (LCME)). Cross-cultural education creates the attitudes, knowledge, and skills necessary to improve the health of cultural minorities and eliminate health disparities. Focusing on a physician's attitudes requires the physician to examine the patient through lenses of humility, empathy, awareness, sensitivity, and, most importantly, respect (Bobo).

Learning about a culture directly from the source provides physicians unparalleled exposure to a community (Betancourt). Oftentimes, this learning comes from patient interviews. Altering medical interviewing skills to fit a standardized approach allows physicians to be more aware of the similarities between the physician's and the patient's cultures and beliefs. This inductive approach to medicine makes patients the starting point for discovering their health issues rather than a deductive approach of broad rules and generalizations (Shapiro). The value and clinical applicability of the cross-cultural educational approach facilitates better treatment of wide demographics. Cross-cultural education provides physicians with the ability to strengthen his or her ability to learn and care for the patient (Betancourt). Having a learning-centered competency course can

motivate students to study other cultures while embracing their own cultures. Students could relate similarities between both cultures to find common ground to build a relationship.

Integrating cultural competency into curriculum raises the question of learned competency versus practiced competency. *Learned competency* is competency that is taught through literature and lecture (Wear). *Practiced competency* is competency that is experienced (Wear). While learned competency can provide more educational structure, cultural competency should be learned from experiences, not taught by a potentially biased educator. These experiences call upon physicians to ask themselves and their patients tough questions, take risks in extending their understanding, interrogate their own privileges and shortcomings in relations to the cultures in which they practice medicine, and commit themselves to social justice (Wear). Physicians can only learn so much about cultural competency from books and lectures; to truly get an immersive understanding of how cultures are and how cultures influence lifestyles, physicians should get to know the communities they serve. They should step out of their comfort zone and become one with the community.

Through modifying medical school curriculum, it is possible to train future physicians to approach patients who are unvaccinated or have opted out of vaccination. In the case of the unvaccinated patient, cultural competency education should teach that not every patient who is unvaccinated is an anti-vaxxer. Simply, the curriculum should encourage students to consider other factors when patients are unvaccinated. Additionally, the curriculum should relate the physician to the patient's culture, both through immersion and through education. This relation would allow the physician to

truly appreciate and understand what patients go through to maintain their health, as well as give the physician the ability to treat and care for the patient at a higher rate. In the case of anti-vaxxers, cultural competency education should teach physicians to listen to and understand these patients and their viewpoint in maintaining their health. Respect should be given to these patients or they will choose to ignore or avoid any attempt at conversation. From there, physicians should educate these patients on the importance of vaccinations. Whatever the case, by educating physicians at the start of their medical school careers, it is possible to implement cultural competency practices that can influence patient health care indefinitely.

***

Increasing cultural competency can be accomplished by improving communication techniques, improving the facilitation of medical operations, improving shared decision-making, and modifying medical school curriculum.

Conclusion

In targeting physician-patient relationship termination, this thesis analyzes how to decrease health disparities by increasing cultural competency. By examining health disparities related to termination, defining cultural competency and discussing the barriers that impede the growth of cultural competency, and explaining the issue with a vaccination case study, this thesis aimed to streamline a comprehensible connection between cultural competency, termination, and health disparities.

Health disparities continue to be a problem in the United States. Although eliminating these disparities is a major goal of Congress and health advocates, there has yet to be consensus on the specific factors that have created and maintained them.

Additionally, the increasing demographic of cultures will significantly influence how medicine is practiced. The benefits of cultural competency cannot be undersold. Cultural competency has significantly improved the quality of care many patients receive, especially minority culture patients, by moving away from one-size-fits-all medicine. Cultural competency represents the possession of cultural knowledge, respect for cultural differences, and the ability to use skills efficiently and effectively in cross-cultural situations. Termination, however, decreases a former patient's exposure to medicine and could perpetuate health disparities. While cultural competency can reduce the potential of termination, communication issues and implicit biases are barriers to cultural competency. These barriers lead to a lack of cultural competency and can result in a physician commonly deeming a patient as nonadherent, noncompliant, and difficult. This perception of the patient leads to the potential of termination of the physician-patient relationship, resulting in a perpetuation of health disparities, especially for minority cultures. Studying this issue within the vaccination context, especially of the unvaccinated versus the anti-vaxxer, provides multiple avenues to discuss termination and to comprehend that issues cannot always be taken at face value.

The four-pronged approach of solutions provides a novel attempt to consolidate multiple methods of improving cultural competency within medicine in hopes of improving patient health care and minimizing termination. Moving forward, medicine should continue to promote cultural competency through communication, facilitation, shared decision-making, and modification of medical school curriculum. Through these efforts, the field of medicine can significantly improve health care for patients of all racial, ethnic, and socioeconomic cultures.

