

Racial stereotyping and medicine: the need for cultural competence

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In almost every nation in the world, increased burdens of morbidity and mortality afflict racial and ethnic minorities and new immigrant populations. In the United States, inferior health status has been documented for African-Americans, people of Hispanic origin, American Indians and some groups of Asian origin;¹ in the United Kingdom, for people of Indian, Pakistani and West Indian origin; in France, for people of North African origin; in Germany, for Turkish residents and in Turkey for Kurds; and in Israel, for Jews of Ethiopian, North African and Russian origin. In Canada, the health status of the Aboriginal population² and of a number of immigrant groups³ is equal cause for concern. If good public health data were also available for every developing nation, it would be easy to demonstrate that this is a global phenomenon.

Although the poorer health status of these populations is primarily attributable to poverty and related environmental factors — social, physical, biological, economic and political — as well as lack of access to health care, a significant contribution may be made by racial and ethnic disparities in the quality of medical care, specifically, by differences in the diagnostic work-up and treatment of minority patients already in the health care system. Recent reviews of the relevant peer-reviewed literature in the United States^{4,5} have provided overwhelming evidence that African-Americans, people of Hispanic origin and American Indians are strikingly less likely to receive coronary artery angioplasty or bypass surgery,⁶⁻⁸ advanced cancer treatment, renal transplantation or surgery for lung cancer⁹ compared with white patients matched for insurance status, income or education, severity of disease, comorbidity, age, hospital type and other possible confounders. Even more disturbingly, these differentials were also found in basic elements of clinical care such as the adequacy of physical examinations, history-taking and laboratory tests^{10,11} — even the adequacy of medication for pain¹² — and across the whole spectrum of disease. There is evidence in some studies that the patients who were denied appropriate or necessary care included some who were at greatest risk, and who suffered accelerated mortality in consequence.¹³

These are issues of an ethical as well as a practical nature, because such systematic disparities in treatment conflict with our fundamental professional commitment to equitable care and concern for every patient. We know far too little about

the causes of these differentials, but they are surely complex. A few have been attributed to biological differences, however, because “race” is a social rather than a biological construct, that is not very helpful. Speculative explanations include patient choice (now recognized as a minor contributor); patients’ mistrust of the health care system, which is often based on past experiences perceived as discriminatory;¹⁴ unmeasured socioeconomic variables; unconscious bias on the part of physicians; impairment of physician–patient communication; and lack of cultural sensitivity and cultural competence on the part of physicians and other health care workers. Of these, covert or unconscious bias, that is, the projection of stereotypes onto individual patients in ways that affect clinical decision-making, and lack of cultural competence may be the most directly remediable, if they are honestly recognized and if programs are designed to address them.

Fortunately, both of those conditions are beginning to be met. An elegantly designed prospective study has demonstrated clearly that disparaging racial stereotyping, not clinical data, was predictive of refusal to recommend bypass surgery for many African-American patients in one large series of cases.¹⁵ In the United States, 2 distinguished organizations, the Institute of Medicine of the National Academy of Sciences and Physicians for Human Rights, have appointed blue-ribbon panels of clinicians, ethicists, medical educators, lawyers and nurses to review the evidence and make recommendations for change. A joint working group in the United States and the United Kingdom has considered the role of institutional racism in creating disparities in care. Studies of the roles of race, ethnicity, gender and language in physician–patient communication, which were once the province of medical sociologists, are now appearing in mainstream clinical journals.¹⁶⁻¹⁸

What is most heartening is an explosion of interest in undergraduate and graduate training for cultural competence and the continuing development of resources to assist physicians and other health care workers in that process.¹⁷⁻²⁰ There are proposals to make such efforts a requirement for the accreditation of health professional schools. There is a steady stream of journal articles, curricular proposals, new courses and books,¹⁷⁻²⁷ and a plethora of conferences, devoted to the subject that have academic, foundation and government sponsorship. What is still lacking is evaluation, namely, measures not merely of changes in knowledge and

attitudes but also of changes in outcomes. We do not yet know what really works.

In sum, as the population of patients grows ever more diverse, cultural competence and freedom from bias are becoming increasingly urgent professional responsibilities. It is important to note that in the vast majority of cases these documented disparities in diagnosis and treatment do not reflect conscious racial bias or calculated cultural insensitivity. Time pressure and cognitive complexity (the need to think about many tasks at once) stimulate stereotyping and what has been called “application error,” that is, the inappropriate application of epidemiological data to every individual in a group. These constraints, which are familiar in every medical practice, may also inhibit the kinds of communication that may be necessary to identify and bridge cultural gaps between physician and patient.

It is equally important to recognize that physicians and other health care workers are not mere empty vessels into which new cultural knowledge and attitudes need to be poured. They are already participants in 2 cultures: that of the mainstream society, in which some degree of bias is always a component, and the culture of medicine itself, which has its own values, assumptions and understandings of what should be done and how it should be done. Reducing racially or culturally based inequity in medical care is a moral imperative. As is the case for most tasks of this nature, the first steps, at both the individual and societal levels, are honest self-examination and the acknowledgement of need. That process, which is now well underway, will enrich physicians and patients alike.

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