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Are Your Eye Exams Culturally Competent? Ethically and Legally Serving the Hispanic and Latino Population

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Are Your Eye Exams Culturally Competent? Ethically and Legally Serving the Hispanic and Latino Population

**Description**
This paper discusses the cultural differences within the Hispanic/Latino population that could both positively and negatively affect a quality eye examination. Ethical and legal guidelines are offered to help the optometric professional become more culturally competent.

**Keywords**
cultural competency, eye exam, curandero, health care

**Disciplines**
Alternative and Complementary Medicine | Clinical Epidemiology | Community Health and Preventive Medicine | Optometry | Other Public Health

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Excerpt from the Optometric Oath-\url{http://www.aoa.org/x4881.xml}

Introduction

By 2030 there will be 1.1 million Hispanic or Latino people living in the United States. That will be 150% jump from the 441,509 in the year 2000\textsuperscript{1}. This heterogeneous group of people is the fastest growing of all ethnic and minority groups in our country. They are in particular need of eye care due to the incidence of specific health conditions within the population. Currently this demographic is 1.5 times more likely to die from diabetes than the rest of the populace\textsuperscript{1}. Along with diabetes, stroke and heart disease are among the top causes of death\textsuperscript{1}. In order to keep up with these statistics, the eye care professional must be better equipped to relate to cultural differences and idiosyncrasies that could negatively affect quality eye care. Cultural competency is an optometric ethical issue. The consequences of not being culturally competent are sight-threatening and potentially life-threatening when patients do not receive proper care.

![Hispanic Population in the U.S.](image)


The term culture itself can be described as “an integrated pattern of learned beliefs and behaviors that can be shared among groups and include thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs\textsuperscript{2}.” Take a moment and think about what makes up the culture around you. There are all kinds of cultures that connect and clash continuously (pop(ular) culture, work culture, family culture, etc.).
Whether or not you agree with American culture, if you are comfortable operating within United States society it’s because you are familiar with its worldviews, values and customs. You can relate to patients from your culture because you come from a similar foundation.

The ASKED Model of Cultural Competency

When serving a patient from another cultural group, you need to be sure that you are able to relate in a way that allows you to collect reliable data and gets your patient education across. Have you ASKED yourself if your eye exams are culturally competent and thus, fulfilling the optometrist’s ethical obligation to provide care to all those in need of it? Using the acronym “ASKED” created by Josepha Campinha-Bacote, is a first step in moving towards cultural competency. **A** is for awareness. Are you aware of any unethical personal biases and prejudices towards Hispanic or Latino cultural groups, as well as racism and other ‘isms’ in healthcare? Pause and think about any patient encounters or conversations with other health practitioners that may have left you biased in a negative manner toward this population group. Once you identify these negative views you can then move onto the “**S**” and “**K**” of “ASKED:” skills and knowledge. You should pause and question if your bias or prejudice could be rooted in a cultural misunderstanding and if you have the skills or knowledge to understand a certain behavior. If you are unsure, then obtaining education and training in biocultural ecology is the next step. Biocultural ecology is the study of a given society and its natural environment. By reading this article you are actively engaging in the skills and knowledge steps of the ASKED principle. The “**E**” of “ASKED” is encounters. Once you have gained the skills and knowledge to help you understand your biases, you then actively seek out encounters with Hispanic or Latino patients to practice what you have learned. The final step of ASKED, is desire. This is the most important step. You must have a desire to work with a different population in order to pursue all other portions of the ASKED principle. This article will help you achieve the skills and knowledge you need to honestly evaluate unethical personal biases.

