

# Case Studies in Cultural Competency



*Diversity and Cultural Competency Committee*

## **About Case Studies in Cultural Competency**

The following case studies were entries in Cultural Competency Case Study Competitions for optometry students and residents implemented in 2014, 2015, and 2020 by the Diversity and Cultural Competency Committee of the Association of Schools and Colleges of Optometry (ASCO).<sup>\*</sup> Entrants in each of the three competitions were asked to describe how cultural competency played a role in a patient-based encounter during their clinical education.

The case studies augment the *ASCO Guidelines for Culturally Competent Eye and Vision Care*, and faculty members and institutions are encouraged to use the case studies as tools to help educate students about cultural competence and promote it in the clinical setting and across the curriculum.

The ASCO 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 field of optometric clinicians who will be culturally competent, i.e., ready to address the vision and eyecare needs of a diverse, multicultural, and global community.

If you have questions about the Committee, e-mail LaShawn Sidbury, CMP, CAE, ASCO Director, Meetings and Special Interest Groups, at [lsidbury@opted.org](mailto:lsidbury@opted.org).

*(\* The first two Cultural Competency Case Study Competitions were supported by funding from Walmart.)*

## Contents

<b>Case 1:</b>	Navigating the Gray Area of Mental Illness in Health Care	1
<b>Case 2:</b>	Dismantling Barriers to Care for Glaucoma Patients in the Hispanic Community	5
<b>Case 3:</b>	Individualized Care: Treating Patients with Autism Spectrum Disorder and Other Intellectual Disabilities	10
<b>Case 4:</b>	Overcoming Bias Surrounding Female Veterans with Traumatic Brain Injury	14
<b>Case 5:</b>	Cultural Competence through Preferred Naming	19
<b>Case 6:</b>	Behavioral Health, Access to Care, and the Native American Population	26
<b>Case 7:</b>	White Coats, Windsor Ties, and Western Medicine	30
<b>Case 8:</b>	Cultural Competency with the Navajo Nation	34
<b>Case 9:</b>	At Home for an Hour: Competent Health Care for the Homeless	39
<b>Case 10:</b>	“Breaking the Ice” in a Remote Alaskan Village	43
<b>Case 11:</b>	Language Barriers and Socioeconomic Status Can Compromise Health Care	47
<b>Case 12:</b>	Unexplained Vision Loss in a Young, Hearing-Impaired Hispanic Male	52
<b>Case Discussion Questions</b>		57

## CASE 1

### **Navigating the Gray Area of Mental Illness in Health Care**

Poor mental health has become one of the leading causes of disability in the United States. Prior to the COVID-19 pandemic, it was estimated that 1 in 4 Americans had a mental-health disorder, most commonly anxiety or depression.<sup>1</sup> During the pandemic, mental health was tested even more. Mental illness has been shown to be closely linked to conditions such as hypertension, diabetes, cancer, and other chronic diseases.<sup>2</sup> Although optometrists primarily treat and manage ocular conditions, we must take into consideration the patient as a whole person.

#### **Getting “a Good Night’s Rest” was the Wrong Prescription**

In my first month of residency, a 53-year-old White male was added to our medical eye clinic schedule as an “urgent care” case. He was complaining of eye pain and irritation. His records showed multiple visits to our dry eye clinic during the previous year, and his medical history included prior antidepressant use, recurrent skin lesions on his face and neck, and high blood pressure. Immediately after we walked into the exam room, the patient rustled through his backpack and pulled out an assortment of items, including a thick notepad and a plastic baggie filled with eye sprays and over-the-counter artificial tears, all previously unsuccessful at relieving his symptoms. His first question was to ask my name. He wrote my name and drew a dark line underneath. He took attentive notes throughout the exam.

I asked questions about his pain, the duration, context, positive symptoms, negative symptoms, etc. He proceeded to pull items from his baggie one by one and explained when and how he’d been using all of the drops, eyelid sprays, and warm compresses with little improvement in symptoms. He was extremely anxious and uncomfortable throughout the whole case history. His incoming visual acuities were 20/20 in each eye. Upon examination, his eyes were white, quiet, had no corneal fluorescein staining, and had adequate meibomian gland expression on palpation with just a few capped glands. The non-mydriatic 90D examination was unremarkable. His Schirmer test results were 3 mm OU, suggesting aqueous-deficient dry eye, which had not been documented previously. After discussing my findings with him, I dispensed a 30-day sample supply of a prescription cyclosporine eye drop and told him to continue his current dry eye regimen and we could follow up in 1 month.

Two weeks later, while I was on call, he called our emergency line and I immediately recognized the name. He reported “severe eye pain” that had been keeping him up for the past three nights. The only things that helped were taking

melatonin and a medication for anxiety, but even then, he slept for only about 30 minutes the night before. He seemed extremely distressed on the phone and said he was almost ready to “check himself into a mental-health facility.” While I was on the phone, I asked myself many questions, wondering whether I had missed something serious during his exam. What could possibly cause such severe eye pain that the patient is unable to sleep through the night? But after further questioning, it just seemed like his eyes were dry. He denied any photophobia, decrease in vision, or eye redness. He described what he was experiencing as extreme grittiness and dryness that had been causing him extreme distress. After reassuring him that it was not an ocular emergency, I encouraged him to try to get a good night’s rest and we could meet the next morning.

He arrived with his notepad and baggie in hand. Once again, his incoming visual acuities were 20/20 in each eye. His eyes were white and quiet, his corneas were clear, and his posterior segments were unremarkable. At this point, I felt like I’d exhausted all my options. I knew he wanted an answer, but I couldn’t attribute any ocular signs to his severe symptoms. After lengthy discussion and constant reassurance that his eyes were healthy, I suggested that instead of exploring the idea that the dryness was the reason for lack of sleep, that he should contact his primary care physician to consider medication for insomnia or anxiety. That conversation did not go well. He called me dismissive and pointed out that I was downplaying his symptoms. He called me out on exactly what I was thinking: that his eyes were not dry at all, that instead he had obsessive-compulsive tendencies, or that underlying anxiety, stress, or depression could be the cause for his insomnia. I felt terrible about these assumptions.

### **The Toll of Mental-Illness-Related Stigma**

Mental-illness-related stigma in health care has been proven to create barriers to access and care to many patients.<sup>3</sup> Patients with mental illness commonly report feeling “devalued, dismissed, and dehumanized” by health professionals.<sup>4</sup> Healthcare providers have rated patients with mental illness to be “difficult, manipulative, and less deserving of care.”<sup>4</sup> As cited by Corrigan et al., studies show that people with serious mental illness experience a higher rate of health conditions and die on average 15-30 years younger than other people their age.<sup>5</sup> Also, patients with mental illness are less likely to be referred for specialty testing (e.g., hospitalization, mammography, cardiac catheterization) and significantly less likely to be admitted to the hospital compared with people with no mental illness.<sup>5</sup>

Studies have also shown that healthcare providers are guilty of having “implicit biases,” which are unconscious stereotypes and attitudes that we develop toward certain groups of people, that can affect doctor-patient relationships and care decisions.<sup>6</sup> For example, one study demonstrated physicians were less certain

of the diagnosis of coronary heart disease for middle-aged women, who were then twice as likely to receive a mental-health diagnosis than their male counterparts.<sup>7</sup> Another study surveyed medical residents about their attitudes toward patients with and without a label of “psychiatric illness” and their willingness to treat them. Residents who were told their patient had a psychiatric illness were less likely to want to treat the individual and be involved with them in various ways.<sup>8</sup> While characteristics such as age, gender, race, and prior medical history are necessary to paint a patient’s history, they should not alter the kind of care a patient receives.

“Diagnostic overshadowing” is a process by which physical symptoms are misattributed to mental illness.<sup>9</sup> I found myself overshadowing, assuming that my patient’s symptoms were less than what they could be and that his mental health was the main contributor to his insomnia. Although it is often unintentional, discrimination remains a major hurdle to quality care, treatment, and recovery. Discrimination occurs not only in cases of mental illness, but also in cases where others have different identifying factors than us, including race, ethnicity, religion, sexual orientation, or socioeconomic class. I took a step back and asked myself how I could be failing my patient and displaying my implicit bias regarding mental illness.

I felt that I owed something to my patient, so I researched other potential causes for his ocular condition. I began reading case-study articles, discussing with my mentors, and asking ophthalmologists for their opinions on this case. My attending printed out a paper published in 2017 by Dieckmann et al. studying patients with “neuropathic corneal pain.”<sup>10</sup> The condition exactly mimics the signs and symptoms of my patient, a pain that was out-of-proportion to the signs. After reading more about this condition, I regretted brushing off my patient’s symptoms as anxiety-related. I felt guilty about it and knew I would for a long time.

He came back to the office for another follow-up appointment, and his signs and symptoms were unchanged. This time, I had a different attitude. I excitedly presented him with some new possible causes for his symptoms and explained there could be an alternative solution to his pain. I proposed the Proctor Group Foundation, an interdisciplinary team of ophthalmologists that specializes in investigating rare, atypical ocular diseases. He was ecstatic at the idea. It validated his feelings, and he finally felt a sense of hope and direction. He had shared his frustrations with doctors who were unable to give him answers to his questions, and instead cycled him through temporary symptom relief and a refusal to investigate further. This was the first time in years he felt listened to.

### **Eliminating Unrecognized Assumptions is a Doctor’s Duty**

It takes mental effort to unlearn implicit bias, to make it a habit, to build discipline, and to be more inclusive. Many of us will go through continuing

education, diversity and inclusion training, sexual harassment training, and more, but are we putting in the mental effort to consciously dismiss stereotypes and eliminate assumptions about others? As doctors, it is our duty to deliver impartial care to all, and we should be aware of any negative associations that are linked to a particular group. We must ask these questions when we find ourselves in these gray areas: “Am I taking any shortcuts? Jumping to any conclusions? Have I done the research to familiarize myself with this specific group of people?” Not one of us can completely solve this problem, but all of us can be part of the solution with conscious and active mental effort.

