Emergency Medical Practice: Advancing Cultural Competence and Reducing Health Care Disparities

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Abstract

In an increasingly diverse patient population, language differences, socioeconomic circumstances, religious values, and cultural practices may present barriers to the delivery of quality care. These obstacles contribute to the health care disparities observed in all areas of medical care. Increasing cultural competence has been cited as part of the solution to reduce disparities. The emergency department (ED) is an environment where cultural sensitivity is particularly needed, as it is often a primary source of health care for the underserved and ethnic and racial minorities and a place where high patient volume and acuity place the provider under demanding time pressures, yet the emergency medicine (EM) literature on health care disparities and cultural competence is limited.

The authors present three clinical scenarios highlighting challenges in providing equitable emergency care to minority populations. Using these cases as illustrations, three processes are proposed that may improve the quality of care delivered to minority populations: 1) increase cultural awareness and reduce provider biases, enabling providers to interact more effectively with different patient populations; 2) accommodate patient preferences and needs in medical settings through practice adjustments and cultural modifications; and 3) increase provider diversity to raise levels of tolerance, awareness, and understanding for other cultures and create more racially and/or ethnically concordant patient–physician relationships.

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As patient and provider populations become increasingly racially, ethnically, and culturally diverse, providing quality care has become more of a challenge. Language barriers, economic hardships, differences in held values, and cultural practices all may serve as obstacles to excellent care. These factors are exacerbated by health care providers who fail to recognize and overcome these barriers.[1] Thus, it is of no surprise that African Americans, Hispanics, and immigrant populations often receive a lower quality of care throughout the health care system.[2] Cultural competence and health care disparities are linked. Increased cultural sensitivity fosters better patient–doctor relationships and

communication, and in turn may play a role in reducing observed health care disparities.

Because minority groups disproportionately use the emergency department (ED) for many aspects of their care, the ED serves as an ideal venue to investigate strategies to reduce disparities and advance culturally competent care.[3] Herein, we present three clinical vignettes that illustrate how disparities may arise in emergency medical care. We then proceed to discuss the ethical foundations of the movements for increased cultural competence and reduction of health care inequities and then contextualize both within emergency care. We conclude with a proposed three-step paradigm to reduce health care disparities and further cultural competence.

CASE VIGNETTE 1: LATINA FEMALE WITH DYSPNEA[4]

A 48-year-old female patient of Mexican descent presents to the ED complaining of 3 days of mild shortness of breath. Today, however, she became acutely dyspneic after a family argument. She has no significant

medical history. Her physical exam is remarkable only for a mild tachypnea of 22 breaths per minute and very vocal anxiousness. Her initial workup including an electrocardiogram and chest x-ray is unrevealing, while her past records indicate multiple ED visits with somatic complaints and negative workups. The treating physician decides to order a dose of lorezapam, and upon reassessment 1 hour later finds the patient improved. She is ultimately discharged home with the presumptive diagnosis of anxiety. Two weeks later the patient again presents with dyspnea. She is noted to have an oxygen saturation of 88% on room air, and the exam is remarkable for bibasilar inspiratory crackles and 1 + pitting edema of her ankles bilaterally. Her workup reveals mild pulmonary edema on chest x-ray, and a troponin level of 1.5 ng/mL, with a B-type natriuretic peptide level of 1,400 pg/mL. She is treated appropriately with nitrates, diuretics, and oxygen and admitted to the hospital for congestive heart failure.

CASE VIGNETTE 2: CAMBODIAN REFUGEE WITH HEMOPTYSIS[5]

A 65-year-old male Cambodian refugee presents to the ED complaining of hemoptysis. He does not speak English, so the clinician relies on a 13-year-old grandson for the history. He describes a week of a nonproductive cough and chills, followed by production of bloody sputum today. He is a nonsmoker and his medical history is noncontributory. After an unremarkable physical exam, the treating physician orders a chest x-ray and lab work. Shortly thereafter, the nurse reports that the patient is refusing the blood draw and radiography. Upon reinterview, the patient asks to leave. The physician is flabbergasted by the patient's refusal, and contemplates an against-medical-advice discharge, when the use of a translator phone is suggested by another staff member. As a result, the physician discovers that the patient refused the x-ray, which he thought to be a photograph, because he is fearful of the ''authorities'' finding out his immigration status. Further, he refused the blood draw because he feels he will be made weaker, as the blood draw would further exacerbate his ''bleeding'' problem. After careful negotiation, the patient agrees to the x-ray as it will not involve his face, and the blood draw as the physician agrees to ''replace'' the blood with a normal saline bolus. The workup reveals a cavitary lesion in the right upper lobe, and the patient is admitted for possible tuberculosis.

