

Patients' Rights and Professional Responsibilities:

The Moral Case for Cultural Competence

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Abstract

A right to health care can be derived from basic ethical principles. The empirical evidence revealing significant racial inequities in health status, access to health services, quality of care received and outcomes of health services is reviewed. The need for health care providers to acquire cultural competence in order to fulfill their professional responsibilities is discussed; the insight, knowledge and discipline required to function effectively in the context of cultural differences are described. The broader implications of cultural competence for institutional and public policy, research and professional education are outlined. **Key Words:** Ethics, cultural competence, minority health, physician-patient interaction, physician duties and responsibilities, outcomes, medical effectiveness, patient rights.

TWO AND A HALF DECADES AGO, when I was beginning my medical education, there was a popular slogan: "Health care is a right, not a privilege." This assertion has been, to a large extent, accepted into our collective view. Yet a sizable segment of our population still does not receive health care. I have spent the intervening years as an emergency physician. An emergency department provides an interesting perspective from which to view the health care system. Emergency care is the only type of health care to which access is guaranteed by law in this country. It is, therefore, inevitable that in the emergency department we see the failures of the health care system; we see the results of not having health care available to all. For vulnerable and disenfranchised populations, the emergency department is the health care provider of last resort, the safety net for a system which for many does not work well.

A Right to Health Care

Perhaps because I am so often directly faced with those who have been denied health care, I often reflect on this idea of a "right to health care." It is not difficult to derive the right to health care from basic ethical principles. Both teleological and deontological arguments for such a right can be made. Deontologists can argue that

health is necessary to an individual's availing himself of any moral rights. Utilitarians might assert that, since the preservation or restoration of health is essential to an individual's ability to experience good of any kind, ensuring health care for each individual will result in the greatest balance of good over evil. It follows that depriving a person of the care required to restore or maintain health is unjust.

Severe threats to health can endanger life. So abhorrent have we found the withholding of care in such extreme cases that we have legally mandated the right to emergency care, regardless of an individual's ability to pay (1, 2). Furthermore, we have imposed a legal duty to provide emergency care upon both individual and institutional providers. However, we have limited this duty of providers to situations where care is believed to be necessary to protect persons from immediate threats to life or limb. This limitation would seem to have no basis in either ethical principles or fiscal prudence. Nevertheless, it is the current law of the land.

It is not my purpose here to engage in a debate about whether we as a society can or should provide health care to everyone. Surely we can agree that, as a commodity to which every individual can make a moral claim, whatever health care is available should be equitably distributed among the population. Equitable distribution, in the moral sense, requires the similar treatment of similars (3). For purposes of distributive justice, it is necessary to take a nonmeritarian view; we have a prima facie duty to treat people equally. Equal treatment does not mean identical treatment, but rather that the relative contribution made to the goodness of each indi-

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vidual's life should be the same. Help should be provided according to need (4).

It is morally wrong to deny any individual health care. It is unjust to systematically deny it to certain groups of people. Denial of health care on the basis of race might be regarded as particularly repugnant in a society which has outlawed *de jure* racial segregation. However, there is no doubt that this is the situation in America today.

Minorities, Health and Racism

Philosophers from Socrates onward have emphasized the value of factual accuracy and conceptual clarity as precursors to moral deliberation and ethical reasoning (4). The current situation of racial minorities with respect to health and health care is not a matter for ethical debate, it is a matter of empirical fact. A rigorous examination of the available data leads inescapably to the conclusion that significant racial inequities currently exist with respect to health in this country (5–7).

The need for health care is unequally distributed in the population. The poor health status of certain racial groups is well documented both by population-based data and numerous cohort studies (8–11). Disease-specific indices demonstrate greater mortality and morbidity among certain racial groups for heart disease and hypertension (12–16), asthma (17, 18), end-stage renal disease (20), diabetes (21), cancer (22, 23), low birth weight and infant mortality (24–26), and HIV/AIDS (27–29). African Americans, Latinos and Native Americans have demonstrably poorer health status than white Americans (30–32).

Furthermore, these same racial groups have unequal access to health care. Financial barriers, logistical barriers, cultural, linguistic, organizational, institutional and systemic barriers disproportionately affect African Americans, Latinos and Native Americans (33–36). Not only is access to health care for these racial groups unequal, but much of the evidence suggests that the gap is widening (37, 38). And for minorities who are successful in accessing health care services, (according to a growing number of studies), the quality of the care received is unequal to that received by whites (39–41). It is true that the measures of quality currently available are imperfect. However, it is likely that the measures are biased in a way that minimizes the difference between groups. Even so, they clearly indicate disparities in the quality of care received.