## References

1. Reeves WC, Strine TW, Pratt LA, et al. Mental Illness Surveillance among Adults in the United States. *Morbidity and Mortality Weekly Report* [Internet]. Atlanta, GA: Centers for Disease Control and Prevention; [cited 2021 July 1]. Available from: [http://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm?s\\_cid=su6003a1\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm?s_cid=su6003a1_w).
2. Jonas BS, Franks P, Ingram DD. Are symptoms of anxiety and depression risk factors for hypertension? Longitudinal evidence from the National Health and Nutrition Examination Survey I Epidemiologic Follow-up Study. *Arch Fam Med*. Jan-Feb 1997;6(1):43-49.
3. Pellegrini C. Mental illness stigma in health care settings a barrier to care. *CMAJ*. 2014 Jan 7;186(1):E17.
4. Knaak S, Mantler E, Szeto A. Mental illness-related stigma in healthcare: barriers to access and care and evidence-based solutions. *Healthc Manage Forum*. 2017 Mar;30(2):111-116.
5. Corrigan PW, Mittal D, Reaves CM, et al. Mental health stigma and primary health care decisions. *Psychiatry Res*. 2014 Aug 15;218(1-2):35-8.
6. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics*. 2017;18:19.
7. Maserejian NN, Link CL, Lutfey KL, Marceau LD, McKinlay JB. Disparities in physicians’ interpretations of heart disease symptoms by patient gender: results of a video vignette factorial experiment. *J Womens Health (Larchmt)*. 2009 Oct;18(10):1661-1667.
8. Neauport A, Rodgers RF, Simon NM, et al. Effects of a psychiatric label on medical residents’ attitudes. *Int J Soc Psychiatry*. 2012 Sep;58(5):485-7.
9. Jones S, Howard L, Thornicroft G. ‘Diagnostic overshadowing’: worse physical health care for people with mental illness. *Acta Psychiatr Scand*. 2008 Sep;118(3):169-71.
10. Dieckmann G, Goyal S, Hamrah P. Neuropathic corneal pain: approaches for management. *Ophthalmology*. 2017 Nov;124(11 Suppl):S34-S47.

## CASE 2

### **Dismantling Barriers to Care for Glaucoma Patients in the Hispanic Community**

Glaucoma is a leading cause of blindness worldwide. It is projected that the prevalence of primary open-angle glaucoma (POAG) among Hispanics, one of the largest and fastest growing minority groups in the United States, will increase substantially in the next 30-40 years. Vajaranant et al. anticipated that by 2050, almost 50% of all POAG patients will be Hispanic.<sup>1</sup> Quigley et al. found that the age-specific prevalence of POAG in Hispanic communities ranged from 0.50% to 12.63%, increasing more quickly with age than in other ethnic groups.<sup>2</sup> In addition to these alarming projections, Hispanic Americans are more likely to have lower economic status and are less likely to secure health insurance.<sup>3</sup> According to the Baltimore Eye Survey, blindness from glaucoma was inversely related to both socioeconomic status and education level.<sup>4</sup> These are likely some of the deeply entrenched disparities that result in Hispanics having approximately 2.5 times greater odds of having undiagnosed and untreated glaucoma than non-Hispanic Whites.<sup>5</sup>

During my residency, I managed and co-managed mild- to advanced-stage glaucoma in a predominantly Hispanic community in the Bronx, New York. I witnessed many barriers to obtaining proper health care that this population experiences. Also, I learned that the intersection of clinically competent care and culturally sensitive patient communication has an enormous bearing on patients' treatment and prognosis, especially in the setting of glaucoma.

#### **A Case of Profound Visual Deterioration in Advanced Glaucoma**

I encountered MK early in my residency, and our exchange significantly affected me. He was a 67-year-old Hispanic male with a history of severe POAG in both eyes who had been lost to follow-up for nearly a year. His previous note indicated he had severely progressed glaucoma in his right eye based on visual field loss and evolution of optic-disc cupping. MK was already prescribed maximum tolerated medical therapy, and surgical intervention was indicated to control his recalcitrant intraocular pressure (IOP) and advanced functional vision loss. Cataract extraction combined with placement of an aqueous drainage stent was recommended for his right eye, and MK was scheduled to proceed with surgical clearance.

Initially, I had assumed my visit with MK would focus on determining whether his POAG was stable or progressing. However, now many months after his scheduled follow-up appointment, he was in my chair with a somewhat



disgruntled and apprehensive attitude as I introduced myself to him. Upon reviewing his chart, my heart sank as I realized his visual acuity in the right eye had plummeted from 20/60 at his previous exam to no light perception. Measuring his IOP with applanation tonometry, I was alarmed at the reading I obtained: 54 mmHg. I observed that his cup-to-disc ratio had increased from 0.8 to 0.95, and only minimal nasal rim tissue remained. During the examination, MK revealed that his vision had been deteriorating slowly over the course of the past year when suddenly he noticed vision loss in his right eye. I wondered whether a central retinal vein occlusion secondary to his longstanding elevated IOP had occurred or perhaps whether he noticed only acutely what had been gradual, profound glaucomatous damage. As thoughts whirred through my head, I glanced over at MK and everything came to an abrupt halt.

The expression on his face was one of frustration, dismay, and disbelief of what I was discussing with him in his native language, Spanish. I suddenly registered the fear and concern that MK was experiencing. I stopped talking and invited him to share his concerns, letting him express what was bothering him. He could not understand why his vision kept worsening and whether his eye was going to get any better. I asked about his medication use, and he revealed he had discontinued his drop regimen because it was tedious and he didn't believe it was improving his condition. What he said next was humbling, "I knew that I had to use eye drops but did not realize that I could end up going blind." It was then I realized we had not fulfilled our job as eyecare practitioners to educate the patient about his disease process and ensure he understood. As a result, his negligence due to lack of understanding was just as damaging as if we had managed his glaucoma inappropriately. Regardless of how astute a clinician may be, his or her efforts may be meaningless if a patient fails to realize the significance of the treatment plan.

When I reviewed his case, I realized MK had a very complicated treatment course with a constantly changing medication regimen. Over time, he likely lost motivation to continue with the topical ophthalmic medications and comply with his follow-up appointments. I knew I would need his full understanding of his disease process before we could effectively implement a treatment plan. I started by reviewing glaucoma, its effects on vision, and steps that we could take together to prevent loss of the remaining vision in his left eye. We discussed the risk factors that contributed to his developing glaucoma and the importance of letting his family members know so that they could also get examined for glaucoma. Gradually, MK displayed understanding and a willingness to comply with a closer follow-up schedule to control the glaucoma in his left eye.

Comforted that MK regained motivation to work on treatment, I was able to carry on with the exam. I noted there was no evidence of acute angle closure using the Van Herick technique on slit lamp biomicroscopy and confirmed this using a

gonioscopic mirror. Because he did not feel any discomfort, even with the elevated IOP, management of the right eye would be palliative. For the left eye we restarted a three-drop IOP-lowering regimen. Along with the glaucoma specialist, I educated MK on the option of cyclophotocoagulation of the ciliary body to decrease IOP if he were to become symptomatic in the future. Finally, I prescribed polycarbonate lenses as ocular protection. After my poignant encounter with MK, I decided to further investigate factors contributing to patients' adherence to therapy, particularly in the Hispanic community in the Bronx.

### **Apprehension Toward the Healthcare System**

In a study involving Black and Hispanic residents of the South Bronx, focus groups revealed a fundamental distrust of the healthcare system that was perpetuated by poor doctor-patient communication leading to the sentiment of receiving subpar care.<sup>3</sup> Over the course of three months, the researchers utilized nine focus groups comprised of 110 mainly Hispanic participants to try to understand how people perceived and interacted with their healthcare system. Results showed many individuals felt as if they could not trust the diagnosis they were given and they believed they received second-class care based on their ethnicity or race. While the doubt may largely be rooted in years of historical racial divide, participants also emphasized the role of doctor-patient interaction in currently exacerbating this belief. Several participants commented that it was difficult to understand their doctors. They felt uninformed in areas such as prevention, recognition of symptoms, or treatment options for managing their condition. One woman mentioned having visited several doctors regarding her disease but receiving what seemed like different answers that she could not understand. Evidently, barriers to care for Hispanic Americans living in the South Bronx are deep-seated and extend beyond physical access to health services. This is striking given the affluence of New York City and the abundance of health care available within a minute's walk.

### **Combatting Distrust by Motivating Patients**

With a better understanding of these challenges to care, I sought ways to enhance doctor-patient communication to improve treatment adherence in the setting of POAG. The Glaucoma Adherence and Persistency Study (GAPS) examined the relationship between IOP-lowering drop compliance and patient characteristics.<sup>6</sup> One parameter described as "patient-doctor communication and learning" significantly impacted adherence. The study classified individuals as doctor-dependent, collaborative, or independent learners. Doctor-dependent learners obtained all they knew about glaucoma from their physicians. Individuals who knew most, but not all, of their knowledge about glaucoma from their doctors

were collaborative learners. Those who understood glaucoma through self-research were characterized as independent learners. Results showed that doctor-dependent learners had the worst and collaborative learners had the best adherence to glaucoma therapy. Collaborative learners were also the most confident in their knowledge of glaucoma, while doctor-dependent patients had the least confidence. For these passive learners, adherence was also significantly decreased in patients who did not believe that non-adherence to medication would put them at risk for reduced vision. Evidently, it is crucial to motivate patients to learn about their condition outside of the exam room and clearly delineate the risk posed without treatment.

### **Developing an Effective Doctor-Patient Dialogue**

Revisiting MK's case, it was clear that the anger and uncertainty he displayed initially was due to lack of understanding of the pathogenesis, prognosis, and treatment of POAG. After I took the time to reinforce this knowledge both in Spanish and with comprehensible terminology, MK displayed an openness to adhering to POAG treatment.

In GAPS, a useful method for activating passive doctor-dependent learners — ask-tell-ask dialogue — was described.<sup>6</sup> Starting by asking the patient what he currently knows about POAG and its future effects on his vision can establish a starting point for the conversation. Then, telling him a piece of missing information, such as describing how POAG affects peripheral vision first, then slowly progresses to one's central vision, is the next step. Finally, supporting his correct understanding while correcting his mistaken beliefs is important to solidify knowledge. Employing the ask-tell-ask method is a concrete way to ensure patient comprehension.

Through my experience with MK, I learned that patient care truly involves more than evidence-based medicine. It requires consideration of the patient's cultural and ethnic background and experiences as a whole. This is vital for success in delivering respected clinical care for patients coming from varying environments. For individuals in the Bronx, there may be an underlying uncertainty toward the healthcare system, but it is up to the clinician to combat this with appropriate doctor-patient communication. Optometrists who manage patients with varying stages of glaucoma need to empower their patients regarding their condition and the risks or benefits associated with treatment. I know that the lesson MK taught me regarding cultural sensitivity and making a conscious effort to motivate patients to participate in their own care is one I will carry with me for the rest of my career.