Appendices and Bibliography

A. Appendix A: Key Terms

I define the following key terms:

- *Culture* – "a collective pattern of learned beliefs and behaviors, such as thoughts, values, customs, communications, interactions, roles, relationships, and practices, of a group influenced by race, ethnicity, gender, socioeconomic status, occupation, nationality, and physical and mental ability, among other elements" (Lenhoff, Robins).
- *Cultural Competency* – "the ability of a health care system to provide proper and tailored care to patients from a wide range of cultural, social, and ethnical needs, including, but not limited to, values, beliefs, and behaviors regarding health" (Betancourt).
- *Health Disparities* – "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." (Healthy People 2020).
- *Patient Abandonment* – "the unilateral severance of the professional relationship without reasonable notice at a time when there is still the necessity of continuing medical attention and without confirming another healthcare provider's services"

(Texas Medical Association (TMA), Health Law Firm (HLK), King v. Fisher, Drechsler).

- *Physician* – "a licensed practitioner in a recognized field of medicine" (Drechsler).
- *Termination* – "withdrawing from a case or an obligation to maintain continuity of care for their patients" (American Medical Association (AMA)).

B. Appendix B: Sample Termination Letter

a. Termination of the physician/patient relationship

Date Certified receipt # _____

[patient address] Also sent first-class mail.

Dear [patient name]:

Please be advised that I will no longer be able to treat you as a patient. The termination of our physician/patient relationship will be effective in 30 days from the date of this letter. Your medical condition requires continuing physician supervision, and it is important you select another physician as soon as possible.

Contact your insurance plan or the county medical society for names of other physicians. Upon written authorization, a copy of your medical record will be sent to your new physician. A release form is enclosed.

Sincerely,
[physician name]

b. Termination for nonpayment

Date Certified receipt # _____

[patient address] Also sent regular mail.

Dear [patient name]:

On [date], I sent you a letter requesting that you contact the business manager or me regarding any problems that may have occurred resulting in non-payment of your account. In the letter, I stated that it would be necessary to terminate our physician/patient relationship if we did not hear from you.

Since we have not heard from you, please be advised that I will no longer be able to treat you as a patient. The termination of our relationship will be effective in 30 days from the date of this letter. A release form is enclosed for your written authorization. Please contact us with the name of your new physician so we may forward your records to his or her office.

Sincerely,

[physician name]

C. Bibliography

Ali, Nasreen, Karl Atkin, and Richard Neal. "The Role of Culture in the General Practice Consultation Process." *Ethnicity & Health* 11.4 (2006): 389-408. Web.

American Medical Association. "AMA Code of Medical Ethics." *Code of Medical Ethics | AMA*. American Medical Association, 1996. Web. 14 Apr. 2017.

August, Kristin J., Hannah Nguyen, Quyen Ngo-Metzger, and Dara H. Sorkin. "Language Concordance and Patient-Physician Communication Regarding Mental Health Needs." *Journal of the American Geriatrics Society* 59.12 (2011): 2356-362. Web.

Baker, David W., Risa Hayes, and Julia Puebla Fortier. "Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients." *Medical Care* 36.10 (1998): 1461-470. Web.

Bakir, Amira H., and Martin Skarzynski. "Health Disparities in the Immunoprevention of Human Papillomavirus Infection and Associated Malignancies." *Frontiers in Public Health* 3 (2015): n. pag. Web.

Barker, Lawrence E., Susan Y. Chu, and Phillip J. Smith. "Disparities In Immunizations." *American Journal of Public Health* 94.6 (2004): 906. Web.

Beach, Mary Catherine, and Thomas Inui. "Relationship-centered Care. A Constructive Reframing." *Journal of General Internal Medicine* 21. S1 (2006): n. pag. Web.

Beck, Melinda. "The Doctor Will Never See You Again." *The Wall Street Journal*. Dow Jones & Company, 08 Feb. 2010. Web. 14 Apr. 2017.

Betancourt, Joseph R., Alexander R. Green, and J. Emilio Carrillo. "Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches." *The Commonwealth Fund* (2002): n. pag. Web.

Betancourt, Joseph R., Alexander R. Green, J.emilio Carrillo, and Owusu Ananeh-Firempong. "Defining Cultural Competence: A Practical Framework for Addressing Racial/ethnic Disparities in Health and Health Care." *Public Health Reports* 118.4 (2003): 293-302. Web.

Betancourt, Joseph R. "Cross-cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation." *Academic Medicine* 78.6 (2003): 560-69. Web.

