

PATIENTS USING ALTERNATIVE MEDICINE SOLUTIONS SHOULD DISCUSS IT WITH THEIR DOCTORS

Many patients, including ethnic minority patients, use both traditional medicine (seeing a primary care doctor) and complementary and alternative medicine (TM/CAM). Many times, patients do not tell their doctor that they are using other forms of treatment. It is important for patients to tell their doctors about alternative forms of care they are receiving because it may reduce misunderstandings between patients and providers, may strengthen the quality of the patient-provider relationship, and may help identify potential problems when patients are using both traditional and conventional treatments that might be in conflict.

Doctors may not have much time with patients and, the little time they have is spent covering many topics, and may not have time to find out if a patient is using TM/CAM. In our study, we wanted to find out ways for

doctors to quickly identify, perhaps through style of dress or language use, patients that would be most likely to use TM/CAM. We focused on two ethnic minority groups - Southwestern Hispanic and American Indian - in which traditional medicine remains an important part of health and healing.

We conducted focus groups with a total of 41 clinic staff and community people, 93 Hispanic and American Indian patients from eight primary care settings, 14 primary care doctors at the same clinics and five additional doctors.

We did not find any easy ways that doctors could recognize patients who might be more likely to use TM/CAM. We did find three observable patient characteristics that could help guide doctors identify those who used TM/CAM. First, we found that TM/CAM use is most closely linked to how connected a person is with his or her

traditional culture. This link seemed to be related to how patients were cared for as children. Finally, TM/CAM use seemed to be influenced by the patient's health condition.

Based on our findings, we believe that doctors should assume that every patient might be using TM/CAM and should take the time to ask the patient about possible use. Patients should realize that clinicians are often interested in talking about TM/CAM use but may not know how and if it is alright to talk about TM/CAM with the patient.

SOURCE: Can We Rapidly Identify Traditional, Complementary and Alternative Medicine Users in the Primary Care Encounter? A RIOS Net Study

Andrew L. Sussman, PhD, MCRP; Robert L. Williams, MD, MPH; Brian M. Shelley, MD

STUDY REVEALS LEADING CAUSES OF DEATH AMONG ASIAN INDIANS

More than 1.6 million Asian Indians live in the United States, with nearly 25% living in California and representing 1% of the state's population. Yet, causes of death as well as other key health measures and accessibility of health services for Asian Indians in California are relatively unknown. Many studies often focus on "Asian/Pacific Islanders" collectively and do not reflect the Asian Indian population alone. Because of this, we do not have death rates or disease rates for Asian American subpopulations.

To address the lack of specific health information known about Asian Indians, we examined US Census data from 1990 and 2000 and California mortality data from 1990 to 2000. We wanted to identify the leading causes of death for Asian Indians older than 25 years of age. With the recent separation of Asian Indians from the larger "Asian/Pacific Islander" category in death records, it is now possible to collect information on causes of death for this population group.

The three leading causes of death for women 25 and older were cardiovascu-

lar disease (38%), cancer (22%), and diabetes (4%). The three leading causes of death for men 25 and older were cardiovascular disease (44%), cancer (14%) and accidents (6%). For women older than 65, and for men of all age groups, the leading cause of death was cardiovascular disease. For women 25 to 44 and 45 to 64, the leading cause of death was cancer. Our results found that breast cancer was the leading cause of cancer death for Asian Indian women 25 years of age and older. For men 45 to 64 and older than 65, lung cancer was the leading cause of cancer deaths. For

men 25-44, leukemia was the leading cause of cancer deaths.

Our findings provide valuable baseline information for analysis of cause of death in Asian Indians. Research in this ethnic group should be focused in ways

to reduce cardiovascular disease, cancers, diabetes and accidents. Findings from future research in a culturally sensitive manner will ensure better treatment and health for this emerging immigrant population.

SOURCE: Leading Causes of Mortality of Asian Indians in California

Latha Palaniappan, MD, MS; Arnab Mekherjea, MPH; Ariel Holland, BS; Susan L. Ivey, MD, MHSA

APPROACH TO ELIMINATING HEALTH DISPARITIES

Racial and ethnic differences in health are complex problems that have existed for a long time. Often public health research has focused more on why these problems exist rather than exploring why the problems persist despite our best efforts.

The answer to this problem seems to be rooted, in part, in having a clear understanding of the underlying social processes that help to explain differences in health outcomes. Understanding these social processes requires a more thorough examination of cultural notions of race, and how these cultural concepts are rooted in formal policies and informal practices of organizations and institutions that contribute to health disparities. The goal of this article was to highlight cultural processes that contribute to racial health disparities and argue for an increased

focus on such root cultural factors that shape formal policies and practices.

In this commentary, we argue that racism is a key cultural and institutional factor that underlies racial and ethnic differences in health. Racism describes processes and features of US culture that underlie how perceived differences in socially defined racial and ethnic groups become parts of practices, structures, beliefs and representations that yield differences in health outcomes by self-identified race.

Racism influences health over people's lives by shaping their access to resources that may help to protect or improve their health and exposure to stressors that may harm their health. We highlight how cultural beliefs, values and ideas about race influence institutional policies and practices that contribute to racial and ethnic differences in

health. Focusing on these cultural and institutional aspects of racism helps to identify potential points of intervention that may break the cycles and processes that concentrate disadvantage for specific racial and ethnic groups and make their lives and environments worse.

If racial and ethnic differences in health outcomes are to be eliminated, it will be critical for public health professionals to consider how cultural factors and institutional policies contribute to persistent racial and ethnic health disparities.

SOURCE: Cultural Context and a Critical Approach to Eliminating Health Disparities

Derek M. Griffith, PhD; Jonetta Johnson, MPH; Katrina R. Ellis, MPH, MSW; Amy Jo Schulz, MPH, PhD

DESIGNING RECRUITMENT EFFORTS TO ENCOURAGE PARTICIPATION FROM HISPANICS AT HIGH-RISK OF OBESITY

Recruiting minorities to participate in research studies can be difficult, but it is important to make sure they are represented. In particular, Hispanics are often underrepresented in research studies, yet persons of Hispanic origin were the largest and fastest growing minority group in the 2000 census, totaling nearly 13% of the US population.

Kaiser Permanente Colorado participated in a research study with four

other HMOs across the country in order to evaluate whether a personalized web-based nutrition program could persuade people to increase their daily fruit and vegetable consumption. Kaiser Permanente Colorado had the largest proportion of Hispanics out of all of the HMOs (they total approximately 16% of Kaiser Permanente Colorado membership), so instead of randomly choosing members to participate,

50% of the people we invited to join the study were Hispanic. This was done in hopes of increasing the total number of Hispanics enrolled in the entire study and making it more likely that we could apply our findings to a more diverse population.

Out of the 514 members that enrolled in the study, 174 (33.9%) were Hispanic and 340 (66.1%) were non-Hispanic. The Hispanics that enrolled in the study were younger

FOR THE PATIENT

and more likely to be female than the non-Hispanics. Overall, we found that Hispanics were less likely to enroll in the study than non-Hispanics, while persons from higher income levels and older females who were more likely to enroll. When looking at the Hispanic

enrollees separately, we found that females and those living in higher income level were more likely to enroll.

This study helped to identify who is more likely to enroll in a nutritional web-based research study.

SOURCE: Identifying and Oversampling Hispanics by the Passel-Word Surname List for Enrollment in a Web-based Nutritional Intervention

Nikki M. Carroll, MS; Debra P. Ritzwoller, PhD; Melanie A. Stopponi, MPA; Christine Cole Johnson, PhD