

Case Studies in Cultural Competency



Diversity and Cultural Competency Committee

About Case Studies in Cultural Competency

The following case studies were entries in the Association of Schools and Colleges of Optometry's (ASCO) *Cultural Competency Case Study Competition for Optometry Students and Residents*. Faculty members are encouraged to use the case studies as tools to help educate students about cultural competence.

The case study competition was implemented for two years (2014 and 2015) by ASCO's Diversity and Cultural Competency Committee and was generously supported by Walmart. Entrants were asked to describe how cultural competency played a role in a patient-based encounter in any aspect of their clinical education. The authors of winning entries each received \$2,500. The students and residents who entered the competition granted ASCO permission to use the case studies in this compilation. ASCO owns all rights to the material.

The Diversity and Cultural Competency Committee supports member institutions as they embrace the concepts of diversity and multiculturalism in optometric education and in the profession. Through various initiatives, it assists the schools and colleges of optometry in the preparation of a diverse pool of optometric clinicians who will be culturally competent, i.e., clinically ready to address the vision and eyecare needs of a multicultural and global community. If you have questions about the Committee, e-mail Carol Brubaker, ASCO Manager, Professional Affairs, at cbrubaker@opted.org.

Contents

Case 1: White Coats, Windsor Ties, and Western Medicine	1
Case 2: Cultural Competency with the Navajo Nation	5
Case 3: At Home for an Hour: Competent Health Care for the Homeless	10
Case 4: “Breaking the Ice” in a Remote Alaskan Village	14
Case 5: Language Barriers and Socioeconomic Status Can Compromise Health Care	18
Case 6: Unexplained Vision Loss in a Young, Hearing-Impaired Hispanic Male	23
Case 7: Optometrists Must Overcome Obstacles to Patient Understanding	28
Case Discussion Questions	31

CASE 1

White Coats, Windsor Ties, and Western Medicine

At the midpoint of my third-year rotation in the Glaucoma Service, three of my colleagues and I were gathered in a small office, ready to discuss the morning's cases. As the Chief of Clinic described each case, it sounded as if we'd be having a routine day. Then, the case of a patient I'll call "Mr. Z" snatched my attention. The Chief explained that he had previously suspected that Mr. Z was suffering a brain aneurysm and referred him out to undergo brain scans. On this day, Mr. Z was back at our clinic for his 3-month glaucoma follow-up. The Chief told us that during the exam we may see an afferent pupillary defect, a depressed and abducted eye (i.e., "down and out" eye), and an aberrant regeneration of the third nerve. He also mentioned that the patient was very ill. As an inquisitive optometry student who had never seen this type of case, I went out of my way to ensure that Mr. Z would be my patient.

Putting an Apprehensive Patient at Ease

Mr. Z was hunched over and barely able to walk even with the help of his son and wife. I doubted whether he would be able to finish the exam. He occasionally flashed a smile; nonetheless, I was immensely concerned about his health. I was obligated to acquire answers to case history questions and to find out why he was so ill, but it wasn't as simple as that. He and his wife spoke limited English, and based on quick judgment of my patient's complexion and appearance, I knew I needed to make some cultural considerations.

As mentioned previously, Mr. Z had been to our clinic before. As a matter of fact, he had been coming for 6 years. Despite this, I sensed apprehensiveness from both him and his wife. They were quiet and especially respectful when they asked questions pertaining to his health and what procedures were being done. While being in an exam room with a doctor wearing an immaculate white coat can make patients anxious, Mr. Z and his wife also were not natives of Western culture, and English wasn't their first language. I had seen the same uneasiness in other patients in similar circumstances. In these situations, a separation can manifest between patient and doctor.

My job as the student optometrist was to reassure the patient, so I did what I was trained to do. I lowered my seat below his wife's level and used a welcoming tone. Although I knew his wife would be the one answering my questions, I made an effort to keep eye contact and turn towards Mr. Z. I made sure to nod and smile as they shared information about his health condition with me, and I listened intently when they expressed their concerns. Then, I stopped the examination for 2

minutes. I asked about their son in the waiting area and about how they found our clinic. I wanted to briefly distract their minds from the examination, hoping it would help me to gain their trust. I understood from past experience that once our patients trust us, they are noticeably more open with us. This leads to a more complete and accurate history as we ask the many questions necessary to complete the chart.

During these 2 minutes, we laughed and shared stories. Mr. Z's wife asked me where I was from, so I asked their ethnicity as well. I felt the barriers between us dissolve. For them, it seemed as if my white coat and tie suddenly blended in with my character. Mr. Z smiled every few seconds and was eager to set his head onto the chinrest as I prepared to applanate his right eye.

What I was able to witness in this case was that although Mr. Z barely spoke, and his wife knew little English, she was still able to effectively convey to me why her husband was feeling ill and what they expected that day. In turn, I was able to obtain essential details, including how Mr. Z had been using his glaucoma medication.

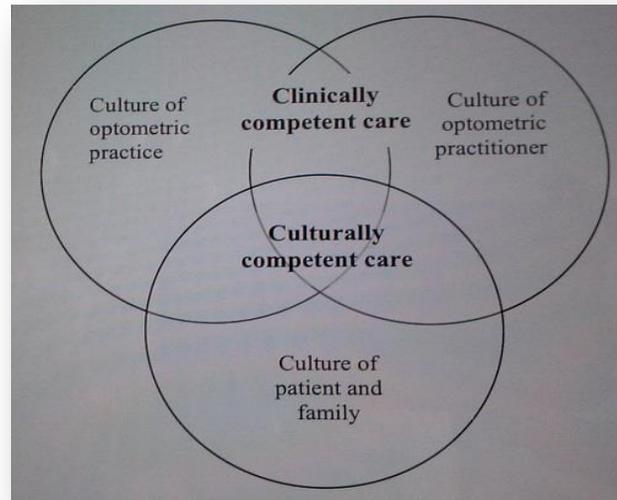
How Can We Accomplish Patient-Centered Care?

At the end of the day, reflecting on the case, I thought more about what it means to deliver patient-centered care. I realized I was short-sighted initially, eager to take the case because it would be a learning experience for me. Until I got into the exam room with Mr. Z and his wife, I had neglected the fact that I was unfamiliar with their surname, that the patient had limited English proficiency, and that he also happened to be very ill that morning. I hadn't considered what could be very important issues, such as where Mr. Z had come from, his ethnic and religious background, and whether the person accompanying him was his wife. Ignoring such details about our patients can compromise communication, skew the examination in a biased direction, and potentially lead to disparate outcomes.