Blair, Irene V., John F. Steiner, and Edward P. Havranek. "Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here?" *The Permanente Journal* 15.2 (2011): 71-78. Web.

Bobo, Loretta, Robin J. Womeodu, and Alfred L. Knox. "Society of General Internal Medicine Symposium Principles of Intercultural Medicine in an Internal Medicine Program." *The American Journal of the Medical Sciences* 302.4 (1991): 244-48. Web.

Boutin-Foster, Carla, Jordan C. Foster, and Lyuba Konopasek. "Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence." *Academic Medicine* 83.1 (2008): 106-11. Web.

Brach, C., and I. Fraserirector. "Can Cultural Competency Reduce Racial and Ethnic Health Disparities? a Review and Conceptual Model." *Medical Care Research and Review* 57.4 (2000): 181-217. Web.

Brondolo, Elizabeth, Linda C. Gallo, and Hector F. Myers. "Race, Racism and Health: Disparities, Mechanisms, and Interventions." *Journal of Behavioral Medicine* 32.1 (2008): 1-8. Web.

Brugge, Doug, Timothy Edgar, Kelly George, Janette Heung, and M. Barton Laws. "Beyond Literacy and Numeracy in Patient Provider Communication: Focus Groups Suggest Roles for Empowerment, Provider Attitude and Language." *BMC Public Health* 9.1 (2009): n. pag. Web.

Burgess, Diana J. "Are Providers More Likely to Contribute to Healthcare Disparities Under High Levels of Cognitive Load? How Features of the Healthcare Setting May Lead to Biases in Medical Decision Making." *Medical Decision Making* 30.2 (2010): 246-57. Web.

Butow, Phyllis N., Ming Sze, Priya Dugal-Beri, Michelle Mikhail, Maurice Eisenbruch, Michael Jefford, Penelope Schofield, Afaf Girgis, Madeleine King, and David Goldstein. "From inside the Bubble: Migrants' Perceptions of Communication with the Cancer Team." *Supportive Care in Cancer* 19.2 (2010): 281-90. Web.

Cave, Andrew J., U. Maharaj, Nancy L. Gibson, and Edgar L. Jackson. "Physicians and Immigrant Patients. Cross-cultural Communication." *Canadian Family Physician* 41 (1995): 1685-690. Web.

Chapman, Elizabeth N., Anna Kaatz, and Molly Carnes. "Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities." *Journal of General Internal Medicine* 28.11 (2013): 1504-510. Web.

Charles, Cathy, Amiram Gafni, and Tim Whelan. "Shared Decision-making in the Medical Encounter: What Does It Mean? (or It Takes at Least Two to Tango)." *Social Science & Medicine* 44.5 (1997): 681-92. Web.

Chesanow, Neil. "The Noncompliance Epidemic: Why Are So Many Patients Noncompliants." *Medscape*. N.p., n.d. Web. 14 Apr. 2017.

Chipidza, Fallon E., Rachel S. Wallwork, and Theodore A. Stern. "Impact of the Doctor-Patient Relationship." *The Primary Care Companion For CNS Disorders* (2015): n. pag. Web.

Chu, Susan Y., Lawrence E. Barker, and Philip J. Smith. "Racial/Ethnic Disparities in Preschool Immunizations: United States, 1996-2001." *American Journal of Public Health* 94.6 (2004): 973-77. Web.

Consumer Reports. "What Doctors Wish Their Patients Knew: Surprising Results from Our Survey of 660 Primary-care Physicians." *Consumer Reports.* U.S. National Library of Medicine, Mar. 2011. Web. 15 Apr. 2017.

Cooper, Lisa A., and Neil R. Powe. "Disparities in Patient Experiences, Health Care Processes, and Outcomes: the Role of Patient–Provider Racial, Ethnic, and Language Concordance." *The Commonwealth Fund* (2004): 1-24. Web.

Cooper, Lisa A. "Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race." *Annals of Internal Medicine* 139.11 (2003): 907. Web.

Cooper, Lisa A. "Race, Gender, and Partnership in the Patient-Physician Relationship." *Journal of American Medical Association* 282.6 (1999): 583. Web.

Croskerry, P. "Achieving Quality in Clinical Decision Making: Cognitive Strategies and Detection of Bias." *Academic Emergency Medicine* 9.11 (2002): 1184-204. Web.

Croskerry, Pat, and Douglas Sinclair. "Emergency Medicine: A Practice Prone to Error?" *Canadian Journal of Emergency Medicine* 3.04 (2001): 271-76. Web.

Crozer-Keystone Health System. "Terminating the Physician-Patient Relationship." *Crozer-Keystone Health System*. Crozer-Keystone Health System, 22 Sept. 2016. Web. 15 Apr. 2017.

