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Cultural Competency in Cleveland

Introduction

At the moment a patient decides to visit a medical clinic, he/she should feel confident the medical team providing treatment is knowledgeable, sensitive and understanding of cultural competency. That is, that the staff understands that depending on which minority or culture group the patient belongs to can dictate unique needs of the patient and their medical care. Physicians are asked to show respect and understanding toward various heritages, family environments, economic factors, races, genders, sexual orientations, and ages. Unfortunately, because medical school does not traditionally provide such a foundation, it becomes the responsibility of the healthcare institution to provide physicians and other staff with the necessary tools and skills to adequately prepare them for patient interaction and cultural sensitivity. Presently, the above mentioned patient variables are indirectly indicative of patient treatment. A medical clinic that can successfully and appropriately manage the care of a culturally diverse group of patients is potentially a financial windfall.

Within Cleveland, Ohio local clinics have successfully “branded” themselves as sensitive to the cultural differences found in specific populations (i.e. Hispanic, African American, Homeless, etc.) as related to treatment. However, this designation may indirectly suggest those individuals who are part of another demographic (i.e. illiterate, uninsured, under-insured, working poor, immigrant, or lesbian/gay populations) will not gain the same access to treatment as their demographic counterparts. Furthermore,

patients who cross over the cultural norms of populations (i.e. gay, Hispanic male) may face additional obstacles in gaining access to care.

This forces the healthcare institution to choose one of two options: provide comprehensive medical services appropriate for all patients despite demographic variables, or, focus those efforts on specific population(s) that their staff persons can identify with. While both options are an incredible undertaking and require the thorough training of not only medical staff, but clinic staff of all levels, the potential gains from ensuring a culturally competent staff are undeniable.

Thus, this chapter will provide substantial support for the inclusion of cultural competency training, identification of patient needs, and identification of current staff strengths (as it relates to cultural competency) within a healthcare setting.

Background and Definitions

According to the United States Department of Health & Human Services Office of Minority Health, cultural competency is defined as “a set of congruent behaviors, attitudes and policies together in a system, agency or among professionals that enables effective work in cross cultural situations.”¹ The culture referred to includes “integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, religious or social groups. All of these patterns of behavior, on both the patient and provider’s parts can influence whether or not “equal and quality health care” is practiced.

¹ The Office of Minority Health. (2007). What Is Cultural Competency, Retrieved February 3, 2007, from: <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>

Cultural competency has been incorporated into different settings for many years; within the past ten years numerous institutions on the national stage have prescribed standards and policies regarding how to implement the theories and practices into the clinic setting. One set of such theories known as The CLAS (Culturally Linguistically Appropriate Services). The CLAS standards were adopted by the Federal Register on December 22, 2000 and are now required of any organization receiving Federal funds. CLAS standards provide guidelines rather than mandatory requirements, a wise choice by the authors because

Examples of the CLAS standards include:

- Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient with limited English proficiency at all points of contact in a timely manner during all hours of operation.²

² The Office of Minority Health. (2007). National Standards on Culturally & Linguistically Appropriate Services, Retrieved February 8, 2007, from: <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>

San Francisco, California has adopted the CLAS standards into their current healthcare practices. In 2002, all San Francisco city health department clinics and contract agencies were mandated to adhere to the CLAS standards.³ The resolution acknowledges that CLAS standards are not encompassing of all cultures and minority groups and that certain communities, such as San Francisco, need to modify the CLAS standards to fit the needs of their population (i.e. the larger gay/lesbian population of San Francisco.)

Levels of Cultural Competence

Any city, hospital, clinic or private practice has to decide which level of cultural competent care they are going to provide and which level of staff will be appropriately trained. In *The Healthcare Professional's Guide to Clinical Cultural Competence*, Rani H. Srivastava, RN, MScN describes four levels of cultural competence—Individual Cultural Competence, Organizational Cultural Competence, System Level Cultural Competence and Team Level Cultural Competence.⁴ Srivastava proposes that individual cultural competence would allow a healthcare provider to serve as a “cultural broker who serves as a bridge between the culture of the client and that of the healthcare system.” Organizational cultural competence should reduce health disparities and increase the capacity to serve diverse populations. For example, members of the minority population would be recruited for the clinic faculty and staff or board of directors and/or the clinic could partner with traditional healers as an alternative to traditional medicine. System level cultural competence includes the recruitment of minority students to the profession, further research related to cultural competency and address funding needs. Team level

³ San Francisco Department of Public Health. Retrieved February 24, 2007, from <http://www.sfdph.org/CLAS/default.htm>

⁴ Srivastava, Rani. 2007. *The Healthcare Professional's Guide to Clinical Cultural Competence*. United States of America: Mosby Elsevier.

cultural competence “makes the values explicit, clarifies group norms and draws on the strength of the collective.”

