Training of Medical Professionals and the Delivery of Health Care as Related to Cultural Identity Groups

(Revised for the Monograph from the original publication Acad Emerg Med, Vol 10, No 11, pp1149-1152, November 2003)

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Introduction

Publication of the Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*[1] gives us renewed opportunity to discuss differences in the training of medical professionals and the delivery of health care as they relate to cultural identity groups. Since the early 1990s, emergency physicians have explored these important issues at annual meetings of the American College of Emergency Physicians (ACEP) and the Society for Academic Emergency Medicine (SAEM)[2-4] and in published articles.[5-7] In 1996, ACEP/SAEM included "diversity" as a line item in its core content curriculum,[8] making our specialty among the first to incorporate this concept formally into our teachings. SAEM published a position statement on diversity in 2000 that stated the following: “The Society for Academic Emergency Medicine (SAEM) believes that attaining diversity in emergency medicine residencies and faculty that reflect our multicultural society is a desirable and achievable goal. SAEM encourages all academic medical centers to recruit, retain, and advance a faculty reflective of the community served. SAEM encourages its members to respect, support, and embrace the existing cultural differences of its membership. SAEM encourages the development of didactic, educational, research, and other programs to assist academic emergency medicine departments to improve the diversity of their faculties and residencies.”[9]

Discussion

At the request of the U.S. Congress, the Institute of Medicine, through its Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, conducted a study with the purpose of assessing differences in the kinds and quality

of American health care. Specifically, the study was designed to 1) assess the extent of racial and ethnic differences in the quality of health care ***not*** attributable to known factors such as access to care, ability to pay, or insurance coverage; 2) evaluate potential sources of these disparities, including the role of bias, discrimination, and stereotyping at the provider, patient, institutional, and health system levels; and 3) provide recommendations regarding interventions to eliminate health care differences. The committee has accomplished the impressive task of compiling and analyzing the massive body of literature published on these topics during the past 10 years and distilling those reports into five broad findings and, as an appropriate extension, 22 recommendations intended to illuminate existing disparities and thereby identify means of eliminating them.

FINDINGS OF THE INSTITUTE OF MEDICINE STUDY

The key findings presented in *Unequal Treatment*[1] are summarized as follows:

1. Racial and ethnic disparities in health care exist even when insurance status, income, age, and severity of conditions are comparable. Death rates from cancer, heart disease, and diabetes are significantly higher in racial and ethnic minorities than in whites. These disparities are unacceptable.
2. Differences in health care occur in the context of broader historic and contemporary social and economic inequality and of persistent racial and ethnic discrimination in many sectors of American life.
3. Although a few studies suggest that racial and ethnic minority patients are more likely than white patients to refuse treatment, the differences in refusal rates are small. The rate of treatment refusal among minority patients does not fully explain disparities in health care.
4. Many sources contribute to racial and ethnic disparities in health care. These include health systems as a whole, health care providers, patients, and health care plan managers.
5. Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care. A greater understanding of the prevalence and influence of these processes is needed and should be sought through research.

The committee concluded that disparities could partly be attributed to a complex, often fragmented, and economically driven health care environment. Ten of its critical legal, regulatory, and policy recommendations are presented below:

1. A disproportionate number of minorities are in “lower-end” health care plans. The same managed care protections that apply to private health maintenance organization (HMO) enrollees under a "Patient's Bill of Rights” should be accorded to publicly-funded HMO enrollees.
2. Racial and ethnic minorities among U.S. health professionals are underrepresented, and their numbers need to be increased.
3. More resources should be given to the Office of Civil Rights within the Department of Health and Human Services to investigate and enforce civil rights violations.
4. Strategies should be employed that ensure that clinical practices are uniform and based on the best available science.
5. Payment systems should be structured to ensure an adequate supply of services to minority patients and to limit provider incentives that may promote disparities. *Can/Should include a management decision-making case scenario re: EP Group pay structure for a Multi-ED Group where the partners staff different EDs at different staffing ratios and with different levels of compensation based on adequate payer mix in the community,*
6. Communication and trust between patients and providers should be enhanced through financial incentives for practices that reduce barriers and encourage evidence-based decision-making. *How is that applied to disparity and minorities differently than for whites? Clarify and use example that demonstrate how minorities in underserved communities with low payer mix have less adequate means to get the same degree or quality of access*
7. The use of language interpretation services should be promoted where the community need exists. *(Interpreter case / types: 1) Interpreter relays his own summary and not the word of the patients; 2) MD does not take time to get phone access to interpreters via phone due to a rare language and*

concern with costs to patients / assumes patient is poor or call is too expensive and/or not covered)