Descours, Emmanuelle L. *"I Try to Connect with Them on Something": A Qualitative Study of Patient-Centered Care from the Doctor's Perspective*. Thesis. University of Houston, 2015. N.p.: n.p., n.d. Print.

Diekema, D. S. "Responding to Parental Refusals of Immunization of Children." *American Academy of Pediatrics* 115.5 (2005): 1428-431. Web.

Drechsler, C. T. "Liability of Physician Who Abandons Case." *American Law Reports*. N.p., 1958. Web. 14 Apr. 2017.

Dyregrov, Kari M. "Intel-Cultural Communication in General Practice." *Norwegian Medical Association* 117.17 (1997): 2444-446. Web.

Engel, John D., Joseph Zarconi, Lura L. Pethtel, and Sally A. Missimi. "Narrative in Health Care." *Canadian Family Physician* 56 (2010): 84. Print.

EOFF v. HAL AND CHARLIE PETERSON FOUND. Court of Appeals of Texas, San Anthonio. 15 May 1991. Print.

Epstein RM. Franks P. Shields CG. Meldrum SC, et al. Patient-centered communication and diagnosis testing. Ann Fam Med. 2005; 3:415–421.

Ferguson, Warren J., and Lucy M. Candib. "Culture, Language, and the Doctor-Patient Relationship." *Family Medicine* 34.5 (2002): 353-61. Print.

Fernandez, Alicia, Dean Schillinger, Kevin Grumbach, Anne Rosenthal, Anita L. Stewart, Frances Wang, and Eliseo J. Parez-Stable. "Physician Language Ability and Cultural Competence." *Journal of General Internal Medicine* 19.2 (2004): 167-74. Web.

Flanagan-Klygis, Erin A., Lisa Sharp, and Joel E. Frader. "Dismissing the Family Who Refuses Vaccines." *Archives of Pediatrics & Adolescent Medicine* 159.10 (2005): 929. Web.

Ge, Gao, Nancy Burke, Carol P. Somkin, and Rena Pasick. "Considering Culture in Physician-Patient Communication During Colorectal Cancer Screening." *Qualitative Health Research* 19.6 (2009): 778-89. Web.

Gerlach, Heli, and Heinz Abholz. "Black Patients and White Family Doctors." *Journal of General Medicine* 85.11 (2009): 444-50. Web.

Goddu, Anna P., Katie E. Raffel, and Monica E. Peek. "A Story of Change: The Influence of Narrative on African-Americans with Diabetes." *Patient Education and Counseling* 98.8 (2015): 1017-024. Web.

Green, Alexander R., Dana R. Carney, Daniel J. Pallin, Long H. Ngo, Kristal L. Raymond, Lisa I. Iezzoni, and Mahzarin R. Banaji. "Implicit Bias among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients." *Journal of General Internal Medicine* 22.9 (2007): 1231-238. Web.

Greenwald, Anthony G., Debbie E. Mcghee, and Jordan L. K. Schwartz. "Measuring Individual Differences in Implicit Cognition: The Implicit Association Test." *Journal of Personality and Social Psychology* 74.6 (1998): 1464-480. Web.

Gregg, Aiden P., Beate Seibt, and Mahzarin R. Banaji. "Easier Done than Undone: Asymmetry in the Malleability of Implicit Preferences." *Journal of Personality and Social Psychology* 90.1 (2006): 1-20. Web.

Halperin, Beth, Ryan Melnychuk, Jocelyn Downie, and Noni Macdonald. "When Is It Permissible to Dismiss a Family Who Refuses Vaccines? Legal, Ethical and Public Health Perspectives." *Paediatrics & Child Health* 12.10 (2007): 843-45. Web.

Harmsen, Hans, Ludwien Meeuwesen, Joke Van Wieringen, Roos Bernsen, and Marc Bruijnzeels. "When Cultures Meet in General Practice: Intercultural Differences between GPs and Parents of Child Patients." *Patient Education and Counseling* 51.2 (2003): 99-106. Web.

Hawker, Gillian A., James G. Wright, Peter C. Coyte, J. Ivan Williams, Bart Harvey, Richard Glazier, and Elizabeth M. Badley. "Differences between Men and Women in the Rate of Use of Hip and Knee Arthroplasty." *New England Journal of Medicine* 342.14 (2000): 1016-022. Web.

Healthy People 2010. "Healthy People 2010." *U.S. Department of Health and Human Services* (2000): n. pag. Web.

Healthy People 2020. "Healthy People 2012: Midcourse Review." *U.S. Department of Health and Human Services* (2016): n. pag. Web.