Some Cultural Competency Target Populations

A leader in the field of cultural competent care is the Kaiser Permanente system. Kaiser Permanente recognized the importance of cultural competency when they released a series of handbooks on minority populations in 1999. These handbooks included information on the Lesbian, Gay, Bisexual and Transgender (LGBT), African American, Latino, and Asian and Pacific Islander Persons communities. Each handbook provides a thorough review of demographics, health beliefs and behaviors, risk factors, major diseases, special areas of clinical focus, child & adolescent health and mental health per populations.

Please note that these are not the only cultures and populations that need culturally competent care. Rather, they represent some prevalent cultures within Cleveland, Ohio. Also included in the following are some best practices being modeled in Cleveland by healthcare providers.

Lesbian, Gay, Bisexual Transgender

In addition to defining heterosexual, lesbian, gay, bisexual, gender identity and transgender the Kaiser guide to the LGBT population examines the varying levels of LGBT relationships, LGBT families, and research and methodological constraints (including the lack of diverse samples—normally Caucasian homosexual males) and the lack of longitudinal data. Areas of sensitivity include patients’ medical history (disclosure of sexual experience, HIV/AIDS status) and confidentiality (including fear of being “outed” to employer). Special considerations and attention should be given to the

history and intake form. Often on those forms, heterosexuality is assumed. Therefore, be sure to include LGBT friendly language such as significant other or partner. Risk factors that often contribute to LGBT patients not continuing care include homophobia, heterosexism “the belief that heterosexuality is the only form of sexuality acceptable,” hate violence and caregiver attitudes.⁵

The Kaiser handbook provides a thorough description of sexual practices, affiliated terminology, definitions, risk factors and prevention. Other issues that may appear when caring for LGBT patients include mental health, fertility and in vitro fertilization, eating disorders and domestic violence. Additionally, the right of domestic partners during care is a common issue.

On March 28, 2007 MetroHealth Clinic, Cleveland, Ohio announced its PRIDE Center, a LGBT health clinic at the McCafferty Health Center; one of only 13 clinics in the United States, and the only one in Ohio. Henry Ng, MD Director of the PRIDE Clinic stated, “The other clinics do provide comprehensive services for LGBT populations, though some historically have served more men who have sex with men or provided a greater focus on HIV/STD care. Our clinic serves as an access point for LGBT people and their families, however defined, and will provide primary pediatric and adult care with referral services for HIV, subspecialty, and mental health care. The model is not a new one, but new for Ohio.”⁶

African American

⁵ Kaiser Permanente. (1999). A Provider’s Handbook on Culturally Competent Care Lesbian Gay Bisexual Transgender Populations. Kaiser Permanente.

⁶ Kanda, Kathleen. (2007, March). Cultural Competence. Available e-mail: kcanda@nfpmedcenter.org.

29.1% of the population in Cuyahoga County is African American.⁷ Clinics such as North East Ohio Neighborhood Health Services (NEON) have a leading presence in the City when it comes to working with the African American population.

Throughout the Kaiser Permanente handbook, it is apparent that many of the factors to closely consider when treating African American patients are not medically specific. The structure of the African American family is crucial to competent care. Many African American families are non-traditional, meaning, a single parent, grandparent or other guardian raise one or more children. Education, income and occupation are also vital to consider. Additionally, despite the advances in our society, racism is still prevalent in American society and a common reality for many African Americans.