8. Community health workers (non-medical personnel) who help patients navigate the health care system should be supported.
9. Education programs aimed at current and future health professionals should integrate cross-cultural education into the training. *Middle Eastern Patients and the Taboo of psychiatric illness*
10. Better patient education and empowerment programs should be implemented to increase patients' knowledge of how to best access care and participate in treatment decisions. *Use social workers and case managers that have received such training*

The essence of diversity is the uniqueness of the individual. That uniqueness manifests in many ways, including each person's reaction to societal influences. Both health care providers and health care receivers bring their uniqueness to interactions within the health care system. In 1978, in a seminal article, Arthur Kleinman and colleagues[10] articulated the importance of culture in health care. Examples of negative health consequences that result from ignoring culture include missed diagnoses because of lack of familiarity with the prevalence of conditions among certain cultural groups; failure to take into account differing responses to medication; lack of knowledge about traditional remedies, leading to harmful drug interactions; and diagnostic errors resulting from miscommunication.[11-13] Moreover, without an awareness of cultural differences, these interactions can be unsatisfying, unproductive, and, in fact, disconcerting (or worse) for the individuals involved. However, if the participants, particularly the health care providers, come to the encounter with sensitivity and acumen about cultural groups' perspectives and assumptions (cultural competency), the interaction is more likely to yield true communication and meaningful and desired outcomes.

Organizations and individual authors may define cultural competency differently, but most definitions are variants of one developed by mental health researchers more than a decade ago. For the individual, cultural competency is defined as the "integrated

pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group."[14] For a system or organization, cultural competency is defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations." The culturally competent physician and system are sensitive to patients with expectations differing from those inherent in the assumed European-American "norm." Individuals from the cultural groups listed below bring unique views and needs to health care settings:

- At-risk groups (people with limited financial resources, the old, the young)
- Ethnically and racially distinct groups
- Immigrants, migrants, refugees
- Gay men, lesbians, bisexuals, transgenders
- People with disabilities

Predicated on theories that language and culture affect health care beliefs, choices, and treatment, the idea of cultural competency is an explicit statement that "one-size-fits-all" health care cannot meet the needs of an increasingly diverse U.S. population. Citing the need for cultural competency training for health care professionals, the report from the Institute of Medicine contributes to a growing body of federal and state laws, regulations, and standards seeking to guarantee that health systems respond to diverse linguistic and cultural needs by becoming culturally competent.

Cultural competency goes beyond cultural awareness or sensitivity. The concept refers to an ongoing commitment and institutionalization of appropriate practice and policies for diverse populations.[15,16] Cultural competency has been advocated as a matter of social justice.[17,18] However, it has also been posited as a mechanism for changing the health outcomes of minority Americans. In 2000, Brach and Fraser, in a landmark article based on a review of the cultural competency literature, developed a model for reduction of disparities, encompassing nine cultural competency techniques[19]: interpreter services, provider/staff recruitment and retention, cultural competency training programs,

coordination with traditional healers, use of community health workers, culturally competent health promotion, inclusion of family and/or community in decision-making, immersion into another culture, and administrative and organizational accommodations.

As physicians interested in providing the best medical care possible, we have a myriad of opportunities to enhance our cultural competency - in professional societies, on hospital staffs, at universities, and in private offices. In our roles as teachers, students, and leaders, we can seek ways to learn about culturally identified groups and to demonstrate sensitivity to our patients and our peers. Neglecting our responsibility as individuals and health systems to be aware of culturally diverse groups is the equivalent of medical malfeasance.

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