The Association of American Medical Colleges (AAMC) brings to light the fact that there is strong evidence of racial and ethnic disparities in health care. AAMC emphasizes the need for practitioners to be culturally competent.¹ In addition, as stated in the Association of Schools and Colleges of Optometry's Guidelines for Culturally Competent Eye and Vision Care, "A culturally insensitive optometrist may not understand a patient's culturally-based belief that Western medicine is 'too strong,' or that chronic disease is a Western concept and medications are only for acute relief. Misunderstandings about medicinal philosophies could affect patient compliance, particularly with maintenance dosing for a chronic illness like glaucoma."² Furthermore, a culturally insensitive optometrist may not recognize that a nonchalant view towards medicine might be due to a cultural belief system rather than mere passiveness. I see these

“traditional” beliefs even in my own family, where taking medicine is a reflection of one’s health and lifestyle.

Mr. Z and his wife came into our office highly concerned that he could lose the remaining vision in his left eye. It was my responsibility to recognize this concern with the utmost urgency while also taking into consideration what ethnic, racial, or other cultural dissimilarities may exist between them and me. But, to be patient-centered should we take a neutral and unbiased approach in an attempt to erase or diminish differences between ourselves and the patient? Or should we actively attempt to understand the patient’s cultural background in hopes of finding some common ground? Based on my interactions with Mr. Z and his wife, choosing only one of those two approaches would compromise some crucial components of a strong patient-optometrist relationship. Rather, we should be able to delicately weave in between the two approaches and dynamically alter our approach as the patient reveals himself to us.



Although I can partly attribute my understanding of the initial apprehensiveness of Mr. Z and his wife to my education, or even to my own minority background, the professors and students who worked with Mr. Z before me had already diminished cultural barriers. They had figured out a way to show commitment to the patient’s health in a language that both parties understand, thus blurring the margins between the culture of optometric practice, the culture of the optometric practitioner, and the culture of the patient and his family, thereby delivering both clinically and culturally competent care (i.e., patient-centered care).² This is clear in Mr. Z’s case because he and his wife have come to believe in the effectiveness of modern medicine. They consistently return to our clinic for follow-up care, and Mr. Z complies with our recommendation to use his glaucoma medication every evening. In other words, he trusts in his optometrist to help preserve his remaining vision.

What I Learned from this Case

What I learned from this case is that we must not only understand our patients from the standpoint of a symptoms checklist or their diagnosis and treatment but also culturally. The case helped to enlighten me about the complex nature of health care. We're constantly faced with difficult medical cases entangled with the diverse nature of ethnicity, religion, and culture. How we deal with these situations determines our true success as optometrists. The necessary skills, as I've come to understand, can't be fully learned in a classroom. We derive them from the experiences we gain by breaking our habitual, routine protocols and honestly paying attention to the delicate differences between patients and ourselves. Optometrists, unlike many other professionals, are at the forefront of human interaction. Therefore, we have a responsibility to master social relationships as well as provide competent health care. To fulfill this mix of responsibilities and deliver the best care possible, we must be dynamic in the way we think, flexible in the way we practice, and sensitive to the diversity of our patients.

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CASE 2

Cultural Competency with the Navajo Nation

Delivery of health care with sensitivity to all aspects of a patient's background is crucial to obtaining the best possible clinical outcomes. Cultural competency is tailoring the delivery of health care to the patient's background, taking into account, among other characteristics, his or her gender, age, ethnicity, socioeconomic status, and religious values. It involves the knowledge that such factors shape a patient's perceptions about health, establish expectations for care, and ultimately guide medical decision-making. Prior to my residency, I had the incredible privilege and responsibility of helping to provide eye care for patients served by the Indian Health Service in the heart of the Navajo Reservation. Given our central location within the 16 million acres that comprise the Navajo Nation, it was an experience of true cultural immersion. I met patients who faced tremendous adversity such as poverty, living in rural areas far from medical centers, and physical disabilities that interfered with their ability to seek timely health care. Being able to receive treatment is crucial for the Navajo people due to their high risk of developing health problems such as diabetes, liver disease, chronic hypertension, heart disease, influenza, and pneumonia.¹⁻²

One of the biggest challenges I faced was evaluating and managing patients who delayed crucial medical treatment because of conflicts between the recommended therapy and the traditional religious beliefs they had held since childhood. One of the many kind and memorable patients I met was Mrs. MB, an 83-year-old grandmother who maintained a steadfast devotion to traditional Navajo medical practices and created a challenging scenario for the healthcare providers, counselors, and patient advocates who were involved in her case.

Barriers and Then Progress

MB initially presented to the optometry clinic 6 years ago with symptoms of reduced vision and severe, boring eye pain. Her systemic health history was significant for hypertension and rheumatoid arthritis that had gone untreated. She was diagnosed with scleritis in both eyes secondary to rheumatoid arthritis but declined treatment despite repeated urgings from her optometrist and primary care physician. Although a translator who shared her religious and ethnic background was always present to facilitate examination, invisible divides existed between doctors and the patient due to the difference in cultural backgrounds. While the patient sought traditional cures from the medicine man, the hospital enlisted the services of a patient advocate, sent a public health nurse for a site visit to the patient's home, and contracted with a medicine man, hoping to increase MB's

understanding of her health conditions and recommended treatments and bridge the cultural divide. MB's healthcare providers remained persistent in urging treatment as she developed bilateral uveitic glaucoma and scleromalacia perforans.

When MB first presented in my exam chair for an intraocular pressure check, I was relieved to know that one of the office technicians would be available to translate throughout the visit. I was extremely pleased to find that MB had been following medical advice for treatment, and her rheumatoid arthritis and glaucoma were stable. After numerous failed attempts to use traditional healing methods with the medicine man, MB had returned to the health clinic where she was cared for by her primary care physician, rheumatologist, and optometrist. Despite her severe visual disability of hand motion acuity in her right eye and light perception in her left eye, she was earnestly and accurately implementing the multiple glaucoma medications into her daily routine by using strategies such as tactile cues from rubber bands to distinguish between the bottles. Although rheumatoid arthritis had contributed to devastating and irreversible changes to MB's visual health, she has been able to maintain her traditional and religious beliefs while continuing her treatment with the health clinic.