Medical effectiveness research is a new conceptual and methodological field of inquiry which examines the patient outcomes associated with

clinical interventions (42). Although population-specific effectiveness research is in its infancy, the extant data reveal racial differences in outcomes, even when intermediate and contextual variables such as access, utilization, provider profiles and socioeconomic patient characteristics are taken into account (43–45).

It is worth mentioning that there are serious methodologic issues which complicate the interpretation of much of the data currently available on racial differences in health status, access, quality and outcomes (46–48). It has been convincingly argued that race is not useful as a biologic taxonomy; intra-racial genetic variation exceeds interracial variation (49, 50). It is most useful to think of race as a complex amalgam of biological, psychological, sociological and environmental factors (51, 52).

One frequently encounters the assertion that minority groups' differences in health can be explained by differences in socioeconomic status. Although many find economic discrimination more palatable, it seems to me that socioeconomic status is no more morally relevant than is race as a criterion for differential health care treatment. In any case, the assertion is incorrect: race is not a proxy for socioeconomic status. Studies reaching such a conclusion are invariably flawed in their sampling, their measures of socioeconomic status or their interpretation of the data.

There is, in America, a statistical correlation between race and the three components of socioeconomic status: education, occupation and income; there are also interactive effects of race and socioeconomic status on health (53–55). Without elaborating upon the complex relationship between socioeconomic status and race, it is fair to summarize the existing literature in this way: when socioeconomic status is adequately measured and controlled for, racial differences in health status, access, quality and outcomes persist. The most compelling models for explaining these racial differences in health among African Americans, Latinos and Native Americans hypothesize that racism, both individual and institutional, plays a role in creating these differences (56–58).

I submit that racial minorities have been and continue to be wronged by the American health care system. I believe that we, as members of this society, have an obligation to correct this injustice and that health care professionals have an even greater obligation. As comfortable as it may be to attribute this wrong to "the system," the system and the institutions that comprise it are ultimately the creation and the result of individual actions. We must assume that, knowingly or unknowingly,

health care professionals have contributed to current racial inequalities in health and health care.

Responsibilities of Health Professionals

What, then, are the responsibilities of health care professionals with respect to racial minorities? The duty of a health care provider to any patient includes several elements. The first is competence. We have a duty to acquire and maintain the skills and knowledge necessary to provide care to our patients. The second element of our professional duty to patients is respect. We must show respect for patients' autonomy and for the values and beliefs upon which they base their choices and decisions. The third important element is the duty to be beneficent, to have compassion for each patient with whom we establish a professional relationship and to act in that patient's interest, rather than our own.

These professional responsibilities are recognized by every statement of professional ethics from the Hippocratic Oath to the current policy of the American Medical Association. These professional responsibilities carry the weight of moral duty. Clearly, health care professionals have an obligation to provide competent, respectful and compassionate care to all of their patients, including those who are members of races other than their own.

I believe that achieving this goal involves the acquisition of cultural competence, that is, the ability to function effectively in the context of cultural differences. Development of cultural competence begins with an honest and insightful inquiry into one's own feelings, beliefs and values in order to detect internalized attitudes which may disadvantage certain patients. Cultural competence requires sufficient professionalism to ensure that culturally, racially or ethnically biased attitudes do not affect the care rendered to patients. Cultural competence also requires knowledge. Health care providers must have a knowledge of ethnic and racial differences in health-related beliefs and cultural values, of ethnic and racial differences in disease incidence and prevalence, and of ethnic and racial differences in treatment efficacy. Cultural competence demands an awareness of the effect of race on these issues and integration of that awareness into one's communication with and treatment of patients (59, 60).

It is our responsibility as professionals to provide effective, respectful and compassionate care to every individual. It is our duty to overcome whatever obstacles threaten to prevent our delivering of such care (61), whether the obstacles are based on racial differences or personal idiosyncrasies. We must have sufficient knowledge to correctly identify

the patient's needs and we must appropriately apply our generalized knowledge to the specific situation. We must be skillful communicators, good listeners and astute observers. We must respect each individual and we must be flexible enough to gain the cooperation and participation of our patient.

Experienced clinicians may recognize that the traits required to achieve cultural competence are the same traits used to engender trust and satisfaction in any provider-patient encounter. It is also interesting to note that arguments for cultural competence are not limited to ethical ones; one can make persuasive arguments that the effectiveness of care and the financial success of the provider or institution are enhanced by culturally competent practitioners (60).

The current racial inequities in health offer health care professionals ethical challenges beyond the physician-patient encounter. We must work to change institutional and public policies which result in the perpetuation of race-based inequities in health. We must address these inequities through our research and develop strategies to improve the health status and health care of racial minorities. We must ensure that our professional education programs produce practitioners with the skills and knowledge they will need to serve an increasingly diverse population. On every level, we must work to eliminate the inequities in health status, access, quality and outcome among the different races, which currently characterize our society.

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