## References

1. Vajaranant TS, Wu S, Torres M, Varma R. The changing face of primary open-angle glaucoma in the United States: demographic and geographic changes from 2011 to 2050. *Am J Ophthalmol*. 2012 Aug;154(2):303-314.e3.
2. Quiqley HA, West SK, Rodriguez J, et al. The prevalence of glaucoma in a population-based study of Hispanic subjects: Proyecto VER. *Arch Ophthalmol*. 2001;119(12):1819-26.
3. Kaplan SA, Calman NS, Golub M, et al. Racial and ethnic disparities in health: a view from the South Bronx. *J Health Care Poor Underserved*. 2006 Feb;17(1):116-127.
4. Tielsch JM, Sommer A, Katz J, Quigley H, Ezrine S. Socioeconomic status and visual impairment among urban Americans. Baltimore Eye Survey Research Group. *Arch Ophthalmol*. 1991 May;109(5):637- 641.
5. Shaikh Y, Yu F, Coleman AL. Burden of undetected and untreated glaucoma in the United States. *Am J Ophthalmol*. 2014; 158:1121-1129.
6. Friedman DS, Hahn SR, Gelb L, et al. Doctor-patient communication, health-related beliefs, and adherence in glaucoma. Results from the Glaucoma Adherence and Persistency Study. *Ophthalmology*. 2008 Aug;115(8):1320-27.

### CASE 3

#### **Individualized Care: Treating Patients with Autism Spectrum Disorder and Other Intellectual Disabilities**

KP, an 8-year-old African American male, presented with his mother for a comprehensive eye exam. I went to greet the patient in the waiting room and immediately noticed he was quite nervous. He wouldn't make eye contact with me when I addressed him by name. In the exam room, KP's mother informed me that her son had been diagnosed with autism and was very nervous about the examination. Like many children, KP had never had his eyes examined before and he was apprehensive and fearful. In addition, KP continued to cover his eyes and repeatedly say he didn't want us to remove his eyes during the exam.

KP's mother informed me that his teachers were concerned about his vision because he was squinting to see in the classroom. Many of his family members noted this issue as well. They had frequently found him bringing reading material closer to his face. At school, KP was in special education classes and a speech therapy program.

I took time to reassure KP that we wouldn't be removing his eyes as part of the examination. I did my best to build rapport with him by asking about his hobbies and favorite subjects at school. Like many children I have worked with, KP began to warm up throughout the case history and became more open throughout the examination. Entering visual acuity — assessed by matching LEA symbols because the patient was reserved and hesitant to speak directly to me — was 20/80 in the right eye and 20/60 in the left eye. Because the patient was losing fixation and closing his eyes throughout retinoscopy, an animated movie was used as a fixation target to increase his attentiveness. Retinoscopy revealed the need for a prescription of -1.25 -3.00 x010 OD and -1.25 -3.25 x170 OS. Through trial frame, with the retinoscopy findings in place, the patient was able to read 20/25 OD and 20/20<sup>-3</sup> OS.

KP did well with most of the examination procedures, but despite reassurance from his mother, grandmother, and me, he wouldn't allow us to check his intraocular pressure with a handheld tonometer or dilate his eyes. Previous experience with prescription eye drops that had stung left him traumatized to the dilation process. The exam had to be discontinued, and KP was sent home with a follow-up appointment scheduled in 4 weeks for completion of the examination. It was suggested that drop instillation could be practiced at home with artificial tears prior to his return for the follow-up appointment.

## **How Can We Best Care for this Patient?**

Based on my initial encounter with KP in the waiting room, I originally thought he was just a reserved child. Learning he had autism spectrum disorder (ASD) allowed me to modify my exam techniques to make the exam as comfortable as possible for him. ASD is one of the most common developmental disorders in the United States.<sup>1</sup> It is diagnosed based on the evaluation of behaviors consistent with marked delay in the development of communication skills, difficulties with social interaction, and the tendency to perform repetitive, stereotyped behaviors.<sup>2</sup> KP had difficulty with eye contact and was inattentive during much of the testing throughout the examination. It has been found that individuals with ASD frequently struggle with knowing how to act in new environments. Social stories can be used to help these individuals know what to expect during a comprehensive eye examination.<sup>3</sup> A social story is a social learning tool, such as a video or picture book, that accurately describes a context, skill, achievement, or concept according to specific defining criteria.<sup>4</sup> It would be beneficial for KP to view a social story in advance of his follow-up appointment so he knows what to expect and can be more at ease.

Sensory processing challenges are also common in ASD, and a comprehensive eye examination involves many visual, auditory, and tactile stimuli. Studies have found patients do best if the stimuli are presented in a predictable manner. The clinician should warn the patient prior to performing any procedures, such as shining a bright light to check pupils or applying a patch to check monocular acuities. Distractions such as the clinician singing or allowing the patient to hold sensory items can also increase patient comfort during the examination.<sup>3</sup>

When an individual with a disability comes to an optometric practice, it is important to inquire about his or her abilities and strengths. It is equally important to obtain information about the individual's vision needs. Case history revealed KP was enrolled in school and receiving support services via an individualized education plan (commonly referred to as IEP). Optometrists should familiarize themselves with the commonly used terminology of support services in the public education system. Optometrists can serve an important role in helping these individuals obtain additional support in school.

It is important to speak to the patient directly as much as possible. At the beginning of the examination, it is important to get a sense of the patient's preferred method of communication and his or her individual mental capabilities.<sup>5</sup> Use terminology the patient can understand and interact with the patient appropriately based on your assessment and family/caregiver insight. The level of complexity and detail of communication should be tailored to the individual patient.

## **The Same Level of Care for All, Regardless of Diagnosis**

Many individuals with a disability, ASD included, have difficulty finding appropriate health care. Many healthcare providers don't feel as if they can sufficiently provide care for these individuals, which may require additional time and resources providers may not have. In addition, many healthcare providers feel they lack sufficient training to adequately provide care for these individuals. A survey of more than 2,000 general pediatricians and more than 700 family physicians found that most had low self-perceived competency in caring for children with ASD.<sup>6</sup> Taking the time to learn about the visual characteristics and needs associated with disabilities can allow optometrists to better serve this patient population. Notable visual characteristics of ASD include photosensitivity, hyper- and hypo-sensitivity, color perception difficulties, and differences in processing central and peripheral stimuli. It is also common to find visual processing issues in this population.<sup>2</sup> Individuals with ASD have a higher incidence of high refractive errors, keratoconus, visual attention deficits, and eye movement disorders.<sup>4</sup> It's important for these individuals to have comprehensive eye examinations to rule out or diagnose these deficits.

Individuals with ASD and other intellectual disabilities often face implicit bias in the healthcare system. The National CLAS Standards<sup>7</sup> guide healthcare professionals to provide equal and understandable health care for all individuals, including those diagnosed with an intellectual disability. Caring for individuals with any disability is an intrinsic part of primary eye care. The goal should be to provide the same level of care to everyone, regardless of diagnosis. Practitioners may enter the exam room believing they won't be able to collect certain data due to a specific patient diagnosis. It's important that optometrists make every effort to communicate with each individual and perform testing and procedures as the patient's ability and comfort level allow.

Optometrists need to be prepared to examine and interact with patients diagnosed with ASD. The profession is uniquely positioned to evaluate the visual system and processing disorders that may be present in this population. Some exam modifications may be necessary, but with appropriate training and practice every optometric practitioner should feel comfortable examining all individuals regardless of disability.

## References

1. Bernier R, Mao A, Yen J. Psychopathology, families, and culture: autism. *Child Adolesc Psychiatr Clin N Am*. 2010 Oct;19(4):855-67.
2. Coulter RA. Understanding the visual symptoms of individuals with autism spectrum disorder (ASD). *Optom Vis Dev*. 2009;40(3):164-175.
3. Coulter RA, Bade A, Tea Y, et al. Eye examination testability in children with autism and in typical peers. *Optom Vis Sci*. 2015;92(1):31-43.
4. What is a Social Story? [Internet]. Carol Gray - Social Stories; c2021 [cited 2021 March 3]. Available from: <https://carolgraysocialstories.com/social-stories/what-is-it/>.
5. Li JC, Wong K, Park AS, Fricke TR, Jackson AJ. The challenges of providing eye care for adults with intellectual disabilities. *Clin Exp Optom*. 2015 Sep;98(5):420-429.
6. Golnik A, Ireland M, Borowsky IW. Medical homes for children with autism: a physician survey. *Pediatrics*. 2009;123(3):966-971.
7. CLAS Standards [Internet]. Office of Minority Health, U.S. Department of Health & Human Services; [cited 2020 Oct 26]. Available from: <https://thinkculturalhealth.hhs.gov/clas/standards>.



## CASE 4

### **Overcoming Bias Surrounding Female Veterans with Traumatic Brain Injury**

The number of female U.S. military veterans seeking care through the Veterans Affairs (VA) healthcare system has increased dramatically in the past two decades, 175% between 2000 and 2015.<sup>1</sup> However, as reported by the VA Women's Health Disparities Research Workgroup, "... many questions regarding their healthcare experiences and outcomes remain unanswered."<sup>2</sup> This is largely due to the fact that the armed forces historically have been predominantly male; therefore, research exploring potential disparities in VA healthcare delivery and outcomes has focused on male veterans.<sup>2</sup>

A growing body of research conducted more recently indicates that health professionals need to be more aware and have a deeper understanding of traumatic brain injury (TBI) among female veterans to ensure they receive the same quality of care as their male counterparts.

More women than ever now serve in combat roles, which increases their risk for TBI. But women also may be at risk for TBI from factors other than combat and may face unique challenges in this regard.<sup>3</sup> This is important for doctors inside and outside the VA healthcare system to know because veterans may seek care in the community more frequently since passage of the federal VA MISSION Act of 2018, which aims to increase access to care both within the VA and in the community while ensuring "the needs of female veterans are specifically considered and addressed."<sup>4</sup> Also, it's been shown that individuals with TBI, particularly when the TBI is caused by a blast injury, are likely to report problems with vision, which optometrists are well-positioned to detect.<sup>5</sup>

### **Traumatic Brain Injury in Female Veterans**

As more is learned about female veterans and TBI, it becomes clearer they may experience TBI at high rates due to a variety of reasons, all of which should be taken into account to foster proper diagnosis, referral, and treatment.