CASE VIGNETTE 3: MUSLIM FEMALE WITH LEFT LEG TINGLING

A 55-year-old female Bosnian immigrant presents to the ED complaining of tingling in her left leg and shortness of breath since falling in her kitchen this morning. She has no medical history and becomes visibly upset when the male staff tries to place her into a gown and on the cardiac monitor. As the male attending physician is about to enter the patient's room, an Arab female medical student tells him that ''she is probably upset because men are trying to touch her body.'' Recognizing the obstacle to optimal care for this patient, the physician asks the medical student to allay the patient's fears before he enters the room. A few moments later the medical student tells the physician that the patient has requested that she perform the physical exam and IV placement. In effect, she would appreciate only females touching her. The attending physician decides to accept the compromise, and the patient's workup reveals a lumbar disk herniation for which she is treated conservatively.

CULTURAL COMPETENCE AND REDUCTION OF HEALTH CARE DISPARITIES AS BIOETHICAL IMPERATIVES

Several theoretical models of ethics have been applied to medicine, including the Principle approach, the Consequence approach, the Virtue approach, and the Moral sentiment approach.[6] In current Western medical education, the Principle approach (or ''principilism'') has received the most attention. Some scholars have summarized this bioethical approach using the following four ideals: Nonmaleficence, Respect for Persons, Beneficence, and Justice.[7,8] Briefly, nonmaleficence is the maxim of primum non nocere—that the physician must first do no harm to the patient, both physically and psychologically. Respect for persons involves empowering the patient to make his or her own informed decisions about his or her care, while also protecting those with diminished autonomy. Beneficence is the idea that health care providers have a central obligation to provide benefits and to balance those benefits against risks while delivering health care. Last, distributive justice is the principle that limited resources must be fairly allocated so as to maximize health care benefit to all.[7]

Without cultural competence, emergency physicians can place all four of these bioethical principles in jeopardy. In cases where provider and patient cultures are different, miscommunication and misunderstandings may lead to patient harm, thus impinging on the principle of nonmaleficence. If the provider and patient speak different languages, informed consent and respect for autonomy are impossible without an interpreter. Similarly, when providers do not carefully traverse cultural obstacles, patients may not receive the full benefit of medical treatment. These barriers arise when providers overlook the importance of culture and view it as something only relevant for the lives of ''others.''[9–12] In reality, culture enriches one's identity and provides a link to family and community through a common bond which informs ''actions, expectations, and assumptions.''[9,11] For example, by allowing family members to be involved in decision-making, a cultural preference can be respected to maximize beneficence. Cultural accommodations may enhance the practice of distributive justice through their ability to reduce barriers to care.

Providers can better meet the standards of bioethical care when access to care is widened, biases are eliminated, and quality of care is made equitable across racial and cultural lines. For instance, if there were reduced disparities in the evaluation and treatment of chest pain, patients would be presented with more

accurate information about their condition and would be able to make more informed decisions, thereby increasing respect for persons and nonmaleficence. Similarly, more appropriate interventions would result in maximizing beneficence. Furthermore, actively decreasing health care disparities will also equalize the quality of care offered to various patient populations, thereby enhancing social justice.

The need for increasing cultural competence and reducing health care disparities can also be derived using other bioethical traditions. Virtue ethics focuses on inculcating certain ''virtues'' and molding one's character to embody these traits. In emergency medicine (EM) these include prudence, courage, temperance, justice, unconditional positive regard, charity, compassion, trustworthiness, vigilance, and agility.[13] Cultural competence is integral to developing many of these virtues. For example, providers can enhance their own trustworthiness by improving their cross-cultural communication skills and developing cultural competence and awareness, thus showing their respect for the patient. Similarly, the just provider will work to ensure that all patients receive quality care regardless of their backgrounds. Doing so necessarily entails educating oneself about the causes for, and remedies to, health care disparities.