Healy, C. M., and L. K. Pickering. "How to Communicate with Vaccine-Hesitant Parents." *Pediatrics* 127 (2011): n. pag. Web.

Hinyard, L. J., and M. W. Kreuter. "Using Narrative Communication as a Tool for Health Behavior Change: A Conceptual, Theoretical, and Empirical Overview." *Health Education & Behavior* 34.5 (2007): 777-92. Web.

Hooper, Elizabeth M., Loretto M. Comstock, Jean M. Goodwin, and James S. Goodwin. "Patient Characteristics That Influence Physician Behavior." *Medical Care* 20.6 (1982): 630-38. Web.

Institute of Medicine. "Crossing the Quality Chasm: A New Health System for the 21st Century." *Institute of Medicine* (2001): n. pag. Web.

Institute of Medicine. "Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Health-Care." *Institute of Medicine* (2002): n. pag. Web.

Jensen, Jakob D., Andy J. King, Lisa M. Guntzviller, and Lashara A. Davis. "Patient-provider Communication and Low-income Adults: Age, Race, Literacy, and Optimism Predict Communication Satisfaction." *Patient Education and Counseling* 79.1 (2010): 30-35. Web.

Jimmy, Benna, and Jimmy Jose. "Patient Medication Adherence: Measures in Daily Practice." *Oman Medical Journal* 26.3 (2011): 155-59. Web.

Johns Hopkins University. "Guides: Bioethics: Hippocratic Oath, Modern Version." *Hippocratic Oath, Modern Version - Bioethics - Guides at Johns Hopkins University*. Johns Hopkins University, 2003. Web. 15 Apr. 2017.

Johnson, Rachel L., Somnath Saha, Jose J. Arbelaez, Mary Catherine Beach, and Lisa A. Cooper. "Racial and Ethnic Differences in Patient Perceptions of Bias and Cultural Competence in Health Care." *Journal of General Internal Medicine* 19.2 (2004): 101-10. Web.

Johnson, Tiffani J., Robert W. Hickey, Galen E. Switzer, Elizabeth Miller, Daniel G. Winger, Margaret Nguyen, Richard A. Saladino, and Leslie R. M. Hausmann. "The

Impact of Cognitive Stressors in the Emergency Department on Physician Implicit Racial Bias." *Academic Emergency Medicine* 23.3 (2016): 297-305. Web.

The Joint Commission. "Implicit Bias in Health Care." *The Joint Commission* 23 (2016): 1-4. Web.

Keating, Dan, and Laris Karklis. "Where the Country Is Becoming More Diverse." *The Washington Post*. WP Company, 25 Nov. 2016. Web. 15 Apr. 2017.

Kennedy, Steven, Michael P. Kidd, James Ted Mcdonald, and Nicholas Biddle. "The Healthy Immigrant Effect: Patterns and Evidence from Four Countries." *Journal of International Migration and Integration* 16.2 (2014): 317-32. Web.

KING v. FISHER. Court of Appeals of Texas, Fort Worth. 21 Mar. 1996. Print.

Kleinman, Arthur, L. Eisenberg, and B. Good. "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-cultural Research." *Annals of Internal Medicine* 88.2 (1978): 251. Web.

Komaromy, Miriam, Kevin Grumbach, Michael Drake, Karen Vranizan, Nicole Lurie, Dennis Keane, and Andrew B. Bindman. "The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations." *New England Journal of Medicine* 334.20 (1996): 1305-310. Web.

Krauss-Mars, A. H., and P. Lachman. "Breaking Bad News to Parents with Disabled Children-a Cross-cultural Study." *Child: Care, Health and Development* 20.2 (1994): 101-13. Web.

Kreuter, Matthew W., Melanie C. Green, Joseph N. Cappella, Michael D. Slater, Meg E. Wise, Doug Storey, Eddie M. Clark, Deborah O. Erwin, Kathleen Holmes, Leslie J. Hinyard, Thomas Houston, Sabra Woolley, and Daniel J. O'Keefe. "Narrative

Communication in Cancer Prevention and Control: A Framework to Guide Research and Application." *Annals of Behavioral Medicine* 33.3 (2007): 221-35. Web.

Larkey, Linda K., and Michael Hecht. "A Model of Effects of Narrative as Culture-Centric Health Promotion." *Journal of Health Communication* 15.2 (2010): 114-35. Web.

Larson, Elaine. "Racial and Ethnic Disparities in Immunizations: Recommendations for Clinicians." *Journal of Family Medicine* 35.9 (2003): 655-60. Web.