"Culture affects our view of the world and the values we apply to that view. Cultural perspectives are shaped by many factors, including socioeconomic status, religion, gender, age, nationality, sexual orientation, education, language, occupation, disability, as well as race and ethnicity; consequently, we all reflect multicultural perspectives that include more than race and ethnicity and which help influence our values, belief systems, and behaviors."^{10,11}

Understanding the Individual in the Context of Culture

At the outset, many barriers prevented the quick establishment of a relationship between doctors and MB. They included differences in spoken language and religious and cultural background, and lack of family support, which contributed to the patient delaying medical treatment. Understanding the cultural, religious, and social principles of the Navajo is of utmost importance in being able to communicate with them effectively.

The Navajo believe in the concept of "Hozho," which embraces goodness, harmony, positive attitude, and universal beauty.³ Illness is thought to occur as a disruption of harmony, and discussion of illness conflicts with this philosophy. As such, educating the patient about a disease or the underlying causes of symptoms may cause conflict when communicating in the exam room. Care should be taken while educating patients about a disease course because discussion of the prognosis is believed to cause a negative outcome.³

There are several subtle social and cultural cues that healthcare providers need to be aware of when examining patients in the Navajo community. Incognizance of these subtleties can lead to misunderstandings in the clinical setting. For example, direct eye contact is uncommon, and touching of hands is used instead of a firm handshake during greetings. Case history should be taken carefully and intertwined with the examination as it may be seen as unnecessary. This is based on the cultural belief that traditional healers are thought to be already “aware” of the person’s past and present condition. Traditional Navajo health culture doesn’t rely on symptoms in the body for diagnosis; diseases are said to be caused by taboo behavior or infection by animals.⁴ Often the Navajo patient may have already assigned an etiology to his or her symptoms based on recent occurrences. Understanding whether an illness or symptom is acute or chronic can be difficult for the healthcare provider because the Navajo perception of time is often vague and referenced to lunar cycles.

Care should also be taken when ordering and reviewing certain types of diagnostic testing, such as fundus photographs, X-rays, or CT scans, because medical imagery is often linked to the soul. When recommending treatment, it’s important to be aware of whether the patient desires to concomitantly seek help from a traditional Navajo healer. This can help improve cooperation with the recommendations. There are many different types of traditional healers, including herbalists, star gazers, hand tremblers, crystal gazers, and bone settlers, whose services involve treating common complaints and symptoms.⁵ Health maintenance is also thought to be dependent upon harmony with “family, community, nature, and one’s physical self.”⁶ Major medical decisions for an individual are often determined by the family, clan, or tribe; therefore, doctors may need to foster a relationship with them as well.⁷

Helpful Information from the Literature

A study published in the *Journal of General Internal Medicine* identified strategies for communicating negative information to Navajo patients.⁸ Negative information goes against the philosophy of Hozho and traditional native values, and it can strain discussions for advance care planning and informed consent. The researchers interviewed Navajo patients, traditional healers, and healthcare providers. The study results indicated that discussions between doctor and patient were most effective when four distinct stages were carried out:

1. Assessment (assess whether the patient is willing to participate in a discussion that involves negative information)
2. Preparation (cultivate a trusting relationship with the patient; involve family members; warn the patient about the nature of the discussion; communicate that no harm is intended; facilitate the involvement of traditional healers)

3. Communication (proceed in a caring, kind, and respectful manner, consistent with the Navajo concept “k'é”; refer to a (hypothetical) third party when discussing negative information [e.g., “some people have this condition”]; respect the power of language in Navajo culture by framing discussions in a positive way)

4. Follow-through (continue to care for the patient and foster hope)

Another study⁹ corroborated previous research, suggesting that alternative medicine is widely used by many cultural groups for common diseases. Interviews with more than 300 Navajo patients revealed that 62% had used native healers (39% on a regular basis). Use of medicine men was significantly less common among members of the Pentecostal faith than among those who identified themselves as Catholic, traditional Navajo, Native American Church, Mormon, Protestant, Christian, no religion, or Baptist. Diabetes, arthritis, and depression or anxiety were common reasons for consulting both a medical provider and a native healer. However, certain diseases such as upper respiratory tract infections and allergies were recognized as the exclusive domain of the medical provider. Other problems such as bad luck, blessings, and family difficulties were recognized as the exclusive domain of the native healer. Interestingly, compliance with medical treatment recommendations didn't correlate with the use of native healers, and a perception that the medical provider and the native healer gave conflicting recommendations was infrequent (21%). Dissatisfaction with care was reported infrequently. Cost was the most common deterrent to seeking traditional native care.

As the case of MB shows, evaluating and understanding a patient's background in addition to his or her medical condition can help lead to more successful clinical outcomes. Delivering health care while embracing the Navajo concept of k'é, which means kindness, love, cooperation, thoughtfulness, friendliness, and peacefulness, helps gain the patient's trust and demonstrates a true sense of cultural competency and sensitivity.

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CASE 3

At Home For an Hour: Competent Health Care for the Homeless

I could've counted her teeth on the fingers of one hand and the holes in her clothes on the other. Her hair was a cheerful orange and her eyes a warm brown. The exam room would smell of tobacco smoke hours after she'd gone. But she left something else, too: a new awareness about people whom I literally bypass every day.

This patient was a Caucasian female in her mid-40s. We last saw her at our clinic 2 years ago. Her last eye exam presumably came with a voucher for a free pair of glasses, as this exam would, but she hadn't filled the prescription. For her moderately high myopia she had been using church-donated glasses, but she lost them last week. The patient was homeless, and a combination of excessive UV exposure and trauma had led to the development of cataracts. She had suffered a blow to the head a few years ago, at which point, predictably, her vision also took a blow. In the right and left eye, best-corrected vision was 20/40 and 20/70, respectively. At her last visit to the clinic, she was advised to consult a physician regarding diabetes and hypertension. Our records showed that she had persistent elevated blood pressure and some risk factors for diabetes. At the current visit she dismissed the idea of blood work, citing a fear of needles.