CULTURAL COMPETENCE AS RELATED TO HEALTH CARE DISPARITIES

As described in the landmark Institute of Medicine (IOM) report, ''Unequal Treatment,'' minority patient populations in the United States often receive an inferior quality of care across the spectrum of medical care, from preventive measures to the management of chronic conditions and treatment of acute conditions.[2] These disparities contribute to the decreased life expectancy and increased disease-specific morbidity and mortality among African Americans, Hispanics, and other minority groups.[14] Further disparities exist despite comparable insurance status, access to health care, and severity of conditions.[2] Even though this report has led to numerous efforts to identify and eliminate health care disparities, the 2006 National Healthcare Disparities Report from the Agency for Healthcare Research and Quality found that some disparities persist, and others are worsening. For example, the hospital care of pneumonia is getting worse for African Americans when compared to whites, and the treatment of myocardial infarction is declining in quality for Asians and Native Americans when compared to whites.[15]

Complex reasons and numerous sources underlie observed health care disparities. Systemic factors such as the legal and regulatory climates of health care, insurance policies, and access to services contribute to disparate levels of care. Patient factors such as differential individual risk factors for disease due to genetics and environmental exposures, lower socioeconomic status, and value-based differential health care–seeking behaviors may result in worse health outcomes. Provider-level factors include bias or prejudice against minorities, stereotypes held about minority health behaviors, and greater clinical uncertainty with minority patients. All of these issues play a role in the delivery of a lower quality of care.[3] Increased cultural competence on the part of the provider can play a role in diminishing health care disparities in a variety of ways.

Patient preferences and health care–seeking behaviors are cited by some as a reason for poorer health care indices in minority populations. For example, minority patients may be more likely to refuse recommended health care interventions and delay seeking treatment.[16] However, these behaviors can result from a lack of trust in providers and health care systems, cultural gaps in understanding disease processes and treatment, or poor prior interactions with the medical system. Through enhancing cultural awareness and improving cross-cultural communication skills, providers develop tools to ascertain and understand the values of various patient populations and become better equipped to negotiate medical interventions based on nuanced understandings. Improved provider–patient communication as a result of cultural training may lead to increased patient trust and satisfaction. Moreover, cultural competency training can aid in combating provider stereotypes and biases and may decrease clinical uncertainty when treating patients from unfamiliar backgrounds. In sum, giving priority to cultural competence in modern medicine is critical, not only to reduce health care disparities, but also to deliver patient-centered care.

THE ED AS THE FRONTLINE FOR HEALTH CARE DISPARITIES

The ED serves as both the frontline and the safety net of the U.S. health care system. It is a noisy, stressful environment, fraught with demanding expectations and time pressure.[17,18] Furthermore, the ED continues to be disproportionately used by racial and ethnic minorities for many aspects of medical care, and is often the entry point into medical care for immigrant populations.[3,19,20] Despite growing patient diversity, the provider population continues to be predominantly white and male.[21]

The discordance between patient and provider racial, ethnic, religious, and cultural characteristics, when coupled with the ED environment, makes ED clinical encounters ripe for misunderstandings, stereotyping, and poor collaboration.[3,22] Furthermore, as the emergency encounter can be defined by three intersecting loci (impending serious harm, the expectation of prevention or reduction of that harm, and time pressure), the formation of the patient–physician relationship, the key to quality care, can be difficult.[23] This was illustrated in a special IOM report on EM, characterizing the ED as overwhelmed, underfunded, understaffed, and ''at the breaking point.''[24]

Most health care disparity research has focused on settings other than the ED. As a result, coverage of emergency care was minimal in the IOM on health care disparities.[19] Recognizing this gap, *Academic Emergency Medicine* convened a consensus conference on disparities in emergency health care in May 2003. This conference brought to light health care disparities in

ED care and renewed interest within the EM research community to study and eliminate them. Some of the areas where disparities have been documented are chest pain/acute coronary syndrome, stroke, and pain control.[25–27] (The November 2003 issue of this journal contains the conference proceedings.)