Lenhoff, Fred G.|Hedrick Hannah L. "Increasing Awareness and Implementation of Cultural Competence Principles in Health Professions Education." *Journal of Allied Health*. PubMed, 30 Nov. 1999. Web. 11 Apr. 2017.

Levin, Michael E. "Language as a Barrier to Care for Xhosa-speaking Patients at a South African Paediatric Teaching Hospital." *South African Medical Journal* 96.10 (2006): 1076-079. Web.

Levinson, Wendy, Pamela L. Hudak, Jacob J. Feldman, Richard M. Frankel, Alma Kuby, Sylvia Bereknyei, and Clarence Braddock. "It's Not What You Say …: Racial Disparities in Communication Between Orthopedic Surgeons and Patients." *Medical Care* 46.4 (2008): 410-16. Web.

Ley P, Bradshaw PW, Eaves D, Walker CM. A method for increasing patients' recall of information presented by doctors. Psychol Med. 1973; 3:217-220.

Liaison Committee on Medical Education Accreditation. *Financial Information, Resources, Services, and Tools*. N.p.: AAMC, n.d. Print.

Lippman, Helen, and John Davenport. "Patient Dismissal: The Right Way to Do It - Under What Circumstances Is It Permissible for a Physician to “fire” a Patient? We Present a Balanced— and Legal—approach." *The Journal of Family Practice* 60.3 (2011): 135-40. Web.

Lu, Peng-jun, Alissa O'Halloran, Walter Williams, Megan Lindley, Susan Farrall, and Carolyn Bridges. "Racial and Ethnic Disparities in Vaccination Coverage Among Adult Populations in the U.S." *American Journal of Preventive Medicine* 49 (2015): 412-25. Web.

Manning-Walsh, J., E. Wagenfeld-Heintz, A. Asmus, M. Chambers, W. Reed, and J. L. Wylie. "The Expanding Cup Model of Relationship-Centered Care." *International Journal of Human Caring* 8 (2004): 26-31. Web.

Mead, Holly, Lara Cartwright-Smith, Karen Jones, Christal Ramos, Kristy Woods, and Bruce Siegel. "Racial and Ethnic Disparities in U.S. Health Care: A Chartbook." *The Commonwealth Fund* (2008): n. pag. Web.

Meeuwesen, Ludwien, Fred Tromp, Barbara C. Schouten, and Johannes A.m. Harmsen. "Cultural Differences in Managing Information during Medical Interaction: How Does the Physician Get a Clue?" *Patient Education and Counseling* 67.1-2 (2007): 183-90. Web.

Meichenbaum D, Turk DC. Facilitating Treatment Adherence: A Practitioner's Guidebook. New York: Plenum Publishing Corp; 1987.

Meyer, Pamela A., Paula W. Yoon, and Rachel B. Kaufmann. "CDC Health Disparities and Inequalities Report — United States, 2013." *U.S. Department of Health*

and Human Services: Centers for Disease Control and Prevention - Morbidity and Mortality Weekly Report 62.3 (2013): 1-189. Web.

Millan-Ferro A, Caballero AE. Cultural approaches to diabetes self-management programs for the Latino community. Curr Diabetes Rep. 2007; 7:391–7.

Murphy, Sheila T., Lauren B. Frank, Joyee S. Chatterjee, and Lourdes Baezconde-Garbanati. "Narrative versus Nonnarrative: The Role of Identification, Transportation, and Emotion in Reducing Health Disparities." *Journal of Communication* 63.1 (2013): 116-37. Web.

National Adult and Influenza Immunization Summit. "Spotlight on Adult Immunization Disparities." *National Adult and Influenza Immunization Summit* (2013): n. pag. Web.

National Adult and Influenza Immunization Summit. "What Works to Improve Adult Immunization." *National Adult and Influenza Immunization Summit* (2013): n. pag. Web.

National Center for Health Statistics. "National Center for Health Statistics: Data on Racial and Ethnic Disparities." *PsycEXTRA Dataset* (2012): n. pag. Web.

Nulty, Dorothy. "Is It Ethical for a Medical Practice to Dismiss a Family Based on Their Decision Not to Have Their Child Immunized?" *JONA'S Healthcare Law, Ethics, and Regulation* 13.4 (2011): 122-24. Web.

O'leary, S. C. Burbano, S. Federico, and L. C. Hampers. "The Truth About Language Barriers: One Residency Program's Experience." *Pediatrics* 111.5 (2003): n. pag. Web.

Paternotte, Emma, Sandra Van Dulmen, Nadine Van der Lee, Albert J.j.a. Scherpbier, and Fedde Scheele. "Factors Influencing Intercultural Doctor-patient Communication: A Realist Review." *Patient Education and Counseling* 98.4 (2015): 420-45. Web.

