

# Saint Louis University Law Journal

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Volume 48  
Number 1 *Unequal Treatment: Racial and Ethnic  
Disparities in Health Care (Fall 2003)*

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Article 7

12-1-2003

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### Recommended Citation

Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 St. Louis U. L.J. (2003).  
Available at: <https://scholarship.law.slu.edu/lj/vol48/iss1/7>

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## RACIAL DISPARITIES IN HEALTH CARE AND CULTURAL COMPETENCY

LISA C. IKEMOTO\*

### I. INTRODUCTION

The basic premise of cultural competency is that the near monoculture of the health care system interferes with the care of the growing number of patients who are not part of that culture.<sup>1</sup> Cultural competence efforts aim at changing the institutional culture of health care and accompanying social services. The efforts include enabling health care and social service workers to provide effective access and care to patients with diverse values, beliefs, and practices. A primary and oft-stated goal of cultural competence is to contribute to the elimination of racial and ethnic gaps in health outcomes.

Race-based health data show that health outcomes, including disease incidence rates, disease mortality rates and infant mortality rates, vary significantly among racial groups. Research shows that social determinants external to health care account for most of that variation, but to a frightening degree, the way that health care is delivered impairs the health of racial and ethnic minorities. The recent Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (Unequal Treatment)*,<sup>2</sup> uses the term “disparities” to capture this problem. *Unequal Treatment* defines “disparities” as “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs,

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\* Professor of Law, Loyola Law School. This article benefited from the valuable contributions of all the other speakers at the St. Louis University School of Law Health Law Symposium on April 11, 2003. I would also like to thank the editors of the *St. Louis University Law Journal*. Finally and particularly, I thank Beatriz Garcia and Kurt Dedrick for their research assistance, Sean Scott and Soo-Young Chin for their thoughtful input, and Marjorie Kagawa Singer for sharing her knowledge.

1. See Cindy Brach & Irene Fraser, *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*, 57 MED. CARE RES. & REV. 181, 183 (2000).

2. COMM. ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* 3-4 (Brian D. Smedley et al. eds., 2003) [hereinafter *UNEQUAL TREATMENT*].

preferences, and appropriateness of intervention.”<sup>3</sup> A close look at the health care industry’s institutional practices reveals an English-only, ethnocentric, racist culture that does interfere with patient care.

Cultural competence has the potential to change the way that health care is delivered, particularly to persons of color and others not included in health care’s institutional culture. Because current institutional culture seriously impairs health care access, patient status, and quality of care, making a change is an urgent matter. Fortunately, the matter is currently receiving a great deal of attention.

In 2000, the United States Department of Health and Human Services published a *Policy Guidance on the [Title VI] Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency*.<sup>4</sup> That publication and the process that preceded it surfaced a vehement debate over the role of law in implementing cultural competence measures in health care. While existing law focuses largely on language access, many health policy scholars, civil rights advocates, and community-based organizations support using the law to require broader cultural competence efforts in health care. Many in the health care industry oppose legally required cultural competency efforts, including those that implement language assistance. Provider organizations have been particularly vocal in their opposition.

The political discourse formed by the debate between cultural competency’s advocates and objectors has so far resulted in a relatively narrow vision of change in health care delivery. The laws and proposed standards resulting from this discourse similarly express limited goals for cultural competence. A bigger vision and a more ambitious legal agenda are necessary to avoid shrinking the promise of cultural competence to reduce racial disparities in health care.

Part II of this Article discusses health care’s institutional monoculture. The section will describe some of the standards and practices that unofficially operate as portals for bias in the health care system, and then it will address the potential of cultural competence efforts to change this culture. Part III reviews existing laws and standards that expressly require cultural competence in health care and also sketches the political debate that has surrounded two key federal efforts. In Part IV, this Article will examine threads in the political discourse for what they say about the competing visions of health care and the role of law in achieving those visions. The Article argues throughout for a more ambitious vision of health care and an expanded role of law in effecting change.

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3. *Id.* at 3-4 (footnote omitted).

4. 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. 52,762 (Aug. 30, 2000) [hereinafter 2000 HHS LEP Policy Guidance].

## II. HEALTH CARE'S CULTURE, RACIAL DISPARITIES, AND CULTURAL COMPETENCE

The health care delivery system is complex and has multiple levels. For purposes of this discussion, the system has three levels.<sup>5</sup> The organizational level refers to the allocation of authority, the form of institutional leadership, and the lines of decision-making power between leadership and staff, as well as among staff.<sup>6</sup> The structural level refers to the complex, archaic nature of internal systems.<sup>7</sup> The clinical level is where health care and accompanying social services are directly delivered to patients.<sup>8</sup>

Like other major social institutions, health care is both unique and redundant. Features considered characteristic of health care include the dominance of managed care, the bureaucratic nature of the system, and the apparently scientific nature of clinical care. These features may seem cold, even uncaring, but they also appear to be race-neutral. Yet, health care in a system with these features produces racially disparate health care services. Racial disparities, in turn, produce gaps in health outcomes for communities of color relative to whites. Existing research indicates that cultural competency efforts can reduce race-based disparities in health care.