Recognizing Potential Practitioner Bias

As I examined the patient, I had an increasingly hard time keeping her alert. She slumped forward and her chin sank in the chin rest. When my enthusiasm failed to wake her, and pinning her lids was beginning to affect the quality of my evaluation, I asked her if she'd kindly cooperate so I could better assess her ocular health. I think she saw my earnestness because she sat up. The past 2 nights she hadn't been sleeping, she confessed. A man known to be mentally unstable had pummeled her as she slept in the park, throwing things at her even as he left. She'd reported him to the police, and he was arrested for this and other violations. As she told me she hadn't been able to sleep since then, she cried in the headrest. My heart fell with the heaviness of this news.

I asked if she had a friend who could watch her as she slept. I suggested they could watch over each other. "I have a friend," she said, "but I never tell anyone where I sleep, not even him. I don't like anyone to know." I patted her arm, gave her tissues and suggested that perhaps she take naps during the day in more public spaces, where criminal activity was less likely. My suggestion, I'm sure, was not terribly helpful or wise, yet I think she read it as an expression of empathy. After that, my patient was a new woman, alert and cooperative.

At the end of the exam, while discussing my findings with her, I found myself wanting to omit my usual discussion of warm compresses. In that moment, I had judged her symptomatic dry eye and meibomitis to be, along the scale of diagnoses, secondary issues. However, I checked myself, thinking of the *New York*

*Equitable care: "providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status"*⁵

Times opinion piece by Juliann Garey that I had read, "When Doctors Discriminate."¹ Garey argued that healthcare professionals tend to give lower-quality care to patients with known mental health issues. Though this patient hadn't been diagnosed with a mental health problem, her homelessness was edging me away from discussing her health with her as fully as I might with someone else. I didn't act on this bias, but it

made me realize that the homeless are prone to having worse health secondary to their circumstances, but they also may be receiving worse care due to practitioner bias.

According to a 2011 government fact sheet,² more than 100,000 individuals experience long-term homelessness in the United States. Like my patient, approximately 40% of all homeless individuals are white non-Hispanics, and an equal percentage are female and middle-aged. The report also indicates that among the chronically homeless, approximately 30% have mental health conditions, and approximately 50% have substance abuse problems.

A 2006 fact sheet from the National Coalition for the Homeless (NCH)³ states that, with the exception of obesity, stroke and cancer, homeless individuals are far more likely to suffer from every category of chronic health problem. What's more, conditions that require regular therapy, such as tuberculosis, HIV/AIDS, diabetes, hypertension, addictions, and mental disorders, are particularly difficult to treat and control in the absence of housing. The NCH reports that the homeless also tend to experience multiple simultaneous health problems. Some, such as frostbite, leg ulcers, and upper respiratory tract infections, are a direct result of being homeless. The NCH fact sheet also states that homelessness puts people at greater risk of trauma due to muggings, beatings and rape. My patient experienced the latter two. (The rape had taken place 10 years prior, and was also reported to the police.)

An awareness of these risk factors might prompt a clinician to take special care in asking about a homeless patient's last health checkup, any history of trauma, mental health problems, and substance abuse. Because homeless patients tend to be lost to follow-up for their chronic health problems, a visit to an optometrist may be a rare and important chance to address controlling and managing systemic conditions that may have ocular manifestations.

A Four-Phased Approach

In terms of cultural competency, care for homeless patients is not unlike that of caring for other populations. Still, because of the bias that may color the treatment of a homeless patient, research has been done to help train clinicians to provide the best possible care. In his curriculum for outreach to the homeless,⁴ Ken Kraybill applies the Relational Outreach and Engagement Model (ROEM) described by the Mental Health Chaplaincy's Craig Rennebohm. ROEM organizes competent care for the homeless into four phases: approach, companionship, partnership, and mutuality. Approach pertains to the clinician recognizing her shared humanity with her patient, and can be something as simple as a smile. Companionship entails listening and empathizing. Partnership is building the trust necessary to involve third parties that may further assist the patient. Lastly, mutuality reflects the readiness of patient and clinician to part ways, having arrived at a meaningful improvement in the patient's life.

Though I was not familiar with the ROEM model at the time, the four phases unfolded during the exam: a smile and introduction; my patient's tearful story and my reassurance; the introduction to my attending doctor who provided further reinforcement; and the discussion of cataract surgery as well as the provision of a glasses prescription and artificial tear sample.

Providing culturally competent care may seem overwhelming when one thinks that every potentially marginalized population requires special attention, but the task isn't so daunting when clinicians rely on their intuition. Caring for patients, for me at least, has always been reminiscent of hosting guests. I feel obliged to make them feel welcome, to give them my best, and to send them off in a condition better than that in which they came. For homeless patients in particular, who are perhaps accustomed to inattention, positive approach and companionship can be invaluable and may help to ensure compliance with medical advice.

My patient with the orange hair and brown eyes reminded me never to compromise in the care of the already disadvantaged, and I consider myself successful as a clinician if, for at least the time she sat in my chair, my homeless patient felt at home.

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CASE 4

“Breaking the Ice” in a Remote Alaskan Village

As our team of two optometric professionals unloaded from the small plane, the frigid wind licked my ears and stung my eyes. We had arrived in Shaktoolik, Alaska,¹ a remote village, population approximately 250, just south of the Arctic Circle along the icy waters of the Pacific Ocean. The handful of buildings I could see looked out of place in the vast landscape of ice and tundra. The majority of health care in Shaktoolik is managed by health aides.² These dedicated individuals receive the equivalent of EMT training in order to care for their neighbors with health issues ranging from autoimmune diseases to trauma from hunting accidents. Telemedicine is used, but beyond that, people who require further medical care must either travel 100 miles to Nome or wait for one of the semi-annual visits in which I was currently participating.

Shaktoolik is home to the Inupiaq, a people known for their toughness. As children they participate in Alaska Native games, which test pain tolerance, dedication, and physical abilities.³ Because of the Inupiaq’s geographic isolation, their culture and heritage have been mostly preserved. They maintain a life of subsistence utilizing the sea and its resources.⁴ In addition to geography, financial difficulties can act as a barrier

“The delivery of high-quality primary health care that is meaningful, acceptable, accessible, effective, and cost efficient requires a deeper understanding of the sociocultural background of patients, their families, and the environments in which they live.”⁷

between health care and the residents of villages like Shaktoolik. Furthermore, the villages are known to experience freezing pipes that leave residents without running water for extended periods, another difficulty in maintaining health.

For me, this trip highlighted the cultural differences healthcare providers must be cognizant of and strive to understand in order to effectively treat patients. Here, I describe two cases that created opportunities for me to expand my understanding and ability to adapt treatment to best serve my patients.