Peek, Monica E., Angela Odoms-Young, Michael T. Quinn, Rita Gorawara-Bhat, Shannon C. Wilson, and Marshall H. Chin. "Racism in Healthcare: Its Relationship to Shared Decision-making and Health Disparities: A Response to Bradby." *Social Science & Medicine* 71.1 (2010): 13-17. Web.

Peek, Monica E., Michael T. Quinn, Rita Gorawara-Bhat, Angela Odoms-Young, Shannon C. Wilson, and Marshall H. Chin. "How Is Shared Decision-making Defined among African-Americans with Diabetes?" *Patient Education and Counseling* 72.3 (2008): 450-58. Web.

Peek, Monica E., Rita Gorawara-Bhat, Michael T. Quinn, Angela Odoms-Young, Shannon C. Wilson, and Marshall H. Chin. "Patient Trust in Physicians and Shared Decision-Making Among African-Americans With Diabetes." *Health Communication* 28 (2013): 616-23. *Health Communication*. Web. 15 Apr. 2017.

Rappaport, Julian. "Empowerment Meets Narrative: Listening to Stories and Creating Settings." *American Journal of Community Psychology* 23.5 (1995): 795-807. Web.

Robins, L. S., J. C. Fantone, J. Hermann, G. L. Alexander, and A. J. Zweifler. "Improving Cultural Awareness and Sensitivity Training in Medical School." *Academic Medicine: Journal of the Association of American Medical Colleges.* U.S. National Library of Medicine, Oct. 1998. Web. 11 Apr. 2017.

Rosenberg, Ellen, Claude Richard, Marie-Therese Lussier, and Shelly N. Abdool. "Intercultural Communication Competence in Family Medicine: Lessons from the Field." *Patient Education and Counseling* 61.2 (2006): 236-45. Web.

Rudman, Laurie A. "Social Justice in Our Minds, Homes, and Society: The Nature, Causes, and Consequences of Implicit Bias." *Social Justice Research* 17.2 (2004): 129-42. Web.

Russell, Lesley. "Fact Sheet: Health Disparities by Race and Ethnicity." *Center for American Progress*. Center for American Progress, 16 Dec. 2010. Web. 15 Apr. 2017.

Ryn, Michelle Van, and Jane Burke. "The Effect of Patient Race and Socio-economic Status on Physicians' Perceptions of Patients." *Social Science & Medicine* 50.6 (2000): 813-28. Web.

Sabin, Janice A., and Anthony G. Greenwald. "The Influence of Implicit Bias on Treatment Recommendations for 4 Common Pediatric Conditions: Pain, Urinary Tract Infection, Attention Deficit Hyperactivity Disorder, and Asthma." *American Journal of Public Health* 102.5 (2012): 988-95. Web.

Sabin, Janice A., Brian A. Nosek, Anthony G. Greenwald, and Frederick P. Rivara. "Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender." *Journal of Health Care for the Poor and Underserved* 20.3 (2009): 896-913. Web.

Saha, Somnath, Mary Catherine Beach, and Lisa A. Cooper. "Patient Centeredness, Cultural Competence and Healthcare Quality." *Journal of the National Medical Association* 100.11 (2008): 1275-285. Web.

Saha, Somnath, Sara H. Taggart, Miriam Komaromy, and Andrew B. Bindman. "Do Patients Choose Physicians of Their Own Race?" *Health Affairs: Minority Health* 19.4 (2000): 76-83. Web.

Santoso, Joseph T., Edmundo Yibirin, Mary Crigger, Jim Wan, and Adam C. Elnaggar. "Incidence and Contributing Factors to Termination of the Patient-physician Relationship." *Gynecologic Oncology Reports* 17 (2016): 42-44. Web.

Schouten, Barbara C., and Ludwien Meeuwesen. "Cultural Differences in Medical Communication: A Review of the Literature." *Patient Education and Counseling* 64.1-3 (2006): 21-34. Web.

Seijo, Rosa, Henry Gomez, and Judith Freidenberg. "Language as a Communication Barrier in Medical Care for Hispanic Patients." *Hispanic Journal of Behavioral Sciences* 13.4 (1991): 363-76. Web.

Shapiro, Johanna, and P. Lenahan. "Family Medicine in a Culturally Diverse World: A Solution-oriented Approach to Common Cross-cultural Problems in Medical Encounters." *Journal of Family Medicine* 28.4 (1996): 249-55. Web.

Shapiro, Johanna F., and Eleanor B. Saltzer. "Cross-cultural Aspects of Physician-patient Communications Patterns." *Urban Health* 10.10 (1981): 10-15. Web.