An evaluation of the VA healthcare system's program that screens for TBI among veterans formerly deployed to Afghanistan or Iraq found that 12.7% of females in this group screen positive for TBI or report a prior TBI diagnosis.<sup>6</sup> Furthermore, a large percentage of women enter the military having experienced prior trauma,<sup>3,7</sup> raising the likelihood they suffered a TBI before joining the military<sup>3</sup> and placing them at risk for cumulative trauma exposure while in the service.<sup>8</sup> Intimate partner violence (IPV) is one such traumatic experience. As reported by Amoroso and Iverson,<sup>3</sup> studies suggest female veterans are particularly vulnerable to IPV.<sup>9,10</sup> Therefore, they may be at risk for IPV-related TBI.<sup>3</sup> In a

survey of 176 female veterans, 18.8% met screening criteria for IPV-related TBI history.<sup>11</sup> These women reported significantly higher depression and PTSD scores and symptoms, and poorer perceptions of physical health than women who experienced IPV without TBI. The researchers also found IPV-related TBI was associated with poorer perceptions of mental health.

The ways in which TBI affects females may also differ from how it affects males. Female gender in and of itself has been identified as a risk factor for post-concussion disorder after TBI.<sup>12</sup> And, as concluded by Amoroso and Iverson based on their literature review, a substantial body of evidence suggests that women fare worse than men in psychiatric and neurobehavioral symptoms after TBI.<sup>3</sup>

It stands to reason such outcomes could also be found among female veterans. A study that compared outcomes after TBI for female service members compared with outcomes for male service members found that females consistently experienced more symptoms.<sup>13</sup> Scores on the symptom inventory and checklist the researchers used differed most between males and females with regard to nausea, sensitivity to light, change in taste/smell, change in appetite, fatigue, poor sleep, poor concentration, trouble remembering a stressful event, and disturbing memories/thoughts/images. Another study indicated that female service members with TBI are more likely than male service members with TBI to report somatosensory and vestibular symptoms.<sup>14</sup>

### **Lack of Consideration of Potential TBI in a Female VA Patient**

During one of my fourth-year rotations and my residency in VA healthcare settings, I had the opportunity to perform two comprehensive eye examinations on patient “MB.” MB was a 63-year-old female with a history of blunt-force head traumas related to domestic abuse and working in the prison system, and a skull fracture secondary to a car accident. When MB initially presented to the VA clinic, she stated that she had a longstanding history of reduced visual field in the right eye. This had been given several different ocular diagnoses, including histoplasmosis, atypical retinitis pigmentosa, unknown pigment epithelial dystrophy, and migraine. However, as I reviewed MB’s chart, I saw no mention by previous providers who reviewed her history and posterior segment findings that trauma or TBI was a possible cause of her unilateral vision loss. In fact, as she expressed to me, she was initially perceived as fabricating her vision loss due to history of trauma and psychological distress.

In talking with MB about the vision loss, I sensed it made her anxious and apprehensive, especially when it came to how it was affecting or would further affect her quality of life. Even as she seemed to accept the vision loss, she seemed to feel isolated in the psychological effects of her trauma related to domestic abuse.

My encounters with MB led me to think her experience with healthcare providers had been similar to that of many other women. According to a national women's health survey, for example, 17% of women (compared to 7% of men) have been told a medical condition they felt they had was "all in their head," and 25% of women (compared to 12% of men) are "talked down to" or treated like a child by a physician.<sup>15</sup> A veteran-specific study found that only 61% of women felt extremely or very welcome in VA healthcare facilities.<sup>16</sup>

### **What Can Be Done to Ensure Proper Care?**

As Amara et al. predicted in 2014, there is a need to improve identification and management of TBI and common comorbidities such as post-traumatic stress disorder, depression, and chronic pain in female veterans.<sup>17</sup> The 2018 MISSION Act, as mentioned above, may move the VA healthcare system toward that goal. An expansion of screening for TBI beyond what is currently mandated [only veterans who were deployed for Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom (Iraq)] could also be beneficial. Education and training for VA staff members has been shown to help. Following a brief computerized educational intervention, significant improvements in gender knowledge, awareness, and sensitivity were achieved.<sup>18</sup>

Individual healthcare providers should contribute to addressing the problems surrounding female veterans and TBI by educating themselves on the issues involved. The ability to provide proper TBI care for this patient population hinges on not ignoring its risk factors, especially not because of bias that assumes the risks don't exist because of gender. Empathy and careful listening are also necessary so the extent and nature of patients' symptoms are fully considered and relevant history and follow-up questions can be posed. Perhaps had MB been shown more empathy and understanding she would have received more complete care to adequately address her physical and psychological symptoms. A patient's account of what she is experiencing should never be dismissed due to the doctor's assumptions, subconscious or otherwise, about female veterans' emotional and physical status or how they should react to their experiences. As research into female veterans and TBI continues, knowledge, empathy, and the ability to self-check any existing gender bias will be the healthcare professionals' best tools for ensuring this group of patients receives equal care.

## References

1. Sourcebook: Women Veterans in the Veterans Health Administration. Volume 4: Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution, February 2018 [Internet]. Washington DC: Women's Health Evaluation Initiative, Women's Health Services, Veterans Health Administration, Department of Veterans Affairs; [cited 2021 June 8]. Available from: [https://www.womenshealth.va.gov/WOMENSHEALTH/docs/WHS\\_Sourcebook\\_Vol-IV\\_508c.pdf](https://www.womenshealth.va.gov/WOMENSHEALTH/docs/WHS_Sourcebook_Vol-IV_508c.pdf).
2. Carter A, Borrero S, Wessel C, Washington DL, Bean-Mayberry B, Corbelli J, VA Women's Health Disparities Research Workgroup. Racial and ethnic health care disparities among women in the Veterans Affairs healthcare system: a systematic review. *Womens Health Issues*. 2016 July-Aug;26(4):401-409.
3. Amoroso T, Iverson KM. Acknowledging the risk for traumatic brain injury in women veterans. *J Nerv Ment Dis*. 2017 Apr;205(4):318-323.
4. S.2372 - VA MISSION Act of 2018 [Internet]. Washington, DC: Congress.gov, Library of Congress; cUnited States Copyright Office [cited 2021 June 8]. Available from: <https://www.congress.gov/bill/115th-congress/senate-bill/2372/text>.
5. Goodrich GL, Kirby J, Cockerham G, Ingalla SP, Lew HL. Visual function in patients of a polytrauma rehabilitation center: a descriptive study. *J Rehabil Res Dev*. 2007;44(7):929-936.
6. Hendricks AM, Amara J, Baker E, et al. Screening for mild traumatic brain injury in OEF-OIF deployed US military: an empirical assessment of VHA's experience. *Brain Inj*. 2013;27(2):125-34.
7. Merrill LL, Stander VA, Thomsen CJ, Crouch JL, Milner JS. Premilitary intimate partner violence and attrition from the U.S. Navy. *Mil Med*. 2006 Dec;171:1206-1210.
8. Zinzow HM, Grubaugh AL, Monnier J, Suffoletta-Maierle S, Frueh BC. Trauma among female veterans: a critical review. 2007 Oct;8(4):384-400.
9. Dichter ME, Cerulli C, Bossarte RM. Intimate partner violence victimization among women veterans and associated heart health risks. *Womens Health Issues*. Jul-Aug 2011;21(4 Suppl):S190-4.
10. Gerber MR, Iverson KM, Dichter ME, Klap R, Latta RE. Women veterans and intimate partner violence: current state of knowledge and future directions. *J Womens Health*. 2014 Apr;23(4):302-309.
11. Iverson KM, Pogoda TK. Traumatic brain injury among women veterans. An invisible wound of intimate partner violence. *Med Care*. 2015 April;53(4 Suppl 1):S112-S119.

12. McCauley SR, Boake C, Levin HS, Contant CF, Song JX. Postconcussional disorder following mild to moderate traumatic brain injury: anxiety, depression, and social support as risk factors and comorbidities. *J Clin Exp Neuropsychol*. 2001 Dec;23(6):792-808.
13. Brickell TA, Lippa SM, French LM, Kennedy JE, Bailie JM, Lange RT. Female service members and symptom reporting after combat and non-combat-related mild traumatic brain injury. *J Neurotrauma*. 2017 Jan;34(2):300-312.
14. Lippa SM, Brickell TA, Bailie JM, French LM, Kennedy JE, Lange RT. Postconcussion symptom reporting after mild traumatic brain injury in female service members: impact of gender, posttraumatic stress disorder, severity of injury, and associated bodily injuries. *J Head Trauma Rehabil*. 2018 Mar/Apr;33(2):101-12.
15. National Survey of Women's Health, The Commonwealth Fund, July 1993 [cited 2021 June 10. Available from: <https://www.commonwealthfund.org/publications/other-publication/1993/jul/national-survey-womens-health>.
16. Kressin NR, Skinner K, Sullivan L, Miller DR, Frayne S, Kazis L. Patient satisfaction with Department of Veterans Affairs health care: do women differ from men? *Mil Med*. 1999;164(4):283-288.
17. Amara J, Iverson KM, Kregel M, Pogoda TK, Hendricks A. Anticipating the traumatic brain injury-related health care needs of women veterans after the Department of Defense change in combat assignment policy. *Womens Health Issues*. 2014;24:171-176.
18. Vogt DS, Barry AA, King LA. Toward gender-aware health care: evaluation of an intervention to enhance care for female patients in the VA setting. *J Health Psychol*. 2008 Jul;13(5):624-638.

## CASE 5

### **Cultural Competence through Preferred Naming**

Cultural competence is the capability to function effectively in the context of cultural diversity.<sup>1</sup> Culture is defined as knowledge, experience, beliefs, values, and attitudes acquired and passed from one generation to the next.<sup>1,2</sup> Although the extent varies depending on practice type and location, all healthcare providers encounter cultural diversity. Cultural differences, which can be based on a variety of factors, including race, ethnicity, gender, language, or socioeconomic status, make each patient unique. Providers should be prepared to understand each patient's unique situation. This requires a commitment to lifelong learning. Providers should work toward understanding cultural groups unfamiliar to them, learn the acceptable social behaviors of those groups, and address their own biases, which may be unconscious. Complacency about cultural differences can allow them to act as a barrier to establishing a meaningful and effective doctor-patient relationship.