Patient One: Reluctant to Be Treated

In the first case, an older gentleman was strongly urged by my colleague to come to the clinic because of his complex eye history. At first, the patient lamented that he was “blind and crippled” and didn’t wish to be seen for care, but eventually he agreed to be evaluated. His joints twisted and his back stiff, like many in this region, his body had been ravaged by the arthritic disease process. The prevalence

of spondyloarthritis is high among Alaska Natives.⁵ Inflammation had given the patient's irides an irregular shape; they were fused with synechiae from chronic bouts of uveitis. His visual acuity was only light perception in both eyes. The patient's corneas were scarred from phlyctenular keratoconjunctivitis. He reported eye pain that had gone on for years but intensified in the past few weeks. He voiced that his eyes were "dirty," and he hoped we could wash them out because he could not. Months prior to the current visit, he was given a tube of erythromycin ointment. He said he hadn't used it because he couldn't apply it himself and there was no one to help him. Using a handheld slit lamp in the multipurpose medical building that had been converted temporarily into an eye clinic, I saw a 1.5-mm by 1.5-mm central corneal ulceration in the right eye.

I knew continuing ointment therapy would not be effective, so I tested the patient's ability to use drops. I was encouraged by his ability to instill a drop of artificial tears in the office. However, immediate treatment of the painful condition was barred by a complete lack of drop-form antibiotics in the village. The soonest a fluoroquinolone could be obtained was 3 days, and we were scheduled to leave the next day. Also, the medical standard of care was at odds with this gentleman's prerogative to be treated in his home by fellow Inupiaq. While unlikely, the risk of endophthalmitis and enucleation as a result of under-treatment loomed. To allow the patient to remain in the village while being treated, we ordered moxifloxacin ophthalmic (Vigamox), which was to be flown to us with the next shipment. In the clinic, blepharitis collarettes were removed, anterior segment photographs were obtained, and erythromycin ointment was applied. The patient's son agreed to participate in the treatment, and a compromise was made whereby health aides from the village would photograph the ulceration daily and have the images evaluated via telemedicine.

Patient Two: A Misunderstanding about Treatment

The second patient was a 4-year-old girl with anisometropic amblyopia and a constant right esotropia. Her mother was asked to bring her to the clinic for a 3-month visual acuity and glasses check. She agreed to the appointment, but when the time came did not show. A second appointment was made and kept, but the patient presented without glasses. When questioned about the frequency of the eye turn, now that the patient had prescription glasses for several months, the mother reported infrequent use of the glasses. She gave several reasons for the noncompliance: she didn't want the girl's eyelashes to make the lenses dirty; cousins would play with and bend the glasses; and her daughter didn't like wearing them. She also mentioned that she and the girl's grandmother shared care of the girl and the grandmother wasn't aware of the importance of the eyewear.

At a minimum, the patient wasn't being encouraged to wear the glasses. After a demonstration of the eye turn and an explanation of the potential for vision loss, the mother acknowledged seeing the eye turn but seemed to remain apathetic about the treatment. Notably, she had the preconceived notion that if her daughter wore the glasses, she would become dependent on them. I struggled with respecting the mother's right to raise her daughter as she desired, while knowing her decisions could potentially render the child monocular for life. Even so, I couldn't assume the mother was being deliberately negligent. She may have thought her decision not to enforce the glasses was to the benefit of her daughter.

Ultimately, while not disrespecting the mother, I initiated a long conversation about how the glasses would help her daughter's eyesight. I explained that she couldn't see well without them, and I reiterated the goals of therapy. The patient was given a second pair of glasses in case one broke or was lost. Her mother agreed to be more diligent and to visit the Nome clinic 2 months later.

Building a Cultural Competence Skill Set

My experience with these two cases reinforced for me that the way to address health concerns and find solutions isn't always found in *Clinical Management of Binocular Vision* or a Kanski textbook. Doctors must treat the whole person, not just the disorder. A patient's history, experiences, values, customs, and insecurities regarding medicine are as important for achieving a treatment goal as the history of present illness. A fact relevant to both cases described here is that prior to 1970, Norton Sound Regional Hospital didn't exist.⁶ The elderly patient and the 4-year-old girl's mother had lived in a time when doctors from far away didn't come to their village to tell them how to take care of themselves. This history is part of what shapes the doctor-patient relationships in Shaktoolik, and it can't be ignored.

I feel as if these experiences served to make me a better clinician by reminding me of the need to develop skills for serving communities with cultural backgrounds different than my own.

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CASE 5

Language Barriers and Socioeconomic Status Can Compromise Health Care

I first met “Mr. Chang” (Mr. C) when I examined him in our clinic 1 month after he had been seen by another student at the independent living facility for low-income seniors where he resides. Mr. C is a 75-year-old who came to the United States from China relatively recently. He speaks little English, but always arrives with a smile and a “hello doctor.” With no interpreter present at the initial home visit, only limited testing could be performed, and documenting the full history was delayed until the patient could come to the clinic.

At the home visit, Mr. C’s visual acuities were 20/30+ OD, 20/40 OS, and 20/30 OU. He was using prescription glasses obtained in China that enabled 20/30 near vision OU. His IOPs were 28 mmHg OD and 36 mmHg OS. He had no visual complaints but wanted to take this opportunity to receive a free eye exam. Primary open-angle glaucoma was suspected, and he was referred to our clinic.

At the home visit, Mr. C provided his daughter’s phone number. She was called and accompanied him as an interpreter when it was time for his appointment at the clinic. History taken at this first clinic visit revealed Mr. C was hypertensive and taking one medication as treatment. Key findings included that his uncorrected distance visual acuities were slightly better than at the previous visit, possibly because his daughter was present to interpret. Refraction yielded minimal to no improvement in visual acuity. An updated prescription was written. Gonioscopy revealed 2+ temporal angles OU and 1+ angles in all other quadrants OU. IOP measured with Goldmann tonometry was 18 mmHg in both eyes prior to dilation. Post-dilation, IOPs were 18 mmHg OD and 24 mmHg OS. Dilated fundus examination revealed peripapillary atrophy 360° around both optic nerve heads. Cup to disc ratio was assessed as 0.8 in both eyes, and the neuroretinal rims appeared to be thin.