### A. Key Features of the Health Care Delivery System

#### 1. Managed Care

Since the 1980s, managed care has dominated the financial and organizational features of health care.<sup>9</sup> While patients might regard providers as the key players in a health care system, managed care is not the simple provider-dominated system of old.<sup>10</sup> As a corporate arrangement that combines both the insurance and health care services functions, managed care is largely shaped by cost-containment concerns. Managed care's cost-containment mechanisms include, for example, utilization review<sup>11</sup> and the transfer of financial risk to clinicians, along with financial incentives to reduce costs and deterrents to using expensive tests, treatments, and referrals to

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5. The terms and definitions of the three-level analysis have been adopted from Joseph R. Betancourt et al., *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care*, 118 PUB. HEALTH REP. 293, 295-97 (2003).

6. *See id.* at 295-96.

7. *Id.* at 296.

8. *Id.* at 297.

9. *See* Clark C. Havighurst, *Is the Health Care Revolution Finished?—A Foreward*, 65 L. & CONTEMP. PROB., Fall 2002, at 1.

10. *See* RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 20 (1997). For further discussion, see text accompanying notes 25–29.

11. *See infra* note 25 and accompanying text.

specialists.<sup>12</sup> These cost-containment mechanisms require physicians to decide on a proposed course of diagnosis and/or treatment while balancing their own financial incentives and deterrents. Utilization managers must decide whether or not to reimburse the patient for tests and therapies in that course of treatment. Patients in low coverage plans have fewer choices about providers, settings, and covered services.<sup>13</sup> Providers to those patients must make testing and treatment decisions while facing the toughest cost constraints and utilization review.<sup>14</sup>

## 2. Bureaucracy

From a patient perspective, bureaucracy characterizes the structural aspects of many health care institutions. Patients experience bureaucratic processes directly. These processes include intake, appointment scheduling and resulting waiting times, referrals, lab testing, and planning for follow-up care. Whether and how a patient navigates these processes impacts the quality of care and whether the patient even receives care.<sup>15</sup> Health care bureaucracies do include both formal and informal navigational aids; however, the usefulness and availability of help in navigating the system depends on particular institutional practices and staff discretion in implementing those practices.<sup>16</sup> Thus, institutional culture and staff cultural awareness determine whether or not *all* patients receive aid in navigating the system.

## 3. The Medical Gaze and the Value of Efficiency

The provider–patient relationship is the core feature of the clinical level. The constraints on that relationship are considerable. The constraints include the “medical gaze”—the focus on and definition of “medically relevant” information—and the extraordinary time pressures that providers now face. These constraints tend to reduce the opportunity for patients to use their self-knowledge and to assert their self-identity in the medical encounter; yet logic might say that, if anything, because the medical gaze and time pressures tend to eliminate introduction of social information into the doctor–patient relationship, these constraints would support the claim of provider universalism.

The medical gaze is defined by “the dismantling of patient life narratives and the reconstitution of patient concerns and experiences of illness and

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12. Marcia Angell, *The Doctor as Double Agent*, 3 KENNEDY INST. OF ETHICS J. 279, 279-86 (1993); *see also* Daniel P. Maher, *Managed Care and Undividing Loyalties*, 18 J. CONTEMP. HEALTH L. & POL’Y 703 (2002).

13. UNEQUAL TREATMENT, *supra* note 2, at 147; *see also* M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL’Y, L. & ETHICS 95, 115-16 (2001).

14. *See* UNEQUAL TREATMENT, *supra* note 2, at 147-48.

15. *See* Betancourt et al., *Defining Cultural Competence*, *supra* note 5, at 297.