Therefore, while the mandate for EM is to treat all comers at any time equitably, this ideal remains elusive. In addition, while most research has focused on African Americans and Hispanics, disparities are likely to be similar, if not greater, in smaller minority populations, as they may have less social capital and face greater obstacles in terms of language and culture during medical encounters. Emergency medical providers therefore should become aware of the disparities that currently exist and effect measures to provide competent, sensitive, and equitable health care to all.

A PARADIGM FOR IMPLEMENTING CULTURAL COMPETENCE AND REDUCING HEALTH CARE DISPARITIES IN THE ED

The obligations to provide culturally competent care and reduce disparities stem from the principles of beneficence and social justice, respectively. To accomplish these goals, a deliberate process must be implemented. We propose that the implementation of three strategies will aid in reducing disparities and furthering cultural competence within emergency care: 1) reduce provider bias and increase provider cultural awareness, 2) clinically accommodate patients, and 3) promote workforce diversity.

Bias is an inevitable force that may manifest through stereotyping patients and plays a role in creating health care disparities.[28] For example, characterizing a Hispanic female as histrionic, an African American as likely to be nonadherent, or the oft-returning patient as drug-seeking can lead to suboptimal care. Therefore, providers must be alert to their own biases, as well as the behavior of their colleagues and support staff, and work to limit their influence in the clinical encounter. In addition, biases specific to minority populations may stem from a lack of cultural awareness, and unfamiliarity with patient values may lead to poor collaboration. Thus, increasing cultural awareness may aid in reducing provider biases.

Cultural competence training not only improves provider attitudes towards minority patients, but it also enhances cross-cultural communication.[29] Cultural competency training is not simply learning a list of important values pertaining to a specific patient population; rather, it requires acknowledgment of the importance of cultural practices in people's lives, respecting cultural differences, and actively working to minimize the negative consequences of cultural differences within the health care context.[30] Providers must revise the notion that culture belongs to the patient only, by "inverting the problem" so that the culture and biases of medicine, and of the individual provider, are recognized and addressed.[10] Thus, specific seminars on health care disparities, strategies to overcome physician biases, and cultural sensitivity should be encouraged and fostered within physician training programs.

High-quality care delivered in a culturally sensitive manner is the essence of the patient-centered model of medicine. Culturally sensitive care requires accommodating patient needs and modifying provider practices and behaviors based on patient values. It also involves empowering patients in the negotiation of clinical interventions attuned to their expressed values. This requires that the provider relinquish a degree of "power and control" and allow the patient to set the tone of the encounter as much as feasible. Patient-centered care delivered through participatory decision-making and provider adjustments increases patient trust and may lead to better therapeutic alliances, enhanced health care outcomes, and reduced disparities.[31]

Diversity in the health care workforce must be promoted. Diversity in any workforce is not only a societal good defended by professional organizations, educational institutions, and even the Supreme Court, it also can directly influence change in a variety of ways.[32–35] A diverse health care workforce may promote tolerance and cultural awareness of minority patient populations through peer interaction with professionals from these backgrounds. Furthermore, a more mixed workforce may advocate for systematic changes that would promote an environment that is more responsive to the needs of vulnerable populations. Finally, increasing the number of minority providers may directly affect patient care in a variety of ways. Physicians and patients who share common values and language may find it easier to engender trust and have increased participatory decision-making.[36] Additionally, minority providers may gravitate toward tending to minority populations who have borne the harms of inferior care.[37] This possibility is supported by a growing body of literature illustrating that patients report greater satisfaction within same-race or same-gender physician–patient pairings and that minority providers treat minority patients in greater numbers than do their white counterparts, even when the percentage of African Americans and Hispanics is controlled for.[38–42]

Methods by which clinician diversity can be improved include encouraging hiring practices that value diversity within provider groups, setting up minority training programs for both clinicians and trainees, increasing focused mentoring of underrepresented students and faculty, establishing policies that ensure a welcoming and fair environment for all personnel, and assessing staff and patient satisfaction by ethnicity.[43] It must be noted that provider diversity is not a substitute for technical competence, as quality care in emergent situations requires technical proficiency. Therefore, we must strive for a workforce that is both skilled and diverse.