Due to his Asian ancestry, Mr. C has a high risk of developing angle closure glaucoma.¹ Because he is an Asian American, his risk of having diabetes is

Why Optometrists Need Cultural Competency⁶
Quality of care/clinical outcomes <ul style="list-style-type: none">● patient-centered care/patient compliance● Healthy People 2010/elimination of healthcare disparities
Practice management <ul style="list-style-type: none">● demographic changes● market share/competitive edge● patient satisfaction● performance-based reimbursement● licensing/certification requirements● risk management, malpractice, informed consent
Benchmarking <ul style="list-style-type: none">● accreditation standards for other health professions

relatively high,² and as a Chinese American, he is more likely to have hypertension and poor blood pressure control than a Caucasian American.³ In light of his risk factors and ocular findings, we suspected Mr. C had chronic angle closure glaucoma or primary open angle glaucoma. We discussed with him, with his daughter interpreting, glaucoma's effects on vision, how the disease is treated, and what further testing we wished to perform. We informed them about the symptoms of angle closure and instructed them to call the clinic immediately if he experienced them. Mr. C's daughter had many questions related to the information, and she indicated she was conveying them and our answers to him. Mr. C's initial response was "going blind is part of being old." His daughter said she told him that was simply no longer true. She indicated that, if possible, they would adhere to whatever treatment we recommended. Her father appeared to agree.

At Mr. C's next follow-up visit a week later, his sister-in-law accompanied him as his interpreter. Measured with Goldmann tonometry, IOP was 16 mmHg OD and OS. Based on the van Herrick test, the anterior chamber angles appeared to be grade 1+. Additional glaucoma testing was performed. Pachymetry showed corneal thickness to be within normal range, 524 μ m OD and 505 μ m OS. Optical coherence tomography of the optic nerve heads indicated thinning inferiorly OD as well as thinning inferiorly, superiorly, and temporally OS. (Visual field testing was scheduled for a future follow-up visit.) A formal diagnosis of primary open angle glaucoma in both eyes was made. The diagnosis was explained again to Mr. C via his sister-in-law. Perhaps because he was taken through a thorough explanation at his previous visit, he indicated that he didn't have any questions. He was given a sample of travoprost (Travatan Z) and instructed to instill one drop in each eye every evening. He was scheduled to return to the clinic in 1 month. The attending doctor called his daughter to re-explain the diagnosis and treatment instructions.

Awareness of Economic Issues

At the next appointment, Mr. C's cousin served as interpreter. After a month using the glaucoma medication, the patient's IOPs had decreased to 12 mmHg OD and 14 mmHg OS. Ideally, Travatan Z would have been prescribed, but Mr. C has no health insurance and a limited income. According to the Asian & Pacific Islander American Health Forum (APIAHF), as a group, Asian Americans (with Native Hawaiians and Pacific Islanders) are more likely to be uninsured than non-Hispanic whites. APIAHF also reports, "Many Asian Americans, Native Hawaiians, and Pacific Islanders that qualify for public programs remain uninsured because of language and cultural barriers in the enrollment process, misinformation about eligibility, and other family hardships such as food and housing insecurity. Others do not qualify even if they are low-income or legal immigrants."⁴

Lack of insurance and low income can be especially problematic for patients diagnosed with a chronic disease, such as glaucoma, that requires a lifetime of treatment. These two factors can easily put patients at risk for not receiving the treatments their doctors recommend, or for receiving no treatment at all. In Mr. C's case, one of the clinic's case managers is working to determine if he's eligible for the medication manufacturer's patient assistance program. If not, the next step would be to consider prescribing generic latanoprost instead.

Considerations for Using Interpreters

Mr. C was accompanied to each clinic appointment by a relative who speaks his first language, Mandarin. However, each seemed to have his or her own priorities regarding the exam. While his daughter appeared to be concerned about his health and vision, and indicated that she wanted him to know all of the possible outcomes and treatment options, I had no way to know for sure what she actually conveyed to him. Another of Mr. C's interpreters, his sister-in-law, seemed to be ready to leave the moment she walked through the door. She spent more time asking me questions about my school than she spent ensuring Mr. C knew exactly what was being said.

While Mr. C's interpreters seemed to be successful, because he had been doing well, relatives in this role aren't always desirable. As explained by Hadziabdic and Hjelm in their 2013 literature review,⁵ family members may give the patient a feeling of security, but they have varying language skills and are unlikely to have any training in interpretation. The authors also point out that other options include professional interpreters, who have acquired a specialized set of skills, including knowledge of medical terminology. While using trained interpreters can be ideal, it may also be costly and have limited availability. Hiring bilingual healthcare staff members is another option that can work well, but it can also have drawbacks, such as lack of training and difficulty separating the two roles of interpreter and staff member. Regarding modes of interpretation, the paper states that face-to-face is most desirable, but telephone interpretation, in which the conversation is transmitted via speaker, can also be effective. The main disadvantage is that body language isn't visible. In summarizing their findings, Hadziabdic and Hjelm note that decisions about type of interpreter and mode of interpretation should always be made with not only availability but also the patient's needs and desires in mind.

I've examined many patients who speak limited or no English, and I always try to speak directly to the patient as if no interpreter were in the room. However, as an exam progresses, it's difficult not to slip into looking at the interpreter rather than the patient and asking questions in the third person as if the patient wasn't in

the room. It's important, however, to keep the exam patient-centered. Among the strategies Hadziabdic and Hjelm suggest:

- always speak directly to the patient, not the interpreter
- avoid, as much as possible, turning privately to the interpreter
- position yourself so you're able to look directly into the patient's eyes, but also so you're able to see the interpreter
- show that you're actively listening and interested, by nodding your head, looking directly at the patient, and posing follow-up questions when necessary
- avoid as much as possible the use of specialized medical terminology, which often doesn't translate well
- talk slowly and in moderate sequences
- avoid interrupting the patient/interpreter

Based on my experience, it may be helpful to explain to the interpreter the goals of the exam and the communication prior to the exam. That may include informing the interpreter how you wish him or her to convey your words (directly vs. third-person). Taking the time to plan for success, including deciding where everyone will sit to facilitate communication, helps me to keep my exams involving interpreters patient-centered.

Making sure we're accomplishing effective communication with our patients, whether they speak English, Mandarin, sign language, or any other language, will also help to ensure their health.