16. UNEQUAL TREATMENT, *supra* note 2, at 144.

associated social context into medically meaningful narratives that allow physicians to determine a diagnosis and formulate plans for therapeutic actions and procedures.”<sup>17</sup> The medical gaze is the “dominant knowledge frame,” teaching students that “time and efficiency are highly prized” and valuing biomedical science over other sources of knowledge.<sup>18</sup> Within that frame, providers regard patient life issues as “inadmissible evidence.”<sup>19</sup> The medical gaze strips patients of most of their social and lived experience, including experience arising from cultural beliefs, values, and practices that differ from those embedded in the health care system. The stripping effect is part of what makes medical culture appear to be neutral or even cultureless.<sup>20</sup>

The medical gaze also values time and efficiency. Medical culture’s emphasis on efficiency reflects the time pressures that clinicians face. The medical gaze serves efficiency by filtering out information that makes the patient’s situation complicated and time-consuming. A study of medical culture and how medical students and residents become acculturated used interviews of attending physicians, residents, and medical students.<sup>21</sup> A second-year medical resident at a major teaching hospital noted:

You learn to do a better job by not listening to your patients. . . . When physicians experience difficulties in interacting with patients, it befuddles the doctor, and derails them. In ER shifts, there is the discipline of time, and when a patient derails you, it is glaringly obvious. . . . [T]he faster you make a decision the better you are as an ED [sic] doctor . . . .<sup>22</sup>

There are other diagnostic and treatment planning tools also valued for efficacy. Like the medical gaze, the other tools also tend to strip the patient’s contextual information out of the doctor–patient encounter and hence appear to value sterile, non-political information.

### B. Health Care’s Culture and Racial Disparities

If culture is a set of values, beliefs, and practices, then health care has a culture.<sup>23</sup> The fact that there are racial disparities in health care indicates that

17. Mary-Jo DelVecchio Good et al., *The Culture of Medicine and Racial, Ethnic, and Class Disparities in Healthcare*, in UNEQUAL TREATMENT, *supra* note 2, at 594, 600 (pages 417-738 are not printed in the book but are provided on the CD-ROM attached to the inside back cover).

18. *Id.* at 595-96.

19. *Id.* at 600.

20. Janelle S. Taylor, *Confronting “Culture” in Medicine’s “Culture of No Culture”*, 78 ACAD. MED. 555, 556-57 (2003) (comparing medicine to physics because of the “confidence in the truth of medical knowledge” and the belief that it is “not merely ‘cultural’ knowledge but real knowledge.”).

21. See DelVecchio Good et al., *supra* note 17, in UNEQUAL TREATMENT, *supra* note 2.

22. *Id.* at 600-601.

23. OFFICE OF MINORITY HEALTH, U.S. DEP’T OF HEALTH AND HUMAN SERVICES, NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN

health care's apparently unique institutional features do not separate health care from the dominant culture. More specifically, health care's science-based standards do not filter out the racism, ethnocentrism, and nativism that characterize the dominant culture. A close examination of health care's culture reveals how its systemic practices express racist, nativist, and ethnocentric beliefs and values that, in turn, produce racially disparate health outcomes.

### 1. The Role of Discretion

Cost containment, bureaucratic processes, the imposition of the medical gaze and other efficacious clinical tools are all practices that require health care and social service staff to make discretionary decisions. Therefore, a patient's experience depends largely on how those within the system decide to apply the multitude of rules and practices that accompany these features. Discretion is a portal for bias. It is a mechanism by which the system faithfully reproduces key aspects of the dominant culture, including nativism, ethnocentrism, and racism.<sup>24</sup>

One of managed care's cost-containment measures, utilization review, requires utilization managers to decide whether or not to reimburse providers for the costs of tests and therapies and help ensure physicians provide services deemed medically appropriate.<sup>25</sup> For tests and therapies that do not obviously fit into practice guidelines, a clinician's advocacy can persuade the utilization manager to cover the costs.<sup>26</sup> Providers that have established relationships with patients are more likely to advocate on their behalf.<sup>27</sup> Patients of color are less likely than whites to have a regular provider.<sup>28</sup> Therefore, as noted in *Unequal Treatment*, patients of color "may be less likely to benefit from the advocacy of their provider."<sup>29</sup>

Shifting financial responsibility to physicians increases the role that providers play in allocating medical resources. Financial incentives to keep costs low and the deterrents to clinical generosity force providers to remain conscious of cost-containment goals.<sup>30</sup> Conscious or unconscious bias may influence providers' decisions about which patients should receive which tests,

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HEALTH CARE: FINAL REPORT 4 (2001) [hereinafter NAT'L STANDARDS FOR CLAS]; Lynne S. Robins et al., *Improving Cultural Awareness and Sensitivity Training in Medical School*, 73 ACAD. MED. S31 (Oct. Supp. 1998).

24. For an in-depth assessment of the role of discretion, or lack thereof, in health care, see Bloche, *supra* note 13, at 99-106; UNEQUAL TREATMENT, *supra* note 2, at 151-53.

25. UNEQUAL TREATMENT, *supra* note 2, at 151.

26. *Id.*

27. *Id.*

28. *Id.*; Marsha Lillie-Blanton et al., *Site of Medical Care: Do Racial and Ethnic Differences Persist?*, 1 YALE J. HEALTH POL'Y L. & ETHICS 15, 17-18 (2001).