CASE RESOLUTIONS

In the case of the Hispanic patient with dyspnea, the patient's myocardial infarction, which she suffered at her initial presentation, was overlooked. This case illustrates the need to eliminate physician bias. The physician may have stereotyped the patient as a "histrionic Latino [sic] female" and failed to recognize and treat

her condition appropriately.[4] The physician, in light of her prior ED visits, may also have narrowed down his diagnostic process too quickly, leading to the misdiagnosis of anxiety. On the other hand, the patient's gender and/or Hispanic ethnicity may have contributed to the misdiagnosis, as national studies have demonstrated that women and Hispanics with non-ST elevation acute coronary syndrome receive less aggressive care than non-Hispanic white men.[44,45] Thus, the provider must remain vigilant of the potential harm of biases and stereotyping and develop strategies to eliminate their effects on the care provided.

The case of the Cambodian refugee with hemoptysis highlights the model of patient-centered care through cultural accommodations. In this case, the patient refused medical diagnostics, and while the patients' right of refusal must be respected, one must ensure that the patient understands the medical advice and the consequences of refusal. Further, clinicians should determine whether an alternate but equitable course of action can be undertaken. When language and/or culture may be barriers, the use of a medical interpreter or a cultural mediator may become necessary.[46] In this case, not only did the patient not understand what was to be done, but the physician did not understand the reasons for his refusal and was unable to engage the patient's values until a translator phone was used. Simply giving up care because of "patient preference" or refusal was not warranted.[16,47,48] A patient-centered approach requires the assessment of cross-cultural challenges, an exploration of the patient's beliefs about illness, an understanding the patient's social environment, and "engaging in negotiation with the patient to encourage adherence."[49] In this scenario, such an approach led to the development of an effective patient–doctor alliance.

In the case of the Bosnian immigrant who fell, the benefits of provider diversity as well as clinical accommodation are highlighted. In this case, the availability of a medical student who had insight into the values of the patient enabled effective care to be delivered, as the provider adjusted his clinical behavior to meet the cultural preferences of the patient without compromising quality. Gender-discordant interactions, particularly for some female Muslim patients, may at times cause discomfort and psychological harm.[50] Cultural taboos and/or religious ethics may play a role in some patients having a preference for same-gender providers.[51,52] In cases where cross-gender interactions impede or prevent the seeking of care, the principles of beneficence and nonmaleficence dictate accommodation whenever possible.[50] The acknowledgment of, respect for, and cooperation with cultural beliefs, whether regarding gender relations or health care values, while delivering quality care, is the epitome of cultural competence. Language, gender, and racial concordance may improve patient satisfaction, in part because culturally concordant physicians benefit from "immediate familiarity, expedited development of trust, and intuitive and efficient communication."[41,53,54] Thus, increasing clinician diversity is a means to reduce health care disparities through more effective patient–doctor relationships.[33,55,56]

CONCLUSIONS

An increasingly diverse patient population and noted health care disparities present challenges to the emergency medical provider. In essence, how does one provide quality care to patients who have different value systems, speak different languages, and face different socioeconomic challenges than the provider? Furthermore, how does one ensure that equitable care is provided to these minority patients? We have presented a proposed three-step paradigm that, if implemented, will likely aid in reducing disparities and furthering provider cultural competence. First, we must eliminate provider biases and increase their cultural awareness. Second, we must clinically accommodate patient preferences and needs through modifying our practice style and practicing clinical negotiation as much as is feasible. Third, we must encourage diversity in the health care workforce, as it may assist the health care system in becoming more tolerant of, and receptive to, the needs of minorities. In addition, we must advance a research agenda to study how cultural competency training, clinical negotiation practices, and provider diversity affect patient satisfaction and outcomes in the ED. By implementing strategies aimed at eliminating disparities and fostering cultural competence on a personal and systems level, and then studying and refining them, we will be able to make emergency care more equitable for all.

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