The Appeal and Problems of a Cultural Competence Approach to Reducing Racial Disparities

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Eliminating racial disparities in health care is a high priority goal for health care organizations. Disparities have been observed across a wide range of treatments and health conditions, from treatment of pain due to bone fracture to the treatment of HIV/AIDS. Inequalities between whites and blacks have been documented most frequently, but other non-white groups are disadvantaged as well. Research suggests that access to treatment and provider recommendations tend to account for the inequality.[1]

Seeking to eliminate racial disparities, many researchers and administrators have turned to cultural competence programs. Cultural competence in health care began with efforts to improve immigrant patients' utilization and adherence by educating providers about immigrants' cultures and how to effectively use interpreters.[2] Subsequently, cultural competence programs were deployed to improve care for native-born minority patients as well. The approach is now widespread: the Affordable Care Act mentions cultural competence; several states require cultural competence training for medical students; and it is common in continuing medical education. The ubiquity of cultural competence programs suggests a widespread commitment to reducing racial inequality.

In this issue of *JGIM*, Saha and colleagues contribute to this effort by presenting an empirical assessment of the effect of self-reported cultural competence on patient outcomes.[3] In cultural competence terms, Saha et al. present important findings based on high quality clinical and survey data and methods.[3] In this editorial, I will describe both their contribution, as well as my view that the foundation for cultural competence's popularity is also the source of its fundamental problems.

Saha and his colleagues seek to remedy a significant problem in the cultural competence field. As they note, there have been few empirical studies demonstrating that cultural competence improves the quality of interpersonal or technical care provided to minority race patients. Saha et al. tackle this problem by evaluating whether health care providers who rate their cultural competence higher have patients with better HIV management and whether there is a stronger positive effect among minority race patients.[3]

In order to assess providers' cultural competence, Saha and colleagues had to first define the construct.[3] Starting from the notion that cultural misunderstanding is a primary source of racial disparities, cultural competence programs began with efforts to reduce racial disparities by teaching about the "cultures" of non-white racial and ethnic groups. Quickly, criticism arose that this approach reinforces stereotypes about racial and ethnic minorities, suggests that racial groups have homogenous cultures, and fails to recognize how white racism and other systems of inequality affect care.[4] Subsequently, most academic publications advised that to be cultural competent, providers should inquire about—and respect—patients' individual health beliefs and attitudes rather focus on "cultural traits" of racial groups.[2]

Saha et al. review the literature and develop a survey instrument based on the current conception of cultural competence. Their instrument primarily assesses providers' openness to patients' experiences and perspectives, with some attention to knowledge of inequality. With this measure, they find that for minority race patients, there is a positive effect of provider cultural competence.[3]

These findings suggest that better cultural competence among providers will reduce disparities. Yet, we must proceed cautiously before making that conclusion. While Saha and colleagues' findings contribute to the cultural competence literature,[3] it is unclear that their research will be used to reduce racial disparities in health care. To understand the potential obstacles to reaching that goal, we must examine the cultural competence field in terms of contemporary racial ideology. Doing so reveals what may be an intractable conflict between the appeal of cultural competence and its real potential to reduce racial disparities.

Before describing my perception of the conflict, we must define racial ideology. Generally, ideology is the broad set of beliefs that people in a society use to organize their thinking about the social world. Racial ideology helps people make sense of racial categories and inequality by

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rationalizing them, and by providing "scripts" for talking about them. One of the core principles of contemporary racial ideology is that individuals and organizations should be blind to race. The language of this ideology avoids naming race or racial groups, often substituting other terms (e.g., "cultural group" for "racial group," "urban" for "African American," "middle America" for "whites"). With this linguistic strategy, whites avoid acknowledging inequality.[5]

When confronted with racial inequality, it is usually explained in terms that do not implicate whites, such as cultural deficiencies among disadvantaged racial groups or individual failings of minority race people. Thus, contemporary racial ideology disregards deep-rooted causes for inequality, such as how institutional and interpersonal practices lead to inequality. In sum, racial ideology provides comfortable, "common-sense" explanations of racial inequality for most whites (and some non-whites) by eliding its complexity and supplying rhetorical devices that direct attention away from whites.[5]