During my clinical rotations, I had the opportunity to work with patients who were different from me with regard to race, physical disabilities, language, religion, and socioeconomic status. These experiences taught me the importance of being culturally sensitive in order to provide the best possible care. The experiences also prepared me to build the doctor-patient relationship with a patient I saw during my subsequent ocular disease residency.

#### **Asking the Right Questions**

Patient H presented for an initial appointment at the Visual Impairment Services Outpatient Rehabilitation (VISOR) clinic at the Veterans Affairs (VA) medical center. Patient H was referred from the ocular disease clinic because of vision loss due to exudative macular degeneration OD and advanced non-exudative macular degeneration OS. The patient reported no new ocular symptoms since the last dilated eye exam, which had been one month prior. No changes to history were reported, and safety and depression screenings revealed no issues.

Patient H's chief complaint at the VISOR exam was constant severe blur in both eyes at distance and near. In discussing low-vision needs, the patient stated two main goals: reading and computer use. As such, the visit focused on trialing low-vision devices for near work. Patient H was fitted with a 5X handheld magnifier, 8D prismatic readers, CCTV glasses, and a CCTV video magnifier.

While working on computer-related tasks, patient H revealed a new goal: the ability to accurately apply makeup. This is a task providers and instructors at the VISOR clinic commonly address with patients, but it had not been mentioned with

this patient. The request revealed the need to obtain a more complete social history and prompted further discussion. The VA electronic medical record system includes a self-identified gender-identity field, but it had not been completed for patient H. Therefore, at this time, the patient was asked more questions and given the opportunity to tell providers her preferred name and that she identified as a transgender female and preferred she/her/hers pronouns. The patient also said she felt comfortable discussing her makeup goal at that point because she had seen the LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual) flag in the exam room and the LGBTQIA+ lanyard the attending low-vision provider was wearing.

With a better understanding of the patient and her goals, providers prescribed a different CCTV device. The new device, which features portability and a camera capable of changing focus and direction, assists the patient with reading but is also much better-suited for applying makeup than the device originally prescribed. Providers also reached out to a VA volunteer with cosmetology experience, who helped patient H with skin care steps and application of foundation, eyeshadow, blush, and mascara. After several follow-up visits with the low-vision instructor, the patient mastered the skill of applying makeup. She also started participating in an LGBTQIA+ group on campus and felt more comfortable being herself in the clinics at the VA.

This case demonstrates the importance of treating every patient as an individual, each with his or her own story and unique situation, if we are to provide the best care. Not initially asking patient H gender-identification questions almost led to her not receiving the assistance she needed. Thankfully, a more complete history was eventually obtained so the patient could voice her needs and we could respectfully acknowledge and address them.

### **Key Takeaways**

It has been estimated that 0.39% of the U.S. population identifies as transgender.<sup>3</sup> Therefore, many providers will encounter transgender patients in practice. To deliver patient-centered care, optometrists must educate themselves and increase their comfort level with the related issues in anticipation of these patient encounters.

#### *Practitioner bias*

Practitioners should recognize any bias, including unconscious bias, they may have toward the transgender population. Unconscious bias is the tendency to make decisions based on what feels safe, likeable, valuable, and competent.<sup>4</sup> Unconscious bias must be eliminated so it does not result in discrimination and suboptimal care.

### Disparities faced by transgender patients

It is crucial to be aware of the obstacles transgender individuals face. Among their challenges are verbal and physical abuse, barriers to health care, poverty, substance abuse, and mental-health issues. According to the U.S. Transgender Survey:<sup>5</sup>

- ▶ 24% of transgender individuals are physically attacked in school
- ▶ 33% report a negative experience with a healthcare provider related to being transgender, such as verbal harassment or refusal of treatment
- ▶ 25% experience a problem with insurance, such as denial of coverage for care related to gender transition or denial of coverage for routine care
- ▶ 29% live in poverty, compared with 12% of the general population
- ▶ 29% report illicit drug use

It is valuable to know what changes can be made to improve these situations. For example, it has been found that calling transgender youth by their chosen names decreases suicidal ideation by 29% and suicidal behavior by 56% for each additional context in which the name is used (e.g., at school, among peers, in healthcare settings).<sup>6</sup> Using individuals' chosen names is an important and easy first step toward providing the care they deserve.

### History questioning

Asking questions about gender identity can foster a positive doctor-patient relationship. Standard demographics include legal name and assigned sex at birth, but chosen pronoun and preferred name are also important. Gathering this information can be nuanced. Good methods for obtaining it are to include the questions on intake paperwork or allow patients to register electronically prior to their visit. Ideally, as part of the pre-exam conversation, the provider asks for the patient's gender identification and preferred name and pronoun. (See "Gender Pronouns," right.)

This may be uncomfortable for some providers, but it is the best option because it is the most personal and meaningful to the patient. Whichever method an

**Gender Pronouns**

Please note that these are not the only pronouns. Always ask someone for their pronouns.

Subjective	Objective	Possessive	Reflexive	Example
She	Her	Hers	Herself	She is speaking. I listened to her. The backpack is hers.
He	Him	His	Himself	He is speaking. I listened to him. The backpack is his.
They	Them	Theirs	Themselves	They are speaking. I listened to them. The backpack is theirs.
Ze	Hir/Zir	Hirs/Zirs	Hirself/ Zirself	Ze is speaking. I listened to hir. The backpack is zirs.

Source: *Trans Student Educational Resources*  
(<https://transstudent.org/graphics/pronouns101/>).



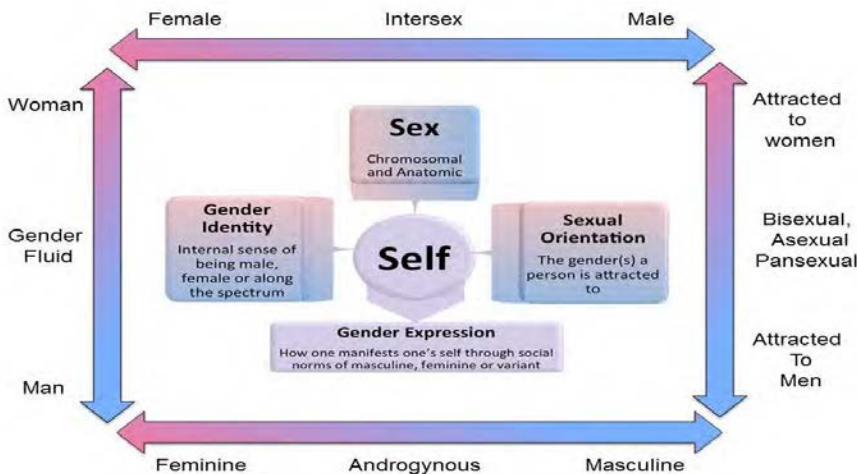
optometrist uses to obtain the answers to these questions should be implemented for all patient exams.

### Deadnaming

Once the social history is collected, the patient’s preferred name and pronoun should be used. In the case of a transgender patient, referring to, or using language that does not align with the affirmed gender is termed misgendering.<sup>7</sup> Furthermore, deadnaming is addressing the patient by his or her birth name instead of the preferred name.<sup>7</sup> Deadnaming is insensitive to the patient’s situation and can be offensive, diminishing the respect the patient has for the provider.

### Terminology

Understanding relevant terminology will help practitioners as they examine transgender individuals. Sex at birth is based on chromosomal and anatomical



*Concepts of Sex and Gender: The term transgender covers a range of gender identities and expressions that might fall outside the idea that all people can be classified as only one of two genders — male or female (gender binary). Source: Mayo Clinic (<https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/transgender-facts/art-20266812>).*

characteristics. Sexual orientation is the gender(s) to which a person is attracted.<sup>8</sup> Gender identity is the internal sense of being male or female and is best understood when viewed as a spectrum to represent fluidity associated with the terms.<sup>8</sup> (See “Concepts of Sex and Gender,” left.) Also, transgender individuals may classify themselves as transgender male

(FtM) or transgender female (MtF) based on the preferred gender identity.<sup>8</sup> Practice modifications may also be useful for providers and the transgender patients they see. They include using gender-inclusive signs, increasing awareness and training for staff members, displaying eyeglass frames in a gender-neutral arrangement, and appointing a committee focused on serving the LGBTQIA+ community. For example, the VA medical center where patient H received care has an LGBTQIA+ committee responsible for outreach to veterans, staff education, and patient advocacy. This committee attends LGBTQIA+ pride events with the goal of reaching veterans so they are aware of the clinic’s efforts to be inclusive.

The committee's care coordinator serves as an advocate for LGBTQIA+ patients to ensure the care they receive is not limited by their gender identification.

### *Systemic complications*

Establishing trust with transgender patients is important to their care, but of equal importance is becoming familiar with the health implications of gender transitions. As a patient goes through gender transition, gender-affirming hormone therapy can cause unintended systemic side effects. Potential unwanted side effects include venous thrombosis, hypertriglyceridemia, diabetes, infertility, and sleep apnea.<sup>9,10,11</sup>

### *Ocular complications*

An ocular side effect of feminizing hormone therapy is dry eye due to decreased meibomian and lacrimal secretions.<sup>12</sup> In transgender males, case studies have shown a link between masculinizing hormones and idiopathic intracranial hypertension (IIH).<sup>13</sup> There is also a significant number of transgender patients taking anti-anxiety or antidepressant medications, making it important to look for pupil mydriasis, accommodative paresis, dry eye, and other side effects resulting from such medications.<sup>14</sup>

### *Gender-specific conditions*

It is necessary for providers to keep in mind that gender-specific conditions may not fit the typical sex profile for transgender patients. Common "female" conditions, such as ocular surface disease, autoimmune disorders, anemia, fibromyalgia, osteoporosis, breast cancer, and IIH, should also be considered in transgender males.<sup>12,13,15</sup> Floppy eyelid syndrome, Reiter's syndrome, prostate cancer, gout, and color vision deficits must be considered as differentials when working with transgender females.<sup>16,17,18,19</sup>

## **Striving for Cultural Competency**

Transgender patients face many healthcare disparities that can compromise their physical health and overall well-being. It is important that providers do not add to these obstacles. Instead, they must self-reflect to find bias, self-educate to better understand, and modify office protocols to better serve the LGBTQIA+ community. Regardless of the cultural diversity practitioners encounter, it is essential to be culturally sensitive and participate in minimizing healthcare disparities for patients to ensure they receive the best care possible.