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<thead>
<tr>
<th>ASKED Model by Josepha Campinha-Bacote</th>
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<td>A  <strong>Awareness</strong>: biases, prejudices and racism</td>
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<td>S  <strong>Skills</strong>: tools for cultural assessment</td>
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<td>K  <strong>Knowledge</strong>: cultural world views, biocultural ecology</td>
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<td>E  <strong>Encounters</strong>: cultural exposure and practice</td>
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<td>D  <strong>Desire</strong>: motivation, “want-to”</td>
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The Hispanic or Latino population is made of an ethnically and racially heterogenous group of individuals with cultures that can vary. For this reason it is important to understand
that all generalizations are, of course, generalizations and do not apply to all people everywhere. “Hispanic” refers to being of Spanish origin and was a designation developed in the 1970s by the US Census Bureau. “Latino” is the term that most people of Latin American origin use to refer to themselves. Latinos come from European, African, Indian, Asian and native ancestries. Most Hispanic or Latino countries speak the Spanish language. It is impossible to tell by just looking at a patient whether or not they consider themselves Hispanic/Latino. Ancestry and country of emigration are very important to your Hispanic or Latino patient. It would be considered incredibly disrespectful to refer to your patient as “Mexican,” when they are in fact from another country, such as the Dominican Republic.

**Familismo, Personalismo, and Respeto**

Not only is origin considered important, but also family roots. You may have encountered a Spanish speaking patient with a very long name. Knowing how to properly address your patient by acknowledging the family names can help foster a good relationship. Patients may have two last/surnames. For a male or unmarried female patient, the first of the last names comes from the father and the second from the mother. A married woman’s first surname is from her father and the second from her husband. When she marries she simply replaces her mother’s name for with her husband’s last name as is common in American culture. Let us look at fictional patient example: with the name Carla Ortiz Chacon, the patient would get Ortiz from her father and Chacon from her husband. When calling the patient from the reception area, the most respectful way to address the patient is with the full name or both last names. Mutual respect is the basis of the doctor-patient relationship and compliance with your prescribed treatment.

The importance of family, known as *familismo*, extends to all areas of Hispanic daily life. This will be reflected in seeking healthcare. Medical decisions are considered family decisions. Do not be surprised when you see entire families coming to support an individual in your exam room. You may need to grab an extra chair or two. Often health advice is sought first within the family before the patient seeks medical care. You may notice patients telling you about a relative with an eye condition or asking your opinion about a different family members’ eye health. The term “family” is also much broader than the nuclear family of parents and children. *Familia* includes grandparents, cousins, aunts, uncles and close family friends. Pause and ask yourself if some behaviors you have seen in your office reflect your new knowledge of *familismo*, and whether patient compliance with your treatment will be improved by having the family on board in a HIPAA-compliant manner.

By acknowledging *familismo*, you are in effect also practicing the concept of *personalismo* or personalism. Creating a one-on-one relationship is very important to the
Hispanic or Latino patient (4). Hispanic or Latino patients respond much better to a warm and friendly demeanor. Taking a moment to ask the patient about themselves or their families is a quick way to gain trust. Sitting closer to the patient and leaning forward demonstrates that you are hearing what they are saying during case history and patient education. Personalismo goes hand-in-hand with being simpatico or kind. Physical contact is much appreciated by the Hispanic/Latino population. A pat on the back, tap on the shoulder or hand-shake are all gestures that show kindness. Eye contact also shows interest but be aware that eye contact may not be reciprocated. The patient may smile at what you have to say, although not always look you directly in the eye out of respect (4).

You will notice that your Hispanic and Latino patients tend to be very agreeable patients out of respeto or respect. In Hispanic/Latino cultures, a doctor is someone who should be respected in the roles of healthcare provider, spiritual and emotional supporter. Your interactions will feel very positive. You do need to be a very cautious observer however, as this group may not openly disagree with you. If they do disagree, they would rather not return or will find alternative opinions rather than tell you that they will not adhere to or don’t understand a treatment plan (4). It is helpful to have your patient repeat back to you concepts like medication dosing or how to obtain an appointment with a specialist to insure your instructions were understood. Another cultural difference that can occur is with the concept of time. It is important to remember that Hispanic/Latino patients respect you and are not intentionally late to an exam out of disrespect. Here in the United States when your appointment is scheduled for a specific time, it is expected that you will show up at that time, if not some minutes early to fill out paperwork. Western cultural can clash with Hispanic culture which has an overall more relaxed conduct when it comes to the concept of time. In some cultures time can be loosely split into morning, afternoon or night (4). Your patients may also be working around getting rides or bringing children with them, which is not a cultural difference, but might be a barrier to health care, which will discuss shortly. You may have to adjust your schedule or move quicker to accommodate patients that do not show up on time. You can combat this disparity by having your staff emphasize the importance of timing the exam when the patient makes the appointment exam (i.e. “If you are more than 10 minutes late, we will have to reschedule you.”).