Futhermore, the beliefs and practices of many African Americans need to be factored in to medical care. Religious doctrine, cultural interaction and the role of family and friends during healing are important to African Americans according to Kaiser.⁸ Common lifestyle risk factors amongst African Americans include smoking, alcohol, drugs, obesity, physical activity and diet and nutrition. Because of the impact of family cooking methods has on health especially that of African American families, The Kaiser Permanente guide provides substantial information on how to combat common cooking practices in the African American community. “Culturally appropriate” recommendations include alternatives to basting meat with fat, the use of cream in

⁷ U.S. Census Bureau <http://quickfacts.census.gov/qfd/states/39/39035.html>

⁸ Kaiser Permanente. (1999). A Provider’s Handbook on Culturally Competent Care African American Populations. Kaiser Permanente.

cooking, and the cooking of meats such as pigs' feet, sausage, spare ribs and high salt lunch meats.

Major diseases in the African American community include hypertension, diabetes mellitus, end stage renal disease, atherosclerotic vascular disease, cerebrovascular disease, cancer, asthma, tuberculosis and HIV/AIDS.

Latino

Caring for the Latino community in a culturally competent manner is more complex than many other minority groups. The numerous sub groups that all identify as Latino is what makes the culture diverse and so complicated simultaneously. The numerous cultures within the culture include Mexican American, Puerto Rican, Central American, South American, and Cuban American. The lack of adequate health care coverage and language boundaries are common concerns for the Latino patient and their families. Similar to that of the African American community, the Latino community has numerous health beliefs and behaviors that complicate their care. From the belief of traditional folk illnesses and their remedies to cultural values such as *simpatia* (value placed on politeness), *personalismo* (warm relationship with provider), *respeto* (provider as a authority figure) and *familismo* (family outranks individual) can be obstacles for clinicians.⁹

Behavioral risk factors include violence, diet and nutrition, obesity, smoking, alcohol and drug abuse. Major diseases include diabetes mellitus, end stage renal disease, gallbladder disease, cardiovascular disease, coronary heart disease, hypertension, HIV/AIDS.

⁹ Kaiser Permanente. (1999). A Provider's Handbook on Culturally Competent Care Hispanic/Latino American Populations. Kaiser Permanente.

Kaiser Permanente advises clinicians to pay special attention to obstetrics and gynecology when treating for Latino patients. The guide notes more common prenatal anxiety for Latino women as well as pregnancy complications. Post natal care is also a careful consideration as Kaiser notes that Latino women breastfeed less than non Latino women. The guide also notes that immunizations and folk medical beliefs such as empacho (belief that substance gets into lining of stomach) or mal de ojo (illness when someone places a spell or wished ill) on the patient.¹⁰

In Cleveland, for over 20 years Neighborhood Family Practice has been a leader in providing medical care for the area's Hispanic population. Kathleen Canda, RN of Neighborhood Family Practice states, "Over one third of our patients are self declared Hispanic. Hispanics also suffer a disproportionate burden of chronic disease, especially diabetes, cardiovascular disease and asthma. They often come to us when their disease is far advanced and this may be the result of poor language skills or they are not culturally skilled at navigating the health care system. We sometimes find that Hispanics have a cultural leaning or attitude about illness: 'It's God's will.' 'What ever will be will be.'"¹¹

Asian and Pacific Island American

The Asian American community is as complex as the Latino community. The issues to address regarding cultural competency and Asian Americans vary from many of the other minorities. Unlike the figures for African American families, Kaiser reports that Asian Americans tend to reside in "highly cohesive families" indicating that over

¹⁰ Kaiser Permanente. (1999). A Provider's Handbook on Culturally Competent Care Hispanic/Latino American Populations. Kaiser Permanente.

¹¹ Kanda, Kathleen. (2007, March). Cultural Competence. Available e-mail: kcanda@nfpmedcenter.org.

“64% of Adult Asian Americans are living in married couple families.”¹² Their education, income and occupation tend to be above the mean and many have adequate health care coverage. Similar to that of the Latino community, Asian Americans identify in a broad spectrum of nationalities including Chinese, Japanese, Korean, Vietnamese, Laotian, Hmong, Mien and Cambodian just to name a few. Each of those countries have at least one major language and countless regional dialects that can make communication difficult enough in the host country, a problem that can be magnified when preparing written communication and translation services for patients here in the United States.

Factor in the numerous religious communities including Buddhism, Confucianism, Hinduism, Taoism and Christianity and Asian and Pacific Islander patients can be some of the most diverse patients to care for. Not only do the religious beliefs affect care and treatment but the views of health and wellness also contribute.