## References

1. Cultural Competence in Health and Human Services [Internet]. National Prevention Information Network, Centers for Disease Control and Prevention; [cited 2021 June 14]. Available from: <https://npin.cdc.gov/pages/cultural-competence>.
2. Culture Defined [Internet]. Stanford, CA: Stanford University; [cited 2021 June 14]. Available from: [https://web.stanford.edu/~hakuta/www/archives/syllabi/E\\_CLAD/sfusd\\_cult\\_03/melissa/Culture%20Defined.htm](https://web.stanford.edu/~hakuta/www/archives/syllabi/E_CLAD/sfusd_cult_03/melissa/Culture%20Defined.htm).
3. Meerwijk EL, Sevelius JM. Transgender population size in the United States: a meta-regression of population-based probability samples. *Am J Public Health*. 2017 Feb; 107(2):e1-e8.
4. Andrade S. Unconscious Bias: Organizational Culture [Internet]. Wheatland Shadow Hills, CA: Sahar Consulting; [cited 2021 June 14]. Available from: <https://www.saharconsulting.com/single-post/2016/11/15/Unconscious-Bias-Organizational-Culture>.
5. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. (2016). The Report of the 2015 U.S. Transgender Survey [Internet]. Washington, DC: National Center for Transgender Equality; [cited 2021 June 14]. Available from: <http://www.ustranssurvey.org/reports>.
6. Russell ST, Pollitt AM, Li G, Grossman AH. Chosen name use is linked to reduced depressive symptoms, suicidal ideation and behavior among transgender youth. *J Adolesc Health*. 2018 Oct; 63(4):503-505.
7. Chiu A. Laverne Cox lambastes 'deadnaming.' What is it and why is it a problem? [Internet]. The Washington Post; Aug. 14, 2018 [cited 2021 June 14]. Available from: <https://www.washingtonpost.com/news/morning-mix/wp/2018/08/14/laverne-cox-lambastes-deadnaming-what-is-it-and-why-is-it-a-problem/>.
8. Adult Health: Explore the Concepts of Sex and Gender and the Different Ways People Experience Them [Internet]. Mayo Foundation for Medical Education and Research; c1998-2021 [cited 2021 June 14]. Available from: <https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/transgender-facts/art-20266812?p=1>.
9. Weinand JD, Safer JD. Hormone therapy in transgender adults is safe with provider supervision; a review of hormone therapy sequelae for transgender individuals. *J Clin Transl Endocrinol*. 2015 Jun;2(2):55-60.
10. Chen D, Simons L, Johnson EK, Lockart BA, Finlayson C. Fertility preservation for transgender adolescents. *J Adolesc Health*. 2017 Jul;61(1):120-123.

11. Deutsch MB. Overview of Masculinizing Hormone Therapy [Internet]. San Francisco, CA: UCSF Transgender Care; c2019 The Regents of the University of California [cited 2021 June 14]. Available from: <https://transcare.ucsf.edu/guidelines/masculinizing-therapy>.
12. Sullivan DA, Rocha EM, Aragona P, et al. TFOS DEWS II Sex, Gender, and Hormones Report. *Ocul Surf*. 2017 Jul;15(3):284-333.
13. Hornby C, Mollan SP, Mitchell J, et al. What do transgender patients teach us about idiopathic intracranial hypertension? *Neuroophthalmology*. 2017 May 10;41(6):326-329.
14. Narayanan V. Ocular adverse effects of antidepressants - need for ophthalmic screening and follow up protocol. *Ophthalmology Research: An International Journal*. 2019;10(3);1-6.
15. Women [Internet]. Orlando, FL: Drugwatch; c2021 [cited 2021 June 14]. Available from: <https://www.drugwatch.com/health/women/>.
16. What is Floppy Eyelid Syndrome and How is it Related to Sleep Apnea? [Internet]. Encino, CA: Advanced Sleep Medicine Services, Inc.; c2021 [cited 2021 June 14]. Available from: <https://www.sleepdr.com/the-sleep-blog/what-is-floppy-eyelid-syndrome-and-how-is-it-related-to-sleep-apnea/>.
17. Reiter's Syndrome [Internet]. Linthicum, MD: American Urological Association; c2021 [cited 2021 June 14]. Available from: <https://www.auanet.org/education/auauniversity/education-products-and-resources/pathology-for-urologists/penis/infections/reiters-syndrome>.
18. 17 Diseases More Common in Men Than in Women [Internet]. Bestlifeonline.com; c2020 Galvanized Media [cited 2021 June 14]. Available from: <https://bestlifeonline.com/diseases-in-men/>.
19. Causes of Color Blindness [Internet]. Bethesda, MD: National Eye Institute [cited 2021 June 14]. Available from: <https://www.nei.nih.gov/learn-about-eye-health/eye-conditions-and-diseases/color-blindness/causes-color-blindness>.

## CASE 6

### **Behavioral Health, Access to Care, and the Native American Population**

During my optometric education and clinical rotations, we seemed to follow a straightforward framework for patient care: arrive at the correct diagnosis, educate the patient on how to fix the problem, and send him or her home with the treatment. During my residency, I learned it can be a lot more complicated than that. As an optometry resident at an Indian Health Center, I began to understand why.

Native American people have suffered greatly throughout history and continue to feel the impact of past traumas.<sup>1,2</sup> Today, according to the Indian Health Service, they also bear a disproportionate disease burden “perhaps because of inadequate education, disproportionate poverty,<sup>3</sup> discrimination in the delivery of health services, and cultural differences.”<sup>4</sup> Distrust of the government and healthcare professionals is also relatively high among Native Americans,<sup>5,6</sup> who are also at higher risk than other groups for behavioral health problems, including alcohol and substance abuse, mental-health disorders, suicide, violence, and behavior-related chronic diseases.<sup>7</sup> These patient circumstances stand in stark contrast to those I was accustomed to encountering. Most of the patients I had treated before residency had insurance and steady incomes. They didn’t need to worry about how to pay for glasses or a co-pay. They had cell phones, cars to get to appointments, and they felt comfortable making choices about their health care.

A patient I worked with during residency — let’s call her “Bonnie” — showed me firsthand how these disparities can affect the health of individuals and their families.

#### **Follow-Up Appointment Reveals Previously Unrecognized Patient Struggles**

Bonnie, a 70-year-old Native American female, arrived at the clinic for a one-month follow-up visit to assess the status of a partial cranial third-nerve palsy causing diplopia. Due to COVID-19 clinic protocols, Bonnie came inside by herself. She was able to get around relatively easily but had trouble with her memory. She had been closing her right eye to cope with the diplopia because she lost the eye patch given to her at the previous visit. She said she wasn’t sure whether the diplopia was improving, but she denied any pain or other concerning symptoms and mentioned she was able to open her eye more easily.

Bonnie had diabetes with a history of poor control. Her previous HbA1c level measured >14.0%, and her fasting blood sugar consistently measured higher than 200 mg/dL. The nerve palsy was her first ocular manifestation of diabetes, and she was understandably concerned about the time it would take for her eye to return to

normal. Her history was also positive for chronic depression, hyperlipidemia with refusal of treatment, multiple complications related to uncontrolled diabetes, and physical abuse by her son who suffered from alcoholism. We spent most of the appointment time on education about her current condition and what to expect in the future. But we arrived at a turning point when she asked how she could make her condition better. I explained good blood sugar control was key to decreasing the possibility this would happen again, but in the meantime patience was important. Then Bonnie opened up to me. She asked if stress and heartache could affect blood sugar control. I said “absolutely,”<sup>8</sup> and asked if anything had changed recently. She replied that her son passed away unexpectedly 2 weeks ago, and she and her husband were struggling with the loss. I didn’t want to make her share more than she was comfortable with, so I let her steer the rest of the conversation. I made sure she knew I was listening and cared about her by offering tissues and attentive body language.

Knowing that stigma surrounds mental health, I carefully offered the patient a behavioral health consult. I didn’t outright ask if she needed it. Instead, I said, “Please, take all the time you need. I am very appreciative that you feel comfortable enough to share this with me, but would you like some more time set aside to talk about what is going on?” Bonnie said the consult would be a good idea and wanted to set something up for her husband as well after speaking with him.

Bonnie was ready to go after a few more minutes of talking. She thanked me for my time and for requesting a consult for her. I’ve tried to keep tabs on her since that visit. She did go to a behavioral consult onsite at our health center. However, it has been difficult for behavioral services to contact her again as her phone was out of service and she didn’t keep several appointments made by the health center.

### **Learning More about the Native American Experience**

Like Bonnie, many Native people have barriers to adequate health care despite being most in need of it. For example, 23.5% of Native Americans older than 18 years have been diagnosed with diabetes, and Native Americans are 2.3 times more likely than non-Hispanic Whites to die from diabetes.<sup>4,9</sup> In addition, as noted above, Native Americans carry a substantial burden when it comes not only to physical health but also to behavioral health,<sup>7</sup> including high rates of suicide.<sup>10</sup> Furthermore, according to data collected by the Office of Disease Prevention and Health Promotion, only 73.4% of Native Americans have a usual primary care provider compared with 79.6% of non-Hispanic Whites.<sup>11</sup> Not having a designated primary care doctor can lead to confusion in patients as they may not know what services are available and how to access them. They, like Bonnie, may need extra help navigating the system and getting to the next step.

To learn more about the healthcare-related experiences of Native Americans, I corresponded with a behavioral health provider at the health center who is Native American herself. She explained that barriers to health care in this population go beyond money or physical obstacles such as lack of transportation. One other factor is the cultural norm of needing to consult with family members prior to making medical decisions and discussing use of traditional medicine.

The provider also explained that shame among Native Americans may cause them to internalize problems and not seek help when they need it. They may think everyone has a hard life so they should be able to handle their pain. This mindset can lead to substance abuse, violence, self-harm, gambling, and abusing others. A cycle perpetuates as the negative coping mechanisms lead to further feelings of shame.