29. UNEQUAL TREATMENT, *supra* note 2, at 151.

30. *See id.*

referrals, and therapies.<sup>31</sup> Also, a physician may include a patient's social status in the "cold calculus" she uses to avoid lawsuits for failure to offer certain tests or treatments.<sup>32</sup>

Two aspects of bureaucracy may reflect racially or ethnically exclusionary decision-making. First, organizational leadership may have set up bureaucratic processes in conscious or unconscious disregard of patient diversity. For example, failure to provide language assistance for patients with limited English proficiency disregards the fact that 8.1% of persons age five years and older living in the United States and counted in the 2000 Census (more than 21 million people) speak English less than "very well."<sup>33</sup> Second, the staff makes decisions about which patients receive assistance in negotiating the bureaucracy. Providers, for example, may coach patients through the process of accessing organizational resources. They may also advocate for patients to receive access to certain resources; however, "clinical uncertainty, stereotypic thinking, and/or lesser personal engagement with patients" may inform provider selection of patients to assist.<sup>34</sup>

At the clinical level, the medical gaze seems objective because it strips patients of their social context. In operation, the medical gaze actually creates space for stereotyping. In place of what the provider knows about the patient, the provider may easily substitute what the provider assumes about patients of that racial or ethnic group. In the study of medical culture and acculturation of doctors-in-training noted previously, one resident described "the stereotype of African-American patients as being 'dreadfully sick and their social life is so disorganized that they are "non-compliant" and living in a state of chaos, with a disorganized household, or that they are socially isolated. And incredibly sick and incredibly difficult to manage.'"<sup>35</sup> Others noted that when faced with patients subject to those stereotypes, "there is a reluctance rather than an inclination to get a good social history and explore the social roots of the

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31. Bloche, *supra* note 13, at 104-106. Note that 22% of Hispanics and 16% of African-Americans have reported accessing specialty care as a major problem. Betancourt et al., *Defining Cultural Competence*, *supra* note 5, at 297 (citing KAREN SCOTT COLLINS ET AL., THE COMMONWEALTH FUND, U.S. MINORITY HEALTH: A CHARTBOOK 84 (1999)). For a discussion of how cost containment and the for-profit ethos of healthcare have affected decisions about the very existence of hospitals that serve the poor and racial minorities, see W. MICHAEL BYRD & LINDA A. CLAYTON, 2 AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE, AND HEALTH CARE IN THE UNITED STATES 1900-2000, at 499-503 (2002).

32. Bloche, *supra* note 13, at 114.

33. U.S. Census Bureau, DP-2 Profile of Selected Social Characteristics: 2000, [http://factfinder.census.gov/servlet/QTTable?ds\\_name=D&geo\\_id=D&qr\\_name=DEC\\_2000\\_SF4\\_U\\_DP2&\\_lang=en](http://factfinder.census.gov/servlet/QTTable?ds_name=D&geo_id=D&qr_name=DEC_2000_SF4_U_DP2&_lang=en); see also Betancourt et al., *Defining Cultural Competence*, *supra* note 5, at 296-97 (discussing structural barriers to care for Spanish-speaking patients).

34. UNEQUAL TREATMENT, *supra* note 2, at 144.

35. DelVecchio Good et al., *supra* note 17, in UNEQUAL TREATMENT, *supra* note 2, at 602.



illness.”<sup>36</sup> The medical gaze narrows in the presence of a patient of color. The decision not to know more enables providers to define the patient’s problem in terms that are fixable and that meet the need for efficiency. The absence of actual knowledge about the patient and her real situation may lock the stereotype into place.

## 2. The Role of Institutional Authority

Social hierarchies are inherent in the doctor–patient relationship. Sociolinguist Sue Fisher has shown how doctor–patient encounters take place within a contextual web.<sup>37</sup> The web is formed by our preexisting assumptions about the impact of education, expertise, income, gender, and race on social status. For example, Fisher’s fieldwork in women’s health clinics shows how those social indicators operate to allocate power in the doctor–patient relationship.<sup>38</sup> The doctor’s expertise, the fact that the patient is seeking that expertise, and the fact that the doctor–patient encounter takes place on the doctor’s turf vest the doctor with institutional authority.<sup>39</sup> Where the doctor is typically male, the patients are female and often racial minorities, and the doctor has both the formal education to claim expertise and more formal education than the typical patient, the power imbalance is exacerbated.<sup>40</sup> That result empowers doctors to claim primary ownership of knowledge and ability.<sup>41</sup>

The social structure of doctor–patient encounters interferes with the communication necessary for adequate treatment. Doctors ask most of the questions, reframe patient answers, cut-off patients’ sentences, and moralize regarding patients’ medical situations.<sup>42</sup> This dynamic inhibits the patient’s ability to communicate her needs and assert the value of her experience and knowledge.