Shepard, Susan. "Terminating Patient Relationships." *Terminating Patient Relationships | The Doctors Company*. The Doctors Company, 2016. Web. 15 Apr. 2017.

Snyder, Lois. "American College of Physicians Ethics Manual." *Annals of Internal Medicine* 156.6 (2012): 73-104. Web.

Staats, Cheryl, Kelly Capatosto, Robin A. Wright, and Danya Contractor. "State of the Science: Implicit Bias Review 2015." *Kirwan Institute* 3 (2015): 1-96. Web.

Stewart, Moira A. "Effective Physician-Patient Communication and Health Outcomes: A Review." *Canadian Medical Association Journal* 152.9 (1995): 1423-433. Web.

Stewart, Moira A., Ian R. McWhinney, and Carol W. Buck. "The Doctor/patient Relationship and Its Effect upon Outcome." *Journal of the Royal College of General Practitioners* 29 (1979): 77-82. Web.

Suurmond, Jeanine, Ellen Uiters, Martine C De Bruijne, Karien Stronks, and Marie-Louise Essink-Bot. "Negative Health Care Experiences of Immigrant Patients: A Qualitative Study." *BMC Health Services Research* 11.1 (2011): n. pag. Web.

TMA. "Termination of the Physician-Patient Relationship." *Texas Medical Association*. Texas Medical Association, 14 Jan. 2005. Web.

Tversky, Amos, and Daniel Kahneman. "Judgment under Uncertainty: Heuristics and Biases." *Science* 185.4157 (1974): 3-20. Web.

United States of America. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *Fact Sheet: Health Disparities in Influenza Vaccination Coverage*. N.p.: n.p., n.d. Print.

USDHHS. "National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report." *U.S. Department of Health and Human Services* (2001): 1-139. Web.

Villagran, Melinda, Christopher Hajek, Xiaoquan Zhao, Emily Peterson, and Elaine Wittenberg-Lyles. "Communication and Culture: Predictors of Treatment Adherence among Mexican Immigrant Patients." *Journal of Health Psychology* 17.3 (2012): 443-52. Web.

Wear, Delese, Arno K. Kumagai, Joseph Varley, and Joseph Zarconi. "Cultural Competency 2.0: Exploring the Concept of “Difference” in Engagement with the Other." *Academic Medicine* 87.6 (2012): 1-7. Web.

Weiss, L. J., and J. Blustein. "Faithful Patients: The Effect of Long-term Physician-patient Relationships on the Costs and Use of Health Care by Older Americans." *American Journal of Public Health* 86.12 (1996): 1742-747. Web.

Weissman, Joel S., Joseph Betancourt, Eric G. Campbell, Elyse R. Park, Minah Kim, Brian Clarridge, David Blumenthal, Karen C. Lee, and Angela W. Maina. "Resident Physicians' Preparedness to Provide Cross-Cultural Care." *Journal of American Medical Association* 294.9 (2005): 1058-068. Web.

Wiking, Eivor, Nuha Saleh-Stattin, Sven-Erik Johansson, and Jan Sundquist. "Immigrant Patients' Experiences and Reflections Pertaining to the Consultation: A Study on Patients from Chile, Iran and Turkey in Primary Health Care in Stockholm, Sweden." *Scandinavian Journal of Caring Sciences* 23.2 (2009): 290-97. Web.

Williams, David R., and Toni D. Rucker. "Understanding and Addressing Racial Disparities in Health Care." *Health Care Financing Reviews* 21.4 (2000): 75-90. Web.

Williams, Lewis. "Empowering Social Action through Narratives of Identity and Culture." *Health Promotion International* 18.1 (2003): 33-40. Web.

Wolfe, Robert M., and Lisa K. Sharp. "Anti-vaccinationists past and Present." *BMJ* 325 (2002): 430-32. Web.

Wong, Geoff, Trish Greenhalgh, Gill Westhorp, Jeanette Buckingham, and Ray Pawson. "RAMESES Publication Standards: Realist Syntheses." *BMC Medicine* 11.1 (2013): n. pag. Web.

Zabar, Sondra, Kathleen Hanley, Elizabeth Kachur, David Stevens, Mark D. Schwartz, Ellen Pearlman, Jennifer Adams, Karla Felix, Mack Lipkin, and Adina Kalet. ""Oh! She Doesn't Speak English!" Assessing Resident Competence in Managing Linguistic and Cultural Barriers." Journal of General Internal Medicine 21.5 (2006): 510-13. Web.

Zweifler, John, and Anna Marie Gonzalez. "Teaching Residents to Care for Culturally Diverse Populations." *Academic Medicine* 73.10 (1998): 1056-061. Web.