Individuals with Disabilities

Approximately 25 million people report some type of disability. The Americans with Disabilities Act of 1990 has outlined a national mandate as to the rights and opportunities of those with disabilities. When providing competent care for those with disabilities it is not just the interaction and communication that the staff need to consider, the built environment from the parking lot to the examination table need to be accessible for those with disabilities.

A major concern facing many with disability is unemployment. Though most have a desire to work, many are just unable to because of their disability. Unemployment leads to numerous factors that need to be considered in care including medical insurance

¹² Kaiser Permanente. (1999). A Provider’s Handbook on Culturally Competent Care Asian and Pacific Island American Populations. Kaiser Permanente.

coverage or lack there of and finances. Kaiser Permanente reports that according to the CDC in 2001 17.2% of people with disabilities did not possess health coverage.¹³

Depending on the disability there are countless adjustments that need to be made. For instance, if a patient is blind, is the office environment safe for a blind individual to maneuver around. How will he or she complete confidential paperwork? What if a patient has a hearing disability? Does someone on staff understand and speak sign language? Cognitive disabilities ranging from autism to Down's Syndrome need to be considered as well. Is the clinic staff patient and sensitive and do the nursing and medical staff possess the expertise needed for adequate care?

According to the Kaiser guide, health factors often prevalent include substance abuse, sexually transmitted diseases, physical injury, and poor nutrition.¹⁴

Others

The above referenced populations are just a handful of the cultures that clinicians should be considering when developing and implementing cultural competence initiatives. Other groups or populations that should be considered include but are not limited to:

- Uninsured
- Immigrants
- Working poor
- Religious groups
- Homeless

¹³ Kaiser Permanente. (1999). A Provider's Handbook on Culturally Competent Care Persons with Handicaps or Disabilities. Kaiser Permanente.

¹⁴ Kaiser Permanente. (1999). A Provider's Handbook on Culturally Competent Care Persons with Handicaps or Disabilities. Kaiser Permanente.

- Illiterate
- Elderly
- Unconventional Families & Lifestyles

The list is endless and in 2007 there are emerging considerations that require cultural competence skills and knowledge but aren't necessarily population specific. For instance, doctors increasingly have to care for patients that are Internet savvy and coming to the doctors with self diagnoses and extensive knowledge about numerous conditions, symptoms and treatments. Because of the continually changing population, cultural competency training should be an ongoing occurrence for all levels of staff.

Training

Government and private sector, the Internet and countless authors have designed websites, conferences, guides, books and pamphlets with endless opportunity for trainings. In Ohio one such agency is OhioKePro, the state's Medicare Quality Improvement Organization. Through the "Think Cultural Health" campaign OhioKePro is providing training and resources to medical providers and administrators across the state.¹⁵

Under the direction of Dr. Ash Seghal of the MetroHealth Center for Health Disparities and Jennifer Scofield, Director of Health Promotion for the City of Cleveland Department of Public Health, the fall of 2007 will see a launch of a new cultural competence program as part of the Steps to a Healthier Cleveland initiative. A comprehensive approach will focus on training clinic staff of all levels from administrative to medical while simultaneously encouraging the general public to seek

¹⁵ Ohio KePro. (2007). Cultural Health Training, Retrieved April 7, 2007, from <http://www.ohiokepro.com/providers/physician/culturalhealth.asp>

culturally competent care from their providers. With guidance from agencies with expertise in the field such as Kaiser Permanente, Asian Services in Action, OhioKepro among others the City of Cleveland Department of Health stands to launch a unique program that easily could become an exciting new model.

Implementing and Managing a Culturally Competent Clinic

The first step in creating a culturally competent clinic environment is to complete a community assessment either independently or with the assistance of city administration or a local community development organization. Simultaneously the staff should be analyzing the patient population and the cultural and societal demographics. This process will help identify the current and future cultural competency needs of the clinic.

Secondly, a thorough review of the cultural makeup of the staff should be performed. This audit should include extensive questioning and honest dialogue regarding the racial make up, language abilities, sexual orientation any handicaps or disabilities of the staff. Completing this process will establish the current capacity and future needs of the staff skill set and outline the necessary trainings.