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36. *Id.*

37. SUE FISHER, IN THE PATIENT’S BEST INTEREST: WOMEN AND THE POLITICS OF MEDICAL DECISIONS 4 (1986).

38. *Id.* at 46-47.

39. *See id.* at 142.

40. *Id.* at 4-5; *see also* Marjorie M. Schultz, *We Are What We Say*, 4 J. GENDER SPECIFIC MED. 16 (2001) (noting that “[p]hysicians commonly use words that betray a starkly hierarchical approach to patients”). It is important to note that “[i]ndividuals coming together in medical dialogue bring with them all of their personal characteristics, including their personalities, social attitudes and values, race, ethnicity, gender, sexual orientation, age, education, and physical and mental health. This applies to the physician as well as to the patient . . .” Lisa A. Cooper & Debra L. Roter, *Patient–Provider Communication: The Effect of Race and Ethnicity on Process and Outcomes of Healthcare*, in UNEQUAL TREATMENT, *supra* note 2, at 552, 557 (pages 417-738 are not printed in this book but are on the CD–Rom attached to the inside back cover).

41. FISHER, *supra* note 37, at 142.

42. *See id.* at 59-89.

A similar effect may interfere with a patient's ability to communicate with others in the health care system. The doctor-patient relationship is not the only point at which communication matters. Communicating with a social worker, insurance company representative or utilization manager, clinic intake staff, public health official, patient advocate, lab technician, or other staff member who facilitates entry to the health care system is essential to both access and quality of care. Each of those positions comes vested with its own form of institutional authority. Patients whose primary language is one other than English, who are persons of color, or who are members of immigrant communities are not only outsiders to the health care system, but they are also outsiders to mainstream culture. That outsider status expands and complicates the power differential between such patients and those insiders with institutional authority.

### 3. Health Care's Culture

#### a. English-Only

The official language of health care in the U.S. is English. More accurately, the language of health care is a patois of English and medical terminology—medicalese, if you will. The medical terminology makes it more likely, if anything, that communication problems between provider or health care worker and patient will arise. Racism and demographics make it more likely that communication problems will arise with a patient of color.<sup>43</sup> The effects of institutional authority make it certain that the communication problem will impact most negatively on the patient.

Linguistic differences between patient and health care worker fundamentally affect the patient's ability to access and receive effective care. Persons with limited English proficiency have difficulty simply getting health care. In a recent survey of twelve hundred adult immigrant residents of California, significant percentages of several immigrant groups identified basic access as a problem. For example, thirty-three percent of Koreans, thirty percent of Russians, and thirty percent of Chinese immigrants responded "yes" to the question, "Have you ever had a problem getting medical care when you

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43. News Release, The Commonwealth Fund, *Minority Americans Lag Behind Whites on Nearly Every Measure of Health Care Quality* (Mar. 6, 2002), [http://www.cmf.org/media/releases/collins523\\_release03062002.asp?link=11](http://www.cmf.org/media/releases/collins523_release03062002.asp?link=11). The statement noted:

Minority Americans were more likely than whites to experience difficulty communicating with their physicians. Hispanics were more than twice as likely as whites (33% vs. 16%) to cite one or more communication problems such as not understanding the doctor, not feeling the doctor listened to them, or that they had questions for the doctor but did not ask. One-fourth of Asian Americans (27%) and African Americans (23%) experience similar communication difficulties.

*Id.*

needed it?”<sup>44</sup> Twenty-nine percent of Vietnamese, twenty-nine percent of Hmong, twenty-seven percent of Latinos/Hispanics, and twenty-three percent of Cambodians also answered “yes.”<sup>45</sup> For many, especially Koreans and Latinos/Hispanics, lack of insurance was a key component of that problem.<sup>46</sup> But others, especially Cambodians and Hmong persons, indicated that linguistic differences were the primary barrier to accessing health care.<sup>47</sup> These responses strongly suggest that linguistic differences alone create a basic problem in simply obtaining access to health care.

Linguistic differences also interfere with diagnoses and other clinical outcomes. Doctors and other providers may miss symptoms or inaccurately evaluate them without adequate conversation with the patient. The inability to communicate during the diagnostic process may lead the doctor to do unnecessary testing, raising the cost, time and risk to the patient.<sup>48</sup> On the other hand, the communication problem may make the doctor less likely to do necessary testing or otherwise provide lower quality of care.<sup>49</sup> Either way, without adequate communication, the doctor is more dependent on simple observation and racial profiling because of language differences.