Because ideology is the unnoticed foundation on which we build our understanding of the social world, it is not surprising that *cultural* competence would become central to discussion of *racial* inequality in health care. Demonstrating the persuasive power of ideology, cultural competence gained prominence, as Saha and colleagues note, "largely based on expert opinions about the theoretical benefits of [cultural competence], rather than empirical research."[3] Furthermore, challenges to cultural competence have not displaced it from its prominence as a solution to racial disparities. Instead, the "culture" moniker has been maintained while the scope of "cultural competence" has been expanded and adapted.

As described above, nearly all academic articles discourage cultural competence instruction based on racial groups' "cultural traits." Yet, with "culture" in its name, can cultural competence overcome teaching cultural generalizations of racial groups as a primary activity? Systematic observation of cultural competence trainings suggests that many have not.

> "In an attempt to show that culture matters in health care, many of these sessions do, in fact, identify specific beliefs, practices, and behaviors associated with particular groups. The oft-repeated warning that not all patients will conform to these traits may do little to challenge taken-for-granted assumptions."[6]

In addition, we can still find the description of racial groups' "cultures" in some, but not all, cultural competence textbooks.[7], [8] The conflict between the application and avoidance of culture to explain racial inequality leads to a pernicious problem for those who employ cultural competence: while critics warn that teaching cultural generalizations of racial groups reinforces stereotypes, racial inequality as cultural difference resonates with common understanding of the social world. We must, therefore, guard against Saha and colleagues' findings being used to advocate for applications of cultural competence that continue to promote cultural generalizations, because Saha et al. do not provide evidence for that definition of cultural competence.[3]

Even if the cultural competence approach were able to consistently instruct providers to inquire about each patient's unique social context, beliefs, and health behaviors, it would not have navigated out of problematic waters. In general, it seems wise that explanations of illness and treatment recommendations be based on patients' experience. Yet, in the context of racial disparities, the individual approach resonates with racial ideology by implying that minorities' disadvantages are due to inappropriate beliefs and practices.

In addition, the individual approach suggests that non-white patients are meaningfully different from their (white) health care providers. In fact, class—not race—differences are more likely to be the source of dissimilar health beliefs and practices. In any case, emphasizing difference may exacerbate inequality because attention to differences increases negative judgment in interactions with strangers.[9]

The challenge of reducing racial disparities in health care requires that whites confront unconscious racial bias and discrimination. Reflecting this, Saha and colleagues' instrument asks providers whether "being white affords people many privileges."[3] The question is an important one, but communicating this to providers under the rubric of culture is difficult.[6] Starting with cultural difference—a starting point presumed by its name, *cultural* competence—avoids whites' collective responsibility for policies and behavior that result in the disadvantage of other racial groups. Because of whites' well-documented discomfort discussing white privilege and racism,[5] cultural competence programs often gloss over it.[6] Research on whites' racial thinking suggests that takeaway messages would be about individual and "cultural differences" among minority race patients rather than the effects of bias on care,[10] even in those cultural competence programs that describe the effects of racism. Again, we must be alert to Saha and colleagues' findings being used to support cultural competence programs that do not address white privilege as Saha et al. do.[3]

Saha and his colleagues confront the difficult problem of racial disparities in health care with the framework most often advocated as a remedy.[3] This can be a savvy approach, as using the common language of the day facilitates engagement with broader discussions. From their analysis, we importantly learn that providers who report more consideration of patients' social context, and who recognize white privilege and their culture, have minority race patients with better outcomes. These findings point to the value of improving these skills among providers. Yet, while putting these skills under the umbrella of "cultural competence" makes them ideologically familiar—and comports with existing discussions—the con-

tradictions it creates may ultimately jeopardize our ability to reduce inequality. Given the persistent and extensive unequal treatment of US-born racial minorities, we must conscientiously attend to how our ideological foundation influences our efforts to eliminate disparities.

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