### **A New Appreciation of the Necessity of Cultural Competency**

I learned a lot from Bonnie's case. Before meeting her and further exploring her situation, I would have felt frustrated when a patient missed a follow-up visit or didn't comply with treatment recommendations. I now understand that in addition to possessing the technical skills of being a doctor, I need to be aware of many cultural factors, including risks for behavioral health problems, which may not be apparent otherwise. And it's crucial to keep in mind that each patient population and individual patient differs based on "education, experiences, beliefs, values, customs, preferences, fears, and expectations."<sup>12</sup> In Bonnie's case, listening and asking her how she was doing other than her physical diagnosis opened the door to better behavioral health care.

### **References**

1. Nahulu L, Roessel MH, Sahlu S. Stress & Trauma Toolkit for Treating Indigenous People in a Changing Political and Social Environment [Internet]. Washington, DC: American Psychiatric Association; c2021 [cited 2021 June 15]. Available from: <https://www.psychiatry.org/psychiatrists/cultural-competency/education/stress-and-trauma/indigenous-people>.
2. Yellow Horse Brave Heart M. Oyate Ptayela: Rebuilding the Lakota Nation Through Addressing Historical Trauma Among Lakota Parents. *J Hum Behav Soc Environ*. 1999;2(1/2):109-126.
3. What Drives Native American Poverty? [Internet]. Evanston, IL: Northwestern University Institute for Policy Research; c2021 [cited 2021 June 15]. Available from: <https://www.ipr.northwestern.edu/news/2020/redbird-what-drives-native-american-poverty.html>.

4. Fact Sheets: Disparities [Internet]. Rockville, MD: Indian Health Service; [cited 2021 June 15]. Available from:  
<https://www.ihs.gov/newsroom/factsheets/disparities/>.
5. Guadagnolo BA, Cina K, Helbig P, et al. Medical mistrust and less satisfaction with health care among Native Americans presenting for cancer treatment. *J Health Care Poor Underserved*. 2009 Feb;20(1):10-226.
6. Call K, McAlpine D, Johnson P, et al. Barriers to care among American Indians in public health care programs. *Medical Care*. 2006;44(6):595-600.
7. Fact Sheets: Behavioral Health [Internet]. Rockville, MD: Indian Health Service; [cited 2021 June 15]. Available from:  
<https://www.ihs.gov/newsroom/factsheets/behavioralhealth/>.
8. Diabetes: Stress & Depression [Internet]. Cleveland, OH: Cleveland Clinic; c2021 [cited 2021 June 15]. Available from:  
<https://my.clevelandclinic.org/health/articles/14891-diabetes-stress—depression>.
9. Diabetes and American Indians/Alaska Natives [Internet]. Rockville, MD: U.S. Department of Health and Human Services Office of Minority Health; [cited 2021 June 15]. Available from:  
<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=33>.
10. American Indian Suicide Rate Increases [Internet]. Albuquerque, NM: National Indian Council on Aging; c2020 [cited 2021 June 15]. Available from:  
<https://www.nicoa.org/national-american-indian-and-alaska-native-hope-for-life-day/>.
11. Disparities Details by Race and Ethnicity for 2016, AHS-3: Persons with a Usual Primary Care Provider [Internet]. Washington, DC: Office of Disease Prevention and Health Promotion; c2014 [cited 2021 June 15]. Available from:  
<https://www.healthypeople.gov/2020/data/disparities/detail/Chart/3970/3/2016>.
12. ASCO Guidelines for Culturally Competent Eye and Vision Care [Internet]. Rockville, MD: Association of Schools and Colleges of Optometry; [cited 2021 June 15]. Available from: <https://optometriceducation.org/files/Guidelines-for-Cult-Com-v2-7-24-2020.pdf>.



## CASE 7

### **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 MZ grabbed my attention. The Chief explained that he had previously suspected that MZ was suffering a brain aneurysm and referred him out to undergo brain scans. On this day, MZ was back at our clinic for his three-month glaucoma follow-up. The Chief told us that during the exam we may see an afferent pupillary defect, a depressed and abducted (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 MZ would be my patient.

#### **Putting an Apprehensive Patient at Ease**

MZ 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, which meant I needed to make some cultural considerations.

As mentioned previously, MZ 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, MZ 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 optometry student was to respectfully and effectively communicate with 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 turn toward MZ and maintain eye contact with him. 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 two 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.

During these two minutes, we laughed and shared stories. MZ'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. MZ 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 MZ 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 MZ had been using his glaucoma medication.

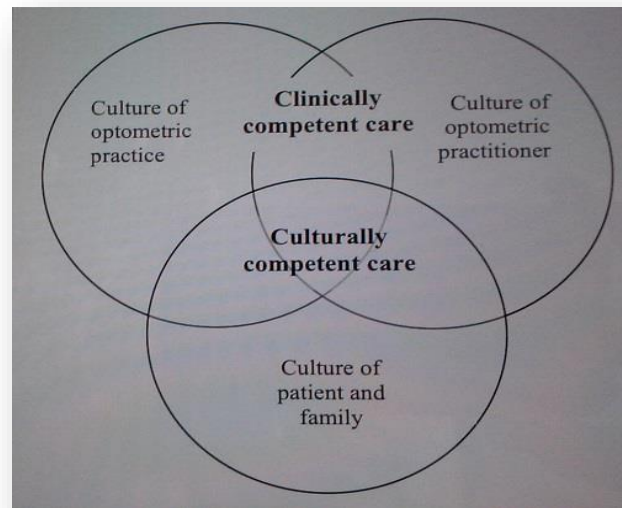
### **How Can We Accomplish Patient-Centered Care?**

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 shortsighted initially, eager to take the case because it would be a learning experience for me. Until I got into the exam room with MZ 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 MZ 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.<sup>1</sup> 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."<sup>2</sup> Furthermore, a culturally insensitive optometrist may not recognize that a nonchalant view toward 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 reflects one’s health and lifestyle.

MZ 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 MZ 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.



*Source: ASCO Guidelines for Culturally Competent Eye and Vision Care*

Although I can partly attribute my understanding of the initial apprehensiveness of MZ and his wife to my education, or even to my own minority background, the professors and students who worked with MZ 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 (see Venn diagram above).<sup>2</sup> This is clear in MZ’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 MZ complies with our recommendation to use his glaucoma medication every evening. In other words, he trusts 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 protocols and honestly paying attention to the delicate differences between patients and ourselves. Optometrists 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.

### **References**

1. Cultural Competence Education for Medical Students [Internet]. Washington, DC: Association of American Medical Colleges; c2005 [cited 2016 April 22]. Available from: <https://www.aamc.org/media/20856/download>.
2. ASCO Guidelines for Culturally Competent Eye and Vision Care [Internet]. Rockville, MD: Association of Schools and Colleges of Optometry; [cited 2016 April 22]. Available from: [http://www.opted.org/files/Guidelines\\_CulturallyCompetentEyeAndVisionCare.pdf](http://www.opted.org/files/Guidelines_CulturallyCompetentEyeAndVisionCare.pdf).

## CASE 8

### **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 and 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.<sup>1,2</sup>

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 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 six 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

*"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."<sup>10,11</sup>*

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.

### **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, 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.<sup>3</sup> Illness is thought to occur as a disruption of harmony, and discussion of illness could be upsetting to the patient. 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.<sup>3</sup>

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.<sup>4</sup> 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.<sup>5</sup> Health maintenance is also thought to be dependent upon harmony with “family, community, nature, and one’s physical self.”<sup>6</sup> 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.<sup>7</sup>

### **Helpful Information from the Literature**

A study published in the *Journal of General Internal Medicine* identified strategies for communicating negative information to Navajo patients.<sup>8</sup> 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 study<sup>9</sup> 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 issues 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 helps gain the patient's trust and demonstrates a true sense of cultural competency and sensitivity.

## References

1. Differences in the Health Status among Racial/Ethnic Groups; Arizona, 2013 [Internet]. Phoenix, AZ: Arizona Department of Health Services; [cited 2016 April 27]. Available from: <https://pub.azdhs.gov/health-stats/report/dhsag/dhsag13/ethnic13.pdf>.
2. Navajo Nation Mortality Report, 2006-2009 Arizona & New Mexico Data [Internet]. Window Rock, AZ: Navajo Epidemiology Center; [cited 2016 April 27]. Available from: <http://www.nec.navajo->



nsn.gov/Portals/0/Reports/Vital%20Statistics%20Report%202006%20to%202009%20FINAL.pdf.

3. Carrese J, Rhodes LA. Western bioethics on the Navajo reservation: benefit or harm? *JAMA*. 1995;274(10):826-829.
4. Mercer SO. Navajo elderly people in a reservation nursing home: admission predictors and culture care practices. *Soc Work*. 1996;41(2):181-189.
5. Levy G. Traditional Navajo Health Beliefs and Practices. In: Kunitz SJ, editor. *Disease Change and the Role of Medicine: The Navajo Experience*. Oakland, Calif.: University of California Press; 1983. Chapter 4.
6. Bell R. Prominence of women in Navajo healing beliefs and values. *Nurs Health Care*. 1994;15:232-240.
7. Guidelines for Healthcare Providers Interacting with American Indian (Native American; First Nation) Patients and Their Families [Internet]. Chicago, IL: Metropolitan Chicago Healthcare Council; 2004 [cited 2016 April 28]. Available from: [https://www.advocatehealth.com/assets/documents/faith/cg-native\\_american.pdf](https://www.advocatehealth.com/assets/documents/faith/cg-native_american.pdf).
8. Carrese JA, Rhodes LA. Bridging cultural differences in medical practice. The case of discussing negative information with Navajo patients. *J Gen Intern Med*. 2000;15(2):92-6.
9. Kim C, Kwok YS. Navajo use of native healers. *Arch Intern Med*. 1998;158(20):2245-9.
10. Betancourt JR. Cross-cultural medical education: conceptual approaches and framework for evaluation. *Acad Med* 2003;78(6):560-569.
11. Betancourt JR, Green AR, Carrillo JE. Cultural competence in health care: emerging frameworks and practical approaches. *The Commonwealth Fund*, October 2002.