Language differences between provider and patient may also prevent the patient from understanding and participating effectively in her own care.<sup>50</sup> In the California survey mentioned above, poll results showed a high correlation between language differences and patient ability to understand a medical situation. Forty-eight percent of poll respondents identified as persons who do not speak English well or not at all said ‘yes’ to the question, “Have you ever had a problem understanding a medical situation because it was not explained in your language?”<sup>51</sup> In response to the question, “Have you ever had a problem understanding the instructions when you were discharged from a hospital because they were not given in your language?,” seventy percent of Cambodians, forty-five percent of Hmong, thirty-five percent of Vietnamese, twenty-nine percent of Koreans, twenty-five percent of Latinos/Hispanics, and

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44. NEW CALIFORNIA MEDIA, BRIDGING LANGUAGE BARRIERS IN HEALTH CARE: PUBLIC OPINION SURVEY OF CALIFORNIA IMMIGRANTS FROM LATIN AMERICA, ASIA AND THE MIDDLE EAST ON HEALTH CARE ISSUES 13 (2003) [hereinafter NEW CALIFORNIA MEDIA].

45. *Id.*

46. *Id.* at 51-52.

47. *See id.* at 15. Substantial percentages (at least fifty percent) of Vietnamese, Hispanics, Hmong, Koreans, and Chinese said ‘no’ to the question, “Does your doctor or anyone at your doctor’s office/clinic speak [your primary language]?” *Id.* at 18.

48. Steven Woloshin et al., *Language Barriers in Medicine in the United States*, 273 JAMA 724, 725 (1995).

49. *Id.* at 725; *see also* DelVecchio Good et al., *supra* note 17, in UNEQUAL TREATMENT, *supra* note 2, at 601.

50. Woloshin et al., *supra* note 48, at 725.

51. NEW CALIFORNIA MEDIA, *supra* note 44, at 21.

twenty-three percent of Iranians said ‘yes.’<sup>52</sup> The survey also showed that “[s]ubstantial percentages of California immigrants, especially Iranians, Hmong, Cambodians and Latinos/Hispanics, are often confused about how to use their prescription medicines.”<sup>53</sup> The resulting misuse of prescription medicine has made more than a quarter of immigrants with a poor understanding of English ill.<sup>54</sup>

Language assistance provided by someone who is untrained or socially inappropriate may harm the quality of clinical health care. Many physicians who think they were sufficiently language-proficient tend to misunderstand their patients or make incorrect, confusing, or insulting replies.<sup>55</sup> A study from the early 1990s conducted by Stanford University medical residents who took a forty-five-hour course in medical Spanish showed that they still made significant mistakes in communicating with patients that had the potential to affect both diagnosis and treatment.<sup>56</sup> Friends or family members often serve as interpreters, but they are not always available, nor is this even the best situation.<sup>57</sup> The persons serving as interpreters may feel inhibited, emotionally overcome, or simply lack the skill to provide accurate interpretation.<sup>58</sup> More importantly, use of friends, family, or strangers from the waiting room may inhibit and embarrass patients.<sup>59</sup> It may also violate patients’ privacy interests.

The English-only standard of our health care culture interferes with the rights and effective care of patients with limited English proficiency. While lack of language assistance makes work difficult for health care and social service staff, the risks of language differences fall squarely on the patient.

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52. *Id.* at 23.

53. *Id.* at 29.

54. *Id.*

55. Linda Haffner, *Translation Is Not Enough: Interpreting in a Medical Setting*, 157 W. J. MED. 255, 258 (1992).

56. NAT’L STANDARDS FOR CLAS, *supra* note 23, at 76.

57. NEW CALIFORNIA MEDIA, *supra* note 44, at 20. In the California survey, thirty-four percent of those who did not speak the same language as the doctor said a family member, friend, or staff member provided language assistance during doctor–patient meetings. Only nine percent said that professional interpreters provided language assistance. *Id.* The survey also asked, “Did you know the law in the United States gives you the right to an interpreter when you visit a clinic or hospital?” *Id.* at 27. More specifically, ninety-four percent of Hmong, eighty-two percent of Chinese, ninety-three percent of Vietnamese, seventy-three percent of Armenian, eighty-one percent of Russian, sixty-seven percent of Cambodian, eighty-five percent of Korean, ninety-five percent of Hispanic, and eighty-eight percent of Filipino respondents did not know of their rights under Title VI giving them the right to ask for an interpreter when visiting a hospital or clinic. *Id.* at 26, 28.

58. Letter from Mara Youdelman & Doreena Wong, Staff Attorneys, National Health Law Program, to Deeana Jang, Office of Civil Rights, U.S. Dep’t of Health and Human Servs. 7-10 (April 2, 2002), <http://www.healthlaw.org/pubs/200204lepcomments.html> [hereinafter NHeLP Letter].

