

# The Deliberate Elimination of Racism from Clinical Practice

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It is well past time we admitted that physicians and the U.S. health care system in general, is no more post-racial than the rest of our society. We are

afraid to talk about racism and can only go as far as to use “culture” as a proxy for race, and “diversity” as a proxy for non-white skin color. Yet we have ample evidence that health disparities by race persist despite decades of awareness around cultural competence. A summary of this fact can be found in recent reports such as the one from National Academies of Sciences, *Communities in Action: Pathways to Health Equity*.<sup>1</sup>

Why is this? My view is that we are paying lip service to the concept while not holding ourselves accountable to measurable modification of skills. We need a new strategy. But I’m getting ahead of myself. Let’s start by taking a look at where we are, since we already mentioned a bit about why. The founding principles behind cultural competence have been around for at least thirty years.<sup>2</sup> Most of us wouldn’t know that unless we did some digging, since the exponentially increasing buzz around this term makes it seem like everyone has been made accountable. Nothing could be further from the truth.

The concept of cultural competence in training wasn’t even broadly adopted in health care until about fifteen years later, around the time Betancore et. al. published their analysis for *The Commonwealth Fund*.<sup>3</sup> Cultural competence, as applied to clinical practice, is the ability of an emergency physician to effectively deliver care to every patient in an increasingly racially and ethnically diverse population. It was clear from Betancore et. al. that access to and quality of health care are impacted by cultural competence. There is general agreement that effective care cannot be provided without it. Although some of the framework for practical approaches they laid out over a decade and a half ago have been adopted, especially at the level of medical schools, these have been limited. Are there any realistic alternative approaches? I believe that our standard of care needs to be modified to reconcile the hypocrisy of stating that we expect the competency, but cannot do more to ensure it is acquired. We can start by specifically modeling that skill set in our specialty.

Enter the Model of the Practice of Clinical Emergency Medicine. First let’s take a brief look at the history of the document which

contains all of the knowledge and skills required to practice emergency medicine.<sup>4</sup> In 1975, ACEP and the University Association for Emergency Medicine (now SAEM), conducted a survey of our emerging specialty and the Core Content of EM. It has since been revised and expanded four times and is in the process of being revised for the fifth time. The Task Force is composed of one voting member from ABEM, ACEP, SAEM, CORD, ACGME-RRC, EMRA, and AAEM. Our own Dr. Jonathan S. Jones was AAEM’s representative to this EM Model Task Force this past spring, and he shared that most changes were simple and minor.

This latter observation may be one of the reasons why we do not see significant change in our cultural competence skills and hence, no



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change in persistent health disparities experienced by non-white patients. The concept of cultural competence itself may reflect its association with dominant culture thinking, but let us focus on the goal at hand: improving training in emergency medicine such as to decrease racism.<sup>5</sup>

Whereas the most current 2016 updated version of the Model of Clinical Practice of EM delineates that patient-centered care requires communication skills that include the ability to establish rapport with patients and their families as described in introductory Table 3. “Physician Task Definitions” notes that the “performance of focused history and physical examination is a requirement,” which cannot be successfully performed if biased or not centered culturally.<sup>4</sup> The present recommendation proposed is that Physician Task Definitions be modified to specifically require four aspects of cultural competence: 1) awareness of differences by race, 2) attention to attitude towards race discordant patients, 3) knowledge of cultural differences with non-white patients, and 4) skills to address aspects 1-3, and that these be specifically included and expanded in the sections and subsections which will be described below.

Similar recommendations to improve cultural competence addressing the four aspects listed above have been made for the purpose of improving medical education. As noted by Sorensen et. al. “enhancing cultural competence in medical education is justified based on attention to diversity issues, and should be considered at all stages of health care planning, including the recruiting and training of health care staff and organizing and providing health care.”<sup>6</sup>

Further, researchers from schools of public health such as Padela et. al. have made such recommendations specifically with regard to potential positive impact of improving cultural competence in emergency medicine practice:

“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.”<sup>7</sup>

Additionally, some state legislatures have required medical boards to adopt and expand such competency. For example, in 2005, the NJ Legislature “enacted law requiring the New Jersey Board of Medical Examiners in consultation with the Commission on Higher Education to prescribe requirements, by regulation, for physician training in cultural competency. Regulations related to cultural competency training were adopted in final form on April 7, 2007. The legislation requires all medical schools in NJ to provide specific instruction to current and future students in cultural competency as a condition of receiving a diploma from the College of Medicine of NJ. It also required cultural competency CME instruction for licensed physicians who did not receive it in their medical school curriculum.”<sup>8</sup>

**Specific initial recommendations are as follow:**

That section 20.1 of the Model of the Practice of Clinical Emergency Medicine be changed to “Interpersonal and Communication Skills with Cultural Competency” such that the cultural competence principle clearly applies and is included in all aspects of patient care, as well as all areas covered by 20.1 Interpersonal Skills

I realize my proposal is ambitious, but if you consider the positive repercussions and potential for reducing human suffering, I believe you will all agree, it is worth the fight.

Sub-categories to reflect cultural competence with application to the following areas:

- 20.1.1.1 Inter-departmental and Medical Staff Relations
- 20.1.1.2 Teamwork and Collaboration
- 20.1.1.3 Patient & Family Experience of Care
- 20.1.2.1 Complaint Management
- 20.1.2.2 Conflict Management
- 20.1.2.3 Crisis Resource Management
- 20.1.2.4 Delivering Bad News

That 20.1.2.5 “Cultural Competence” be replaced with “Institutionalized Racism Awareness” including understanding of the physiologic impact of chronically elevated allostatic load that results from this stress in certain populations of patients.

It is further recommended that “Cultural Competence” be applied to evaluation of scientific evidence:

- 20.2.1 Evidence-Based Medicine
- 20.2.2 Interpretation of Literature
- 20.2.3 Performance of Evaluation & Feedback
- 20.2.4 Research
- 20.2.2 Education & Professionalism (including requirement diversity in role





models)

...that the requirement on “Diversity Awareness” be expanded to imply awareness of the above; that the section on “Medical Ethics” specifically include consideration of the unethical practice of discriminatory assessment such as that of pain tolerance by race; that the incremental stress experienced by inner city communities be acknowledged and considered; the well-being of minority physicians requires incremental consideration as a result of under-representation particularly in the context of 20.3.4.1 Fatigue & Impairment (in consideration of the aforementioned increased allostatic load); that consideration of cultural competence be given to areas of subjective evaluation such as 14.7 “Personality Disorders;” and finally that the scant attention given testable content areas that address these skill sets be expanded to include the four major areas of cultural competence named above.

Of course this will require significant collaboration with the all of the other Task Force members. I realize my proposal is ambitious, but if you consider the positive repercussions and potential for reducing human suffering, I believe you will all agree, it is worth the fight.

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