States Begin Requiring Cultural Competency Training for Doctors

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"All laws, even the most democratic, are designed to prevent equality – which is chaos."
-Justice Charles J. Darling, *Scintillae Juris*

Modern American medicine has come under severe criticism for failing to recognize or respect the religious and ethnic cultural identities of patients. As anyone who has ever been a patient in a large, metropolitan health center should know, many such places may not be focused on empathic care or understanding. Urban medical centers have instead become huge melting pots of different nationalities, languages, religions and cultures. Melting pots because many would argue that in order for what some commentators call "health factories"[1] to work, patients must be standardized and homogenized. It is argued that for efficiency's (and justice's) sake, economic and otherwise, all patients must be treated the same. Tailoring healthcare to each patient from the ground up is considered far too expensive and wasteful of time. It is perceived as far too much to ask of each physician, nurse and healthcare professional to become a cultural anthropologist, fully submerged in the contextuality and lifeworld of a patient in order to give the most sensitive and appropriate care. And imposing a duty on patients who are seeking care to assimilate into the dominant American culture in order to receive optimal healthcare seems neither likely nor correct.

Citing these formidable obstacles to truly meaningful and culturally appropriate clinical encounters, there has been a recent push to homogenize patient populations. Proponents of this philosophy argue that it is the "price we pay"[2] to live in a functioning, pluralistic society.

> One reasonable reaction to questions about how to recognize the distinct cultural identities of members of a pluralistic society is that the very aim of representing or respecting differences in public institutions is misguided. An important strand of contemporary liberalism lends support to this reaction. It suggests that our lack of identification with institutions that serve public purposes, the impersonality of public institutions, is the price that citizens should be willing to pay for living in a society that treats us all as equals, regardless of our particular ethnic, religious, racial, or sexual identities.[3]

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[1] G. Schumperli, *The Threatening Possibility of "Health Factories"*, 21 VESKA 7, 376-8 (1957).
[2] CHARLES TAYLOR & AMY GUTMANN, MULTICULTURALISM: EXAMINING THE POLITICS OF RECOGNITION 4 (1994).
[3] *Id.*

Of course, this parity is not reality. Cases of preferential treatment for some races,[4] genders[5] and socioeconomic strata[6] are too obvious and numerous to merit much discussion here. Moreover, it is far from obvious whether a forced parity in care is beneficial or even possible. Homogenizing healthcare may in fact be wrong-headed and outright dangerous. A person's medical needs are shaped by the individual's culture, religion, environment – in short, his or her *individuality*.[7] However equivalent the exigencies of managed healthcare might want to make patients, we are in fact not the same.

This homogenizing tyranny led to America's democratic ideals sounding a clarion call for the recognition of the particularities of individuals in the 1960s.[8] Today a renewed politics of recognition has taken center stage in medico-corporate America. It is a politics of difference that acknowledges that notions of equality that are blind to the ways in which we differ are wrong[9] and unjust.[10] Accordingly, medical institutions must not only recognize, but also respect and cherish cultural and religious differences.[11]

This criticism has led to a nearly universal fervor in "cultural competency" in medical schools and hospitals.[12] This new focus, aided in no small part by the increasing diversity one now encounters in medical contexts, has prompted no shortage of textbooks, pocket guidebooks, websites, taskforces and training curricula in cultural competency.[13] These programs have become more and more sophisticated in their

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[4] *See, e.g.*, R. Groman & J. Ginsburg, *Racial and Ethnic Disparities in Health Care: A Position Paper of the American College of Physicians*, 141 ANNALS INTERNAL MED. 3, 226-32 (2004), *and* P. Reilly, *Assessing the Problem. AHA Tool to Probe Racial, Ethnic Disparities in Care*, 34 MOD. HEALTHCARE 13, 12-13 (2004).

[5] *See, e.g.*, B.B. McGrath & E. Puzan, *Gender Disparities in Health: Attending to the Particulars*, NURSING CLINICS N. AM. 1, 37-51 (2004), *and* C. Merzel, *Gender Differences in Health Care Access Indicators in an Urban, Low-Income Community*, 90 AM. J. PUB. HEALTH 6, 909-16 (2000), *and* P. Franks & C.M. Clancy, *Physician Gender Bias in Clinical Decisionmaking: Screening for Cancer in Primary Care*, 31 MED. CARE 3, 213-8 (1993).