Next, a random sampling of patients should be surveyed regarding their perspective on the cultural competency of the staff and care. Such a survey should cover the patients thoughts on clinic environment, reception staff, nursing staff, medical staff, procedures (including forms, examination and follow up care). Survey results should be independently evaluated by a third party. The above results should be compiled and a strategic plan for cultural competency designed outlining immediate needs, short term goals and long term objectives identified.

In “Making Cultural Competency Work” by Diane Adams, MD, MPH, Dr.

Adams suggests the following six items to take clinical cultural competence to the next level:

- Tap into good cultural competence resources.
- Assess your staff’s understanding of cultural competence.
- Make training reflective of real life.
- Include minorities in leadership roles.
- Put your organizations plans in writing.
- Put ideas into action.¹⁶

Adams advises agencies to stop paying simply “lip service” to the concept—move above simply showing training videos and to begin small by reviewing printed materials and phone systems but to move quickly beyond those initial steps.

Another approach is that of Glenn Flores, MD whose cultural competency model was printed in *The Journal of Pediatrics* in 2000. Dr. Flores suggests that clinicians analyze their practice cultural competency knowledge in the following five categories:

- Normative cultural values
- Language issues
- Folk illnesses
- Patient/parent beliefs
- Provider practices¹⁷

¹⁶ Adams, Diane. (2000). Making Cultural Competency Work. Office of Minority Health Resource Center.

¹⁷ Flores, Glenn MD. (2000). Culture & the Patient Physician Relationship: Achieving Cultural Competency in Health Care. *The Journal of Pediatrics*, 136, 14-23. Retrieved April 21, 2008 from PubMed.

The Flores model emphasizes the importance of language issues and folk illnesses and advises those treating Hispanic patients to consider its importance in any cultural competency effort.

Acculturation

One important need for the expansion of cultural competent services in healthcare is to combat the effects of acculturation. Defined as “to capture the psychological, behavioral and attitudinal changes that occur when individuals and groups from different cultures come into continuous contact with each other.”¹⁸ As individuals lose sight of the unique needs of their race, gender, nationality or religion healthcare providers are faced with treating a falsely homogenous population. Neighborhoods in Cleveland, Ohio such as Slavic Village which used to have a predominant Eastern European population or Brooklyn Center which was previously known as “Little Puerto Rico” because of its Hispanic population are now losing the identity which set them apart for so many years. Should the revitalization of the city continue and the influx of “urban pioneers” of all ages, income levels and races continue, health clinicians will have to further prepare in the battle against acculturation.

Patient Education

In addition to training staff, cultural competent health care can be increased—and acculturation decreased—by educating the patients themselves, before they get to the clinic or while they wait for their appointments. The University of Michigan Health System has outlined several ways that patients can contribute to cultural competent care.

¹⁸ Cabassa, Leopoldo. (2003). Measuring Acculturation: Where We Are and Where We Need to Go. *Hispanic Journal of Behavioral Sciences*, 25, 2, 127-146. Retrieved April 21, 2008 from PubMed.

One manner to achieve that is to improve doctor patient communication. In order to improve communication between patients and doctors clinicians could include questions on intake forms or direct staff to ask questions such as¹⁹:

- So that I might be aware of and respect your cultural beliefs...
- Can you tell me what languages are spoken in your home and the languages that you understand and speak?
- Please describe your usual diet. Also, are there times during the year when you change your diet in celebration of religious and other ethnic holidays?

Another, and inexpensive manner to educate patients is to take the time to more clearly explain the meaning, methodology and reasoning for procedures as simple as blood withdraws to more intensive CAT scans and MRIs. When cultures, religions, or family beliefs don't allow certain procedures—such as Jehovah Witness beliefs of not accepting blood, clinicians should be prepared to recommend or implement alternative medicines or treatments.

Resources

The Internet, your local medical library and colleagues have an infinitesimal amount of cultural competency resources available. From books to websites to conferences there are toolkits, program models and cultural descriptions. Following is just a sample of the resources available to you, your staff and even patients.

¹⁹ University of Michigan Health System Patient Education. Retrieved April 14, 2008 from <http://www.med.umich.edu/pteducation/cultcomm2.htm>

The University of Michigan Health System

Probably, the most informative site and useful resource identified while researching this chapter. Resources range from an analysis of cultural competency efforts of the US News and World Report top ten hospitals (including Cleveland's very own Cleveland Clinic).