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CASE 6

Unexplained Vision Loss in a Young, Hearing-Impaired Hispanic Male

Cultural competency is a fundamental factor contributing to the success of a healthcare community. A culturally competent healthcare system recognizes and incorporates the importance of cultural differences in health beliefs and behaviors and acknowledges differences in disease prevalence and treatment outcomes for specific patient populations.¹ In the United States, it's becoming more important to embrace cultural awareness because the population is projected to become far more diverse in the next 30 to 40 years. The Hispanic population is among those expected to grow rapidly. In 2014 it accounted for 17.4% of the total U.S. population and is projected to account for nearly 29% of the population by 2060.² As primary eyecare providers, optometrists have the privilege of working with patients of every age, gender, race, ethnicity, and cultural background. It's crucial that they acknowledge sociocultural barriers to good health and take steps to close gaps in healthcare access.^{1,3}

Improvement in Visual Acuity Stalls for Boy with Refractive Amblyopia

The case of a patient who was recently treated at our clinic illustrates how lack of attention to cultural differences can potentially act as a barrier between doctors and patients and prevent patients from receiving the best possible care. The patient is a 5-year-old Hispanic male. His parents brought him to the clinic for a follow-up visual acuity check of his right eye, which was affected by moderate refractive amblyopia. His visual acuity improvement had plateaued at previous exams, so a cycloplegic refraction was scheduled to determine whether his prescription had changed, which might prevent him from making further improvements. His medical history was remarkable for severe congenital hearing loss for which he had been fitted with a cochlear implant. He was unable to speak. His parents spoke only Spanish and had an elementary-school level of education. They were attempting to learn American Sign Language (ASL), which is used at their son's school, an institute for the deaf and blind where he lives during the weekdays.

Anterior segment findings were unremarkable. The patient's pupils were equal, round, and reactive to light, with no afferent pupillary defect. Motilities and confrontations were grossly full in both eyes. Dilated fundus evaluation revealed clear lenses and subtle optic nerve head pallor in each eye. The cup-to-disc ratio was estimated to be 0.4 OU, and the macula was flat with a positive foveal reflex in each eye. Retinal vasculature was normal, and the periphery showed no signs of

predisposing conditions to retinal detachment in either eye. The patient was not taking any medications and had no known drug allergies.

The patient was first seen by providers from our clinic at his school. At that time, it wasn't possible to obtain a visual acuity measurement because the patient didn't understand the task. Previously, he had been a patient at a Lion's Eye Clinic, where he received his glasses for full-time wear and was instructed to patch his right eye (as reported by his parents) for 3 hours each day. During his exam at school, updated glasses were prescribed (OD: +6.50-2.25x180 and OS: +0.50-1.25x180) and weekend atropine was initiated in the left eye for amblyopia treatment in place of daily patching of the right eye that was reported.

When the patient returned to the clinic for a follow-up visit after 2 months, his visual acuity, measured with LEA flipbook, was 20/200 in the right eye and 20/25 in the left eye. His mother reported he had been constantly looking over his glasses, which were challenging to fit because of the cochlear implant. Wearing his appropriate correction was crucial, so a spherical contact lens was recommended for his right eye with glasses on top to correct for his astigmatism. The patient's insurance didn't cover contact lenses, and his parents couldn't afford the cost, so a local nonprofit organization that aids in eye care generously covered the cost of the fitting and the contact lens at the request of the provider. Unfortunately, the patient didn't tolerate the contact lens well due to irritation, and his parents had difficulty with the insertion process. As a result, he returned to full-time spectacle wear with atropine and daily patching of the left eye. To improve spectacle-wear compliance and comfort, a flexible plastic frame was fitted. The patient consistently wore his new frame without comfort complaints.

Cultural Competence vs. Cultural Incompetence⁴	
Competence	Incompetence
Clearer channels of communication	Higher possibility for patient/provider misunderstanding, miscommunication
More positive patient/provider interaction	Greater opportunity for patient/provider discordance
Greater patient/family investment in care plan	Greater likelihood of patient distrust, dissatisfaction, and reduced compliance
More timely and appropriate care	Less likelihood of awareness and appreciation of the cultural influence on health and illness
Reconciliation of Western biomedical and traditional cultural health practices	Greater likelihood of provider uncertainty and cultural stereotyping
Less provider uncertainty and greater familiarity with sociocultural determinants of health	Less probability for positively impacting health disparities
Improved patient compliance	

With approximately monthly follow-up care for 2 years, his best-corrected visual acuity was 20/80 OD and 20/32 OS with large variability observed among measurements. His mother reported questionable compliance with atropine while the patient was at boarding school during the week. His best visual acuity was measured during the summer while he stayed at home and his mother was responsible for instilling the atropine and monitoring the eye patching.

While an MRI could have ruled out intracranial pathology as a cause of the optic nerve head pallor and reduced visual acuity, the patient isn't a candidate for the test due to his cochlear implants. It was decided that if further improvement in visual acuity wasn't observed, a visually evoked potential test would be recommended to help determine whether cortical visual impairment is a factor.

At the patient's most recent exam, an error was made during the check-in process. As a result, the family ended up patiently waiting more than 2 hours past the scheduled appointment time. The parents were very upset but hadn't expressed their frustration to the administrative staff because they didn't want to be disruptive, and they didn't feel comfortable enough speaking English. Due to an apparent growth spurt, the initial flexible plastic frames were causing discomfort and rubbing near the patient's cochlear implant. His mother reported he was constantly pulling them off. After the examination, the patient's new prescription was placed in a larger frame, which was paid for by the nonprofit organization.

Cultural Differences Add Complexity to the Case

Refractive amblyopia is a challenging concept to explain, and cultural differences between doctors and the patient and his family add layers of complexity to this case. Even with a Spanish-speaking doctor and a proficient ASL interpreter present on many occasions, it had been challenging to describe the patient's condition and exam findings to his parents, whose level of education is limited. The patient's hearing loss compounds the communication barrier because he is only able to follow the directions his parents understand to be correct and communicate to him. In this particular case, the parents seemed to understand best when their son's refractive error was demonstrated to them with trial lenses. Following patching or atropine directions is crucial in amblyopia, and the parents originally reported they had been patching the right eye (worse-seeing eye) after visiting the Lion's Eye Clinic. If they were actually patching the right eye, they could have been further embedding the amblyopia and making future treatment more difficult. An incomplete understanding of the situation may also contribute to insufficient communication between the parents and the patient's school. Although it was reported that the patient was receiving the atropine drops each day at school, his visual acuity was much better when he was monitored by his family. The timid nature of the family when their appointment was overlooked is another cultural

difference exhibited in this case. After the discovery of the mistake, the family expressed frustration about their wasted time to the Spanish-speaking doctor. However, even with their frequent visits to the clinic, it appeared they were still too uncomfortable with the environment to interrupt the staff and check the status of their appointment. These examples reinforce the importance of cultural competence in healthcare settings, including among the reception staff, in successfully treating and retaining patients.