## CASE 9

### **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 bypass every day.

This patient was a Caucasian female in her mid-40s. We had last seen 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 had lost them the previous week. The patient was homeless, and a combination of excessive UV exposure and trauma had led to the development of cataracts. Also, she had previously suffered a blow to the head which adversely affected her vision. In the right and left eyes, best-corrected vision was 20/40 and 20/70, respectively. At her previous 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 my attempts to assist her in keeping her eyelids open were 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 two 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. She cried as she told me she hadn't been able to sleep since then. 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 much more 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"*<sup>5</sup>

*Times* opinion piece by Juliann Garey that I had read, "When Doctors Discriminate."<sup>1</sup> 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,<sup>2</sup> 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)<sup>3</sup> 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. Moreover, conditions that require regular therapy, such as tuberculosis, HIV/AIDS, diabetes, hypertension, addictions, and mental-health 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, formalized training programs have been developed to educate clinicians on how to provide the best possible care. In his curriculum for outreach to the homeless,<sup>4</sup> 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.

For homeless patients, who are perhaps particularly accustomed to inattention, strategies such as the ROEM model 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.

## **References**

1. When Doctors Discriminate [Internet]. New York, NY: The New York Times Company; c2016 [cited 2014 March 28]. Available from: <http://www.nytimes.com/2013/08/11/opinion/sunday/when-doctors-discriminate.html?smid=pl-share>.
2. Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States [Internet]. Rockville, MD: Substance Abuse and Mental Health Services Administration; [cited 2014 March 28]. Available from: [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/homelessness\\_programs\\_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf).
3. Health Care and Homelessness: NCH Fact Sheet #8 [Internet]. Washington, DC: National Coalition for the Homeless; c2014. [cited 2014 March 28]. Available from: <http://www.nationalhomeless.org/publications/facts/Health.pdf>.

4. Kraybill K. Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers [Internet]. Nashville, TN: National Health Care for the Homeless Council, Inc.; c2016 [cited 2014 March 28]. Available from: <https://nhchc.org/wp-content/uploads/2019/08/OutreachCurriculum2005-1.pdf>.
5. Institute of Medicine Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC: National Academy of Sciences; March 2001.

## CASE 10

### **“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,<sup>1</sup> a remote village, population fewer than 300, 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.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup> 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.”<sup>7</sup>*

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 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.<sup>5</sup> 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. Months prior to the current visit, he was given a tube of antibiotic 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 antibiotic drops 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 a fluoroquinolone drop, which was to be flown to us with the next shipment. In the clinic, blepharitis collarettes were removed, anterior segment photographs were obtained, and antibiotic 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 non-compliance: 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 two 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.<sup>6</sup> 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.

### **References**

1. Shaktoolik, AK Profile: Facts & Data [Internet]. Malabar, FL: Home Town Locator; c2021 [cited 2021 June 3]. Available from: <https://alaska.hometownlocator.com/ak/nome-ca/shaktoolik.cfm>.
2. Village Health Services [Internet]. Nome, Alaska: Norton Sound Health Corporation; [cited 2016 May 3]. Available from: <http://www.nortonsoundhealth.org/Divisions/Village-Health-Services>.



3. Native youth Olympics [Internet]. Anchorage, AK: Alaska Sports Hall of Fame; c2021 [cited 2021 June 15]. Available from: <https://alaskasportshall.org/inductee/native-youth-olympics/>.
4. Burch ES. Social Life in Northwest Alaska. 1st edition. Fairbanks: University of Alaska Press; 2006.
5. Stolwijk C, Boonen A, van Tubergen A, Reveille JD. Epidemiology of spondyloarthritis. *Rheum Dis Clin N Am*. 2012;38(3):441-476.
6. History [Internet]. Nome, Alaska: Norton Sound Health Corporation; [cited 2016 May 3]. Available from: <http://www.nortonsoundhealth.org/About-Us/History>.
7. Like RC, Steiner RP, Rubel AJ. STFM core curriculum guidelines: recommended core curriculum guidelines on culturally sensitive and competent health care. *Fam Med*. 1996;28(4):291-297.

## CASE 11

### **Language Barriers and Socioeconomic Status Can Compromise Health Care**

I first met MC when I examined him in our clinic one month after he had been seen by another student at the independent living facility for low-income seniors where he resides. MC 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, MC’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 intraocular pressures (IOPs) were 28 mmHg OD and 36 mmHg OS. He had no visual complaints but wanted to take this opportunity to receive an eye exam with no out-of-pocket cost. Primary open-angle glaucoma was suspected, and he was referred to our clinic.

At the home visit, MC 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 MC 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, MC has a high risk of developing angle-closure glaucoma.<sup>1</sup> Because he is an Asian American, his risk of having diabetes is

<b>Why Optometrists Need Cultural Competency<sup>6</sup></b>
<b>Quality of care/clinical outcomes</b> <ul style="list-style-type: none"><li>● patient-centered care/patient compliance</li><li>● Healthy People 2020/elimination of healthcare disparities<sup>7</sup></li></ul>
<b>Practice management</b> <ul style="list-style-type: none"><li>● demographic changes</li><li>● market share/competitive edge</li><li>● patient satisfaction</li><li>● performance-based reimbursement</li><li>● licensing/certification requirements</li><li>● risk management, malpractice, informed consent</li></ul>
<b>Benchmarking</b> <ul style="list-style-type: none"><li>● accreditation standards for other health professions</li></ul>

relatively high,<sup>2</sup> and as a Chinese American, he is more likely to have hypertension and poor blood pressure control than a Caucasian American.<sup>3</sup> In light of his risk factors and ocular findings, we suspected MC 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. MC's daughter had many questions related to the information, and she indicated she was conveying them and our answers to him. MC'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 MC'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  $\mu$ m OD and 505  $\mu$ 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 MC 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 a brand-name prostaglandin analog and instructed to instill one drop in each eye every evening. He was scheduled to return to the clinic in one month. The attending doctor called his daughter to re-explain the diagnosis and treatment instructions.

### **Awareness of Economic Issues**

At the next appointment, MC'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, a brand-name prostaglandin analog would have been prescribed, but MC had 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 who 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.”<sup>4</sup>

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 MC’s case, one of the clinic’s case managers is working to determine whether he’s eligible for the medication manufacturer’s patient assistance program. If not, the next step would be to consider prescribing a generic prostaglandin analog instead.

### **Considerations for Using Interpreters**

MC 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 MC’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 MC knew exactly what was being said.

While MC’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,<sup>5</sup> 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 better outcomes.

## References

1. Lim AK, Giaconi JA, Tripathy K, Salim S. Primary vs. secondary angle closure glaucoma. EyeWiki [cited 2015 April 14]. Available from: [http://eyewiki.aao.org/Primary\\_vs.\\_Secondary\\_Angle\\_Closure\\_Glaucoma#Risk\\_Factor](http://eyewiki.aao.org/Primary_vs._Secondary_Angle_Closure_Glaucoma#Risk_Factor).
2. Diabetes in Asian Americans [Internet]. Boston: Joslin Diabetes Center; c2021. Asian Americans and Diabetes; [cited 2021 June 5]. Available from: <https://www.joslin.org/patient-care/multicultural-programs/asian-american-diabetes-initiative/diabetes-asian-americans>.
3. Chen ML, Hu J. Health disparities in Chinese Americans with hypertension: a review. *Int J Nurs Sci*. 2014 Sept;1(3):318-322.
4. Health Care Access [Internet]. Oakland, CA: Asian & Pacific Islander American Health Forum; c2021.; [cited 2021 June 5]. Available from: <http://www.apiahf.org/policy-and-advocacy/focus-areas/health-care-access>.
5. Hadziabdic E, Hjelm K. Working with interpreters: practical advice for use of an interpreter in healthcare. *Int J Evid Based Healthc*. 2013 Mar;11(1):69-76.
6. ASCO Guidelines for Culturally Competent Eye and Vision Care [Internet]. Rockville, MD: Association of Schools and Colleges of Optometry [cited 2016

May 4]. Available from:

[http://www.opted.org/files/Guidelines\\_CulturallyCompetentEyeAndVisionCare.pdf](http://www.opted.org/files/Guidelines_CulturallyCompetentEyeAndVisionCare.pdf).

7. About Healthy People [Internet]. Washington, DC: U.S. Department of Health and Human Services; c2014 [cited 2021 June 3]. Available from:

<https://www.healthypeople.gov/2020/About-Healthy-People>.

## **CASE 12**

### **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.<sup>1</sup> 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. 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.<sup>1,2</sup>

#### **Improvement in Visual Acuity Stalls for Boy with Refractive Amblyopia**

The case of a patient 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.

Previously, the patient had been prescribed his glasses for full-time wear and was given patching instructions for his right eye at a Lion’s Eye Clinic. He 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 he didn’t understand the task, but updated glasses were provided. Also, a cycloplegic drop for weekend use in the left eye was prescribed for amblyopia treatment in place of daily patching of the right eye.

When the patient came to the clinic for the follow-up visit, 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 non-profit 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 a cycloplegic drop 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.

With approximately monthly follow-up care for two 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 the cycloplegic drop while the patient was at boarding school during the week. His best visual

<b>Cultural Competence vs. Cultural Incompetence<sup>4</sup></b>	
<b>Competence</b>	<b>Incompetence</b>
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	



acuity was measured during the summer while he stayed at home and his mother was responsible for instilling the drops 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 two 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 non-profit 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 seem to understand best when their son's refractive error was demonstrated to them with trial lenses. Following patching or cycloplegic drop 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 cycloplegic 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."<sup>3</sup> 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.<sup>4</sup> In addition, Hispanic (and African American) children in the United States have a higher risk of developing amblyopia than children in other ethnic groups.<sup>5</sup> 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.

## References

1. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O: Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep.* 2003;118(4):293-302.
2. De Jesus M, Xiao C. Cross-border health care utilization among the Hispanic population in the United States: implications for closing the health care access gap. *Ethn Health.* 2013;18(3):297-314.
3. ASCO Guidelines for Culturally Competent Eye and Vision Care [Internet]. Rockville, MD: Association of Schools and Colleges of Optometry; [cited 2014 April 11]. Available from: [http://www.opted.org/files/Guidelines\\_CulturallyCompetentEyeAndVisionCare.pdf](http://www.opted.org/files/Guidelines_CulturallyCompetentEyeAndVisionCare.pdf).
4. De Jesus M, Xiao C. Predicting health care utilization among Latinos: health locus of control beliefs or access factors? *Health Educ Behav.* 2014;41(4):423-30.

5. Multi-ethnic Pediatric Eye Disease Study Group. Prevalence of amblyopia and strabismus in African American and Hispanic children ages 6 to 72 months the Multi-ethnic Pediatric Eye Disease Study. *Ophthalmology*. 2008;115(7):1229-1236.

## **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?