**Bilis, Susto and Ataque**

In western society, it is recognized that pathology comes from tangible sources, like bacteria or cancer. In Hispanic and Latino cultures there is the belief that health is a combination of the spiritual, physical and mental. This means that illnesses can be thought to be brought on by spiritual sources and emotional stress. Strong emotions are the cause of a folk illness known as *bilis*. With *bilis*, strong emotions are thought to cause an imbalance in the
bile, which gets into the blood and causes a variety of symptoms including migraine headaches and dizziness (4). Overwhelming stress is also the cause of susto, a folk illness that causes the soul to leave the body leading to any number of maladies including cancer, diabetes, high blood pressure and kidney failure. Susto is commonly believed take time to manifest itself. When advanced disease is detected in a patient, susto is often labeled as the cause, thereby absolving the patient of any guilt in the delay of seeking proper healthcare (4). This may seem unscientific and even superstitious, but if it is part of the patient's belief system, their doctors need to have knowledge of bilis and susto for proper care. Because patient care can be affected if the doctor is unaware of these beliefs, knowing them becomes an ethical issue.

Another common folk illness called ataque is attributed to the shock one would encounter from receiving bad news. Ataque could be used to explain mental illness symptom including bizarre behavior, violence and an inability to speak (4). Due to the importance of family, any family conflict can also be reported to cause illness. Outside spiritual sources are common etiologies for folk conditions too. Mal ojo (evil eye) can bring on illness due to jealousy, excessive admiration or malice towards someone, especially young children (4). Charms and the color red are thought to ward off mal ojo. You will often see children with red threads tied around their wrists or ankles to act as protection.

Embrujo Bracelet

Embrujo, Fatalismo and Curanderos

The folk illness embrujado or bewitchment is thought to affect mostly men who are being attacked by an evil female. Embujado is often the explanation for mal-adjustment to cultural differences in the United States (4). Yet another explanation for illness is hot and cold imbalances (4). These folk illnesses might lead to a delay in seeking health-care, as the patient might feel they already know the etiology of their symptoms (4).
Another reason for the delay in seeking healthcare is the concept of fatalismo. In fatalismo, it is considered the will of God, fate, or a result of past actions that an individual has a condition or disease and so there is nothing that can be done to prevent or survive a condition. You can do your best to lay out a treatment plan, but be aware that fatalismo may prevent a patient from seeking or continuing care. If you encounter fatalismo, you can suggest that treatment may assist God in keeping the patient well or emphasize that the patient needs to take care of themselves to support his or her family.

Be aware that patients may have already sought help within their families or communities before coming to see you. A patient may have already tried homeopathic or folk medicine remedies and sought the help of a folk healer known as a curandero (Latin American) or santero (Carribean American). These folk healers can be full-time healers or commonly a family member or friend with good success in treating with folk remedies. Once study published by the Archives of Internal Medicine showed that roughly 29% of the patients in a primary care health clinic had seen a curandero for treatment at some time in their life. Common remedies for red eyes include lemon juice, chamomile tea or breast milk in the eyes or pressing silver dollars against the eye. At first glance some of these remedies may seem “off the wall,” but there is some science behind them. Silver has been known to have well-established antiseptic properties for centuries and chamomile tea has anti-inflammatory properties. Patients may also moan loudly to help pain. The patient may not be in as much pain as a moan would suggest. Though these remedies may not be the best treatment, you should be careful to show respeto by acknowledging the treatment and then present your treatment as an alternative. Help increase compliance by showing that you have respeto. You can also find out if a patient has been using a folk remedy by phrasing your history questions to ask if the patient has tried any “remedies” in addition to asking about “medicines.”