According to the Association of Schools and Colleges of Optometry's Guidelines for Culturally Competent Eye and Vision Care, "It is a clinical necessity that optometrists possess the patient-centered attitudes, knowledge, and skills necessary to competently serve a diverse community with its spectrum of education, experiences, beliefs, values, customs, preferences, fears, and expectations that impact the interpersonal interactions of clinical care."⁴ In the Hispanic population in particular, cultural barriers to health care include: lower education level, lower income, lack of health insurance, and unfamiliarity with navigating the U.S. medical system.⁵ In addition, Hispanic (and African-American) children in the United States have a higher risk of developing amblyopia than children in other ethnic groups.⁶ As primary eyecare providers, optometrists need to be cognizant of patients' cultural needs and expectations.

If a patient doesn't understand the importance of a prescribed treatment, the doctor hasn't been successful in managing the case. Efforts such as cross-cultural competency training and utilization of interpreters should be made to reduce the cultural and language barriers that impact families similar to the one in this case. Educating patients and family members of all cultural backgrounds about the natural course of conditions and necessary changes in treatment is of primary importance in building a trusting relationship with patients. That relationship enables the optometrist to more effectively interact with patients so they can be fully involved in their healthcare decisions and behaviors.

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CASE 7

Optometrists Must Overcome Obstacles to Patient Understanding

For Latinos and Hispanics residing in the United States who speak little or no English, language is one of many barriers to seeking and obtaining proper health care.¹⁻³ This is especially unfortunate because Latinos and Hispanics develop vision impairment, blindness, diabetic eye disease, and cataracts at higher rates than non-Hispanic whites,⁴ and open-angle glaucoma is a leading cause of blindness among Hispanics.⁵ In a study evaluating glaucoma follow-up and compliance with treatment recommendations, Latinos (along with Asian-Pacific Islanders) were identified as the ethnicity most affected by difficulties related to medical interpretation.⁶

Sometimes, even when interpreters are used, patients for whom English isn't the first language may not understand their diagnosis, exam findings, and treatment recommendations. As a result, they can become overwhelmed and distressed by their ocular status. Unfortunately, I have cared for a patient, "Maria," whose case exemplifies this. For a long time, Maria didn't fully understand why she was losing her vision. When we finally explained what was occurring in her eye and made sure that she understood, her reaction caught me by surprise.

"It is imperative that optometrists and optometry students understand and respond with sensitivity to the needs and preferences that culturally and linguistically different individuals bring to the eyecare system because culture and language are vital factors in how health services are rendered and received."⁷

Delivering Difficult News

During my low-vision rotation in optometry school, I participated in the care of patients with advanced ocular diseases. Patients are referred to the low-vision clinic for one of two reasons: to be prescribed low-vision aids, or to learn about vision substitution. Unfortunately, Maria needed the latter. Custom optical aids, such as magnifiers and telescopic eyewear, were no longer enough to provide her with functional vision. She had already undergone multiple procedures including cataract surgery, peripheral iridotomy, and trabeculectomy. Our examination and retinal imaging confirmed that end-stage glaucoma, posterior staphyloma, and optic atrophy in both eyes were responsible for Maria's vision loss. Her best-corrected visual acuity was 20/7000 in the right eye and hand motion at 2 feet in the left eye. As the examination was coming to an end, I selfishly dreaded its

conclusion. I knew that for the first time in my life, I'd have to explain to a patient that her vision was permanently damaged, and that she'd never be able to see better than she is seeing now. I'd have to tell her we couldn't do anything further except to recommend resources to help her psychologically and physically cope with her condition. Maria's husband, who was able to communicate in English, albeit not very well, was with her at the exam. As her caretaker, he accompanied her for healthcare appointments.

Sitting about 3 feet from Maria, I leaned forward and looked her directly in the eyes. In Spanish, I explained in the most genuine and empathetic way I possibly could that her condition was irreversible, and we were going to refer her to some helping institutions. (We provided information about optical character recognition technology and made referrals to Blindness Support Services and the Braille Institute of America.) I feared her reaction would be melancholy or denial. Instead, Maria looked in the direction of my voice, smirked, and then cried a bit. Her tone was slightly angry, yet at the same time she sounded relieved. She said she had always known she was going to go blind, that her vision would abandon her at some point. She then clarified that her tears were not of sadness, but of relief. She said she understood for the first time why her vision had degraded so noticeably over the years, why she had been instructed to put drops in her eyes at a certain time every day, why she had to undergo so many office appointments and surgical procedures. It was as if our discussion was the first that explained her suffering. In return, the attending and I earned a big hug from Maria. The spontaneous hug was especially noteworthy given the fact that in Latin American culture doctors are respected as authority figures.⁸

The Optometrist's Responsibility

It was difficult seeing Maria digest the news of her vision loss. It was evident she had been desperate for answers. All low-vision patients have a hard time comprehending the reality of blindness. I can't imagine how difficult it was for Maria because she had never understood what was happening. It bothered me that before this visit no one had taken the time to talk to her about her condition and clearly lay out the realistic options for her vision moving forward. If they did, it certainly appeared they didn't take the time to ensure that she understood.

Optometrists should feel obligated to ensure that patients fully comprehend the status of their vision and ocular health. This may mean having a hard time acquiring a patient history or spending longer than usual on patient education or subjective refraction. Thanks to Maria, I learned it means much more for patients. A language barrier is an obstacle optometrists must be willing and able to overcome.

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CASE DISCUSSION QUESTIONS

Do you agree with the eyecare providers' assessment and handling of the cases?

What, if anything, could have been done differently?

Have you experienced situations similar to those described in the case studies?
How were they similar or different to what is described in the case studies?

What is the difference between race, ethnicity, and culture?

What is the difference between Latino, Hispanic, and Spanish?

What can you do to become more culturally competent?