59. Woloshin et al., *supra* note 48, at 725.

Failure to provide language assistance creates more than practical barriers. It defines dominant culture in narrow, nativistic terms. As such, it treats patients with limited English proficiency as perpetually unwelcome strangers.

b. Ethnocentric

Implementing language assistance in health care will go a long way toward addressing the needs of patients who are outsiders to dominant culture, but language assistance alone will not make health care culturally competent. Health, wellness, illness, disease, and health care are culturally specific social constructs. Efforts to provide health care that disregard the diversity of frameworks for understanding these concepts can interfere with patient health and patient status.

“[U]nderstanding a patient’s culturally determined disease model can be crucial to providing good care.”<sup>60</sup> For example, fatalismo, or “the belief that the individual can do little to alter fate,” among many Latinos discourages some from seeking cancer screening or therapy.<sup>61</sup> This belief may explain why cancer mortality rates are high relative to incidence rates among Latinos. One study has shown that as compared to whites, Latinos are more likely to believe that there is little one can do to prevent cancer, that having cancer is like getting a death sentence, and that cancer is God’s punishment.<sup>62</sup> Culturally competent providers can respect those beliefs and counter their negative effects. Suggestions by experts responding to those beliefs within the patient’s disease mode include “emphasizing the importance of screening and prevention[,] . . . underscoring the efficacy of therapies for chronic disease and cancer. . . .” and incorporating the patient’s cultural beliefs and values, “pointing out that ‘[p]erhaps God doesn’t want you to get sick and die yet,’ or ‘[y]ou need to take care of yourself so that you can be there for your family.’”<sup>63</sup>

Consider how bare language assistance without other aspects of contextual understanding might result in less-than-effective care. As mentioned above, using friends, family, or strangers on hand, is not uncommon.<sup>64</sup> Even if the language assistance is accurate, contextual issues may prevent effective communication. One author recounted that:

[A] 52-year-old Korean-speaking woman had a gynecology appointment at a county hospital. A community-based agency called ahead to request a Korean

60. *Id.*

61. Glenn Flores, *Culture and the Patient–Physician Relationship: Achieving Cultural Competency in Health Care*, 136 J. PED. 14, 16 (2000).

62. Eliseo J. Pérez-Stable et al., *Misconceptions About Cancer Among Latinos and Anglos*, 268 JAMA 3219, 3221 (1992).

63. Flores, *supra* note 61, at 16.

64. *See supra* notes 58-60 and accompanying text.

language interpreter for her. She arrived at her appointment, but the hospital did not provide an interpreter or bilingual worker. Instead, the hospital staff asked a 16-year-old boy sitting in the waiting room—a complete stranger—to be the interpreter for her gynecology appointment.<sup>65</sup>

The interpreter arrangement in this case probably prevented any communication from occurring.<sup>66</sup> For immigrant Korean women, gynecological issues are extremely private. Discussing them with a provider might be awkward and difficult. Discussing them in front of a stranger who is not a physician would be impossible for most. The age hierarchy and gender difference between patient and interpreter complicate the situation. The gender difference makes the subject matter—gynecological health issues—all the more inappropriate for discussion. The age hierarchy placed the woman in the authority position relative to the boy. That hierarchy made her responsible for avoiding the inappropriate subject matter. The result was ineffective care.<sup>67</sup>

The circumstances in this account might inhibit and embarrass any woman patient, but because the official language of health care is English, an English-speaking patient would not face this situation. Similarly, it seems very unlikely that hospital staff would ask a sixteen-year-old boy, a stranger no less, to interpret for a white female patient in a gynecological appointment. From a dominant culture perspective, the improprieties are obvious. The patient's race—white—places her within the dominant culture. Cultural knowledge and, possibly empathy based on assumed cultural concordance, would prevent hospital staff from considering this interpreter arrangement. The Korean-speaking patient's race and foreignness can create distance between the staff and patient. That distance, the objectification of the patient's circumstances that accompanies distancing, and the lack of understanding about Korean or Korean-American culture left staff free to imagine that the interpreter arrangement was acceptable. Perhaps more accurately, those factors led staff to conclude that the arrangement would have to do.

Understanding the ways in which one pays respect and demonstrates courtesy can be just as crucial to establishing communication and facilitating appropriate health care as understanding a patient's disease model. One of the most often cited stories about the harms caused by cultural incompetence—Anne Fadiman's *The Spirit Catches You and You Fall Down*<sup>68</sup>—includes an example of successful communication between a health care worker and a

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65. LORA JO FOO, FORD FOUNDATION, ASIAN AMERICAN WOMEN: ISSUES, CONCERNS, AND RESPONSIVE HUMAN AND CIVIL RIGHTS ADVOCACY 108 (2002), available at [http://www.fordfound.org/publications/recent\\_articles/asian\\_american\\_women.cfm](http://www.fordfound.org/publications/recent_articles/asian_american_women.cfm).