<http://www.med.umich.edu/multicultural/index.htm>

<http://www.med.umich.edu/pteducation/cultcomm2.htm>

The Office of Minority Health

Part of the United States Office of Health and Human Services the website provides information on the CLAS standards, resources, and policies, initiatives and laws.

<http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3>

<https://cccm.thinkculturalhealth.org/>

Ohio General Assembly

This site lists Information on pending legislation in the Ohio General Assembly regarding cultural competency.

http://www.legislature.state.oh.us/bills.cfm?ID=126_SB_160

Cleveland Department of Public Health

The City of Cleveland Department of Public Health provides information and services regarding air quality, environment/food safety, chronic disease management/prevention, HIV/AIDS, sexually transmitted diseases and lead prevention.

www.clevelandhealth.org

www.clevelandhealth.info

Case Western Reserve University/MetroHealth Center for Reducing Health Disparities

Under the direction of Dr. Ash Seghal the Center for Reducing Health Disparities website includes information on education, community resources, upcoming events and trainings and even a blog.

<http://www.case.edu/med/ccrhd/>

Ohio Kepro-Think Cultural Health

An online training module designed to increase self learning and awareness.

<http://www.ohiokepro.com/providers/physician/culturalhealth.asp>

Neighborhood Family Practice

A long standing Cleveland west side based Federally Funded health clinic serving primarily the Hispanic community.

www.nfpmedcenter.org

Asian Services in Action Inc.

Local non-profit organization serving the Asian and Pacific Islander community of Northeast Ohio including Cleveland and Akron. Offers community education, translation and interpreting services.

<http://www.asiainc-ohio.org/>

The Lesbian Gay Bisexual Transgender Community Service Center of Cleveland

The only LGBT Center in Northeast Ohio, commonly referred to as “The Center” offers HIV testing, community events and social services. Referral services also available via the website.

www.lgcsc.org

Conclusions

Cultural competency is a part of each and everyone of our every day lives. While the methods and best practices regarding cultural competency are still developing, the concept and manner of thinking and practice should be further integrated in the medical profession schools curriculum so that the next generation of doctors, nurses and healthcare professionals do not have to be educated into the model after entering the field. Furthermore, administrators must acknowledge that all staff that interact with patients—receptionists, technicians, nurses—must be trained. Cultural competency is an ever growing, ever changing trend in healthcare. By utilizing online or printed training tools and resources or personal trainings—the staff and practice of your clinic will begin providing the cultural competent care that every patient deserves.

Self Evaluation

In each of the following examples, identify the cultural groups each patient or family belong. Ask yourself or staff to list what clinic protocol could be improved to provide better care for each of the patients.

Patient 1

Patient 1 is a Caucasian male, 34 years old and has been clinic patient for 6 years. His wife has recently passed away and normally visited the clinic with him. The patient is in for a routine physical. Since he has new insurance from his employer, he needs to complete the clinic standard paperwork again. After signing in at the registration desk and receiving the forms he is seated. Upon being called for his exam, the nurse notices nothing but a few doodles and random letters on the forms. On previous visits the patients wife would typically complete any paperwork.

Throughout the examination the patient does not exude any discrepancy from his normal behavior. When asked if he's been keeping up on his prescriptions he notifies the doctor he has not been taking his medications for a number of reasons but provides no elaboration. His clothes seem a little worn.

Patient 2

Patient 2 is a 25 year old Hispanic male. He is graduate student at the local university and an above average student. The patient's parents are leading physicians in the community. The patient is at the clinic today having been referred after a rapid HIV test came back positive at a recent university screening event. Familiar with the family, the doctor has heard that Patient 2 has been living with another adult male for several months. The patient history is marked as being sexually active, single and no current knowledge of any sexually transmitted diseases. Throughout the exam, Patient 2 portrays a stereotypical machismo attitude. When asked about his history of sexual partners Patient 2 appears defensive and evasive.

Patient 3

Patient 3 is a 31 year old Pacific Islander female at the clinic today for a prenatal visit. The patient has never been to the clinic before and does not speak a word of English. She has brought a friend who speaks broken English with her to serve as a translator. The patient has no identification and the translator does not leave any contact info for the patient on the medical history. The clinic has recently been audited for its HIPAA protocol enforcement.