Spectacles and Latino Culture

The way you phrase your instructions during the examination can be just as helpful as how you word your case history. The refractive portion of your exam may require a bit more instruction. The concept of “which is better, choice one or choice two,” sometimes does not directly translate conceptually to the Hispanic or Latino patient. You might notice the patient telling you that both choices are “clear” or “blurry,” or find the patient commenting on each lens choice shown. It is best to explain to the patient before subjective forced choice that you they will be shown “two separate lenses.” Emphasize that both lenses might be blurry but that the patient should tell you which lens helps him to see the best between the two lenses. Tell the patient that he will do this several times to help you narrow down the choice for the best
final lens.

Often in Hispanic and Latino cultures there is still a stigma with wearing glasses. This can really impact pediatric vision care. According to data from two studies supported by the National Institutes of Health and published in the October 2011 issue of *Ophthalmology* (8), Hispanic children are more at risk for myopia, hyperopia and astigmatism versus their non-Hispanic white counterparts. Culturally sensitive patient education is therefore crucial to insure compliance with wearing vision correction. Many times parents feel guilt and shame when a glasses prescription is prescribed. It should be emphasized that nothing in particular caused the refractive error and that the child is now very healthy with glasses. Another common idea is that the glasses are temporary and will cure a child of his refractive error. It is necessary that you include the fact that glasses are a lifetime treatment in your patient education. You can help to foster compliance by explaining the negative impacts of non-compliance such as difficulty in school or the inability for the child to obtain a driver’s license when he comes of age. You can also have children at risk for or with amblyopia return to your office for compliance checks to help re-educate the child and parent about the importance of glasses. When possible, contact lenses can offer an alternative for higher refractive errors and patients concerned with cosmesis.

Take a moment and reflect on what you have learned about Hispanic culture. Hopefully you are now able to rethink some biases or prejudices. How can what you now know help you to tailor your exams toward this cultural group? There are certain barriers to obtaining healthcare that are common within the Hispanic population. As far availability, there can be long waits and inconvenient hours as most doctors’ offices are only open during the day, during the week. Access can be difficult due to lack of transportation, cost, lack of health insurance, fear of deportation, loss of pay, and no one to care for children. Acceptability can also be a barrier due to language issues and fear of discrimination.

**Ethics and Proper Use of Medical Language Interpreters**

One way to limit the barrier of language is to learn to use medical language interpreters effectively (1,11,13). If you do not speak Spanish you will need to rely on an interpreter to bridge the gap between you and your patient. In one recent study interpreters were shown to reduce White-Hispanic disparities in reports of care by up to 28 percent in ambulatory care for children (9). Clearly fostering a good relationship with medical interpreters in your office is essential. In certain cases not only is medical interpretation helpful, it’s legally required. “The legal basis for
a patient's right to language access was established with Title VI of the 1964 Civil Rights Act, which states:

No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Because the courts have interpreted ‘national origin’ to include persons with limited English proficiency, recipients of federal funding may be found liable for discrimination for failing to provide access to language services. Based on Title VI, if you are getting reimbursement for Medicare and/or Medicaid patients that do not speak English, a language interpreter must be provided for the examination. The good news is that there are specific guidelines provided by the Health and Human Services (HHS) Office for Civil Rights (OCR) as of August 8, 2003. These guidelines help practitioners adhere to Title VI. These guidelines explain that there are various options available for “oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreters, using telephone interpreter lines, and using community volunteers.” The interpreter does not have to be a professional medical interpreter. The patient may use a friend or family member to interpret as long as the patient feels the person used to interpret is competent. However it is a violation of Title VI to require a patient to bring in his own language interpreter. The patient should be made aware that he has the option for a professional interpreter to be provided without cost to him if he so chooses. HHS recommends that minor children not be used if possible in situations where “…life, health, safety or access to important benefits; or when credibility and accuracy are important to protect the individual.” If you choose to use professional medical interpretive services for Medicare or Medicaid patients you can receive financial reimbursement. The Centers for Medicare & Medicaid Services (CMS) in 2000 determined that Medicaid funds could be used for medical interpretation. Here in Oregon, as of July 15, 2011, Care Oregon (Oregon's Medicaid and Medicare Services) outsourced medical interpretation services to a private vendor, Passport to Languages. These services include on-site interpretation; telephonic interpretation; written translation, and sign language. A private provider need only contact Passport to Languages (https://www.passporttolanguages.com/index.html) to arrange for a Spanish language medical interpreter that would then bill Care Oregon.

If you would like more information Title IV and HHS guidelines, http://www.lep.gov, Let Everyone Participate/ Limited English Proficiency website will be of great help.
When meeting an interpreter you can avoid misunderstandings by setting up some common goals and expectations. Always ask the interpreter if he has experience interpreting with eye-examinations and terminology. If not, encourage the interpreter to feel free to ask questions at anytime if he is unfamiliar with a word, concept or idea. You can also alert the interpreter to what you hope to accomplish by letting them know when issues are urgent or need to be approached with care (i.e. bad news). You can help establish a stronger bond with the patient by having your interpreter speak in first person instead of using “he said or she said”.

During the examination there are also methods you can use to improve your interpreted experience. Sit facing the patient in order to make eye contact. The interpreter can sit to the side, forming a triangle. Speak directly to the patient as if the patient understands everything in English. Even if the patient looks at the interpreter the entire time, your obligation is to the patient. Talk to the patient. When you speak, speak in clear short phrases, pausing often, so that the interpreter may interpret. You may also want to avoid colloquialisms and idioms that may have no direct translation. Try avoiding changing ideas in the middle of a sentence and don’t ask multiple questions at a time.

When it comes to treating your interpreter with respect, make sure to never blame the interpreter for the message he delivers. He is just the mouthpiece. Understand that some concepts may have no linguistic equivalent in English and so it may take the interpreter longer to talk around a concept (i.e. forced choice refraction). You can encourage the interpreter to alert you of any cultural misunderstandings that come up as well. At the end of the examination is always a good idea to have your patient repeat back to you the plan of action so that you may know you were understood.

From an optometric legal-ethical standpoint is never okay to give an interpreter generic instructions and then leave the room. One example is dilation. You legally cannot say to an interpreter, “Please explain dilation drops to the patient,” then leave the room. Statute 683.02 of the Oregon Board of Optometry states that a “license is required to practice optometry. No person shall engage in the practice of optometry or purport in any way to be an optometrist or an expert in the field of optometry without having first obtained a license from the Oregon Board of Optometry…. If you are NOT speaking directly to the patient, you are forcing the interpreter to act in your place. How do you know everything you wanted said was said? What if the patient has a question? What if the interpreter has a question? Please be present. Do not force the interpreter to fill in the blanks when they legally cannot. Pause and think how you have used interpreters in the past. Now ask yourself if there are any ways you can improve your rapport with these professionals.
Conclusions

The goal of this article is to help you become more culturally competent with Hispanic patients. Now that you have more knowledge regarding cultural barriers to quality eye care, the next step is to work at eliminating any barriers you are able to identify in your own practices. You can let the ASKED principal lead you in the right direction. The concepts of *familismo*, *personalismo*, *respeto*, folk medicine and exam timing are very important to your Hispanic patient. Hopefully your new familiarity with the cultural differences in the Hispanic/Latino population will help lead you to more productive and comfortable examinations with improved patient compliance.

Sources:


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