[6] *See, e.g.*, M.A. Dowell et al., *Economic and Clinical Disparities in Hospitalized Patients with Type 2 Diabetes*, 36 J. NURSING SCHOLARSHIP 1 (2004), *and* V. Mor et al., *Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care*, 82 MILBANK Q. 2, 227-56 (2004).

[7] *See generally* ARTHUR KLEINMAN, THE ILLNESS NARRATIVES (Basic Books 1988) where Dr. Kleinman argues persuasively that as important or, in many instances, even more important than the empirical diagnostic findings of disease are the patient particulars of history, culture, environment, religion, etc. in the effective treatment of an illness.

[8] TAYLOR & GUTMANN, *supra* note 2, at 51-52.

[9] *Id*.

[10] In fact, one definition of justice is that while similarly situated people should be treated alike, dissimilar people should be treated differently.

[11] *See, e.g.*, 42 U.S.C. §2000d, 45 C.F.R. §80.1 et seq. (including Office for Civil Rights Guidance, "Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency," 65 FED. REG. 52762-52774, Aug. 30, 2000); *and* Office of Minority Health, "National Standards for Culturally and Linguistically Appropriate Services in Health Care," *available at* http://www.omhrc.gov/clas/cultural1a.htm (last visited Aug. 29, 2005).

[12] *Id*.

[13] For a good overview of the cultural competency field and its resources, *see* http://www.amsa.org/programs/gpit/cultural.cfm (last visited Aug. 29, 2005).

language, research and science. The programs are now well known for their expediency in satisfying certain regulations and guidelines[14] as well as appeasing boards of directors that all is being done to ensure a culturally competent workplace. In fact, so important have these programs become to American medicine's conception of competent health care, that New Jersey now mandates that all physicians who want a medical license to practice in the State must first complete a cultural competency training program.

The first State to pass a law requiring diversity training for medical licensure,[15] New Jersey, like everywhere else, suffers from real disparities in health care access, usage and satisfaction between socioeconomically and racially disparate groups. Proponents of the law argue that teaching physicians to be more sensitive to cultural and linguistic differences will ensure that doctors more competently assess the differing needs of diverse patients and that care is more carefully tailored for a patient's cultural preferences and needs. "What all of this says," comments Dale Austin, chief operating officer and senior vice president of the Texas-based Federation of State Medical Boards, "is [that] there is an appreciation that the population in our country is changing and evolving, and that means, as health care [practitioners], we have to change also to meet the needs of that population."[16]

In the New Jersey law, signed by Acting Governor Richard J. Codey on March 23, 2005, physicians must take cultural competency training before they are provided a medical license by the State Board of Medical Examiners.[17] Approximately 30,000 already licensed physicians will have to complete the same training in order to renew their licenses.[18] And New Jersey won't be alone for long. Four other state legislatures have studied and introduced similar bills that would require cultural competency training for doctors.[19]

There is no doubt that cultural competency training programs will continue to gain a greater role in medical education and licensure. What remains to be seen is whether the cultural competency training programs will actually improve the bleak picture of health care disparities in America. The reality may be quite different. With the time constraints placed on residents and the limited funds, personnel and facilities available for the care of a more and more diverse population, modern American medicine may find it difficult to practice anything but a culturally insensitive, homogenized healthcare while paying lip service to culturally sensitive care through well-meaning laws such as New Jersey's.

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[14] U.S. D.H.H.S. OFFICE OF MINORITY HEALTH, NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE (2001).
[15] S. 144, 211th Leg. (N.J. 2005).
[16] *Quoted in* Damon Adams, *Cultural Competency Now Law in New Jersey*, AMNEWS, Apr. 25, 2005.
[17] *Id*.
[18] *Id*.
[19] Arizona, California, Illinois and New York are "considering similar legislation." Andrew Damstedt, *Tracking Cultural Training in Healthcare*, WASH. TIMES, May 27, 2005, *available at* http://washingtontimes.com/upi-breaking/20050526-031844-5891r.htm (last visited Aug. 26, 2005).