66. Interview with Soo-Young Chin, Assistant Professor of Anthropology, University of Southern California (Aug. 25, 2003).

67. *Id.*

68. ANNE FADIMAN, *THE SPIRIT CATCHES YOU AND YOU FALL DOWN: A HMONG CHILD, HER AMERICAN DOCTORS, AND THE COLLISION OF TWO CULTURES* (1997).

Hmong family. In that example, the interpreter not only provided basic language service for the hospital social worker and the patient, but also coached the hospital social worker on the most appropriate terms for opening the conversation:

A hospital social worker in San Francisco, accompanied by an interpreter, was sent by the public health department to visit a woman with tuberculosis who had refused to take her isoniazid tablets. The social worker, whose name was Francesca Farr, began to talk to the patient, who was in her eighth month of pregnancy. “No, no,” said the interpreter. “You should talk to her *husband*.” So Farr asked the husband why he didn’t want his wife to take the medicine. “No, no,” said the interpreter. “Don’t ask him that yet. First, you should wish him some things.” Farr told the husband she wished that his children would never be sick, that their rice bowls would never be empty, that his family would always stay together, and that his people would never be in another war. As she spoke, the husband’s hands, which had been clenched, relaxed. “Now,” said the interpreter, “you can ask him why his wife isn’t taking the medicine.” Farr did. The husband answered that if she took the medicine, their baby would be born without arms or legs. Farr touched the patient’s abdomen, and told the husband that if the baby didn’t already have arms and legs, the woman wouldn’t be so big, and the baby wouldn’t be kicking. The husband . . . said that his wife would take the pills.<sup>69</sup>

As a result of this culturally-mediated exchange, the woman began taking the medication. Fadiman then favorably compared the hospital social worker’s approach in this example to the health care workers’ failures in the main story of her book. She noted the key components of the successful communication:

[Francesca] made a house call. She took along a capable and assertive interpreter whom she treated as a cultural broker (by definition her equal, and in this case her superior), not a translator (her inferior). She worked within the family’s belief system. She did not carry *her* belief system—which included a feminist distaste for being forced to deal with the husband instead of the wife—into the negotiations. She never threatened, criticized, or patronized. She said hardly anything about Western medicine.<sup>70</sup>

Fadiman’s commentary not only emphasizes the way in which language and contextual understanding are intertwined, but it also highlights the narrow and imperial character of health care culture in the main story.<sup>71</sup> In the course

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69. *Id.* at 264.

70. *Id.* at 264-65.

71. An early and highly influential article on cultural competency made this point about this characteristic of the health care industry’s culture. Arthur Kleinman, Leon Eisenberg and Byron Good’s article in a 1978 issue of the *Annals of Internal Medicine* identified discord between medical practice and patient expectations. Arthur Kleinman et al., *Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research*, 88 ANNALS OF INTERNAL MED. 251 (1978). Everyone can agree that physicians aim to cure disease, while patients seek relief from the experience of illness. The authors used case studies to show that “illness is

of Fadiman's recounting, it becomes clear that this particular success story was the exception to the rule of monocultural health care.

Contextual understanding may also be race-based. An oft-cited study of the role of race and gender in participatory decision-making showed that even when adjusted for patient age, gender, education, marital status, health status, and length of the patient-physician relationship, "African Americans had significantly less participatory visits than whites."<sup>72</sup> In addition, "[p]articipatory decision-making style was highest in relationships that were race and gender concordant . . . compared with relationships that were race and gender discordant."<sup>73</sup> The authors cited the racial bias of physicians as a possible barrier to partnership and effective communication.<sup>74</sup> The authors' commentary included the observation that "[p]hysicians and patients belonging to the same race or ethnic group are more likely to share cultural beliefs, values, and experiences in the society, allowing them to communicate more effectively and to feel more comfortable with one another."<sup>75</sup>

The authors' commentary on the results also indicated that both positive and negative aspects of racial identity play a role in provider-patient relationships.<sup>76</sup> Racialized identity continues to be a basis for community building. In the community-building process, shared values, beliefs, and practices form and become the means of sustaining positive identity and group-based relationships. To the extent that the health care staff is a diverse group, health care culture may allow room for the positive aspects of racial identity. On the other hand, racial identity also arises from racial exclusion. Shared experiences may include those of exclusion. To the extent that health care culture solely expresses dominant cultural values, it not only allows, it actually reinforces the negative aspects of racial identity. The lower levels of patient participation in racially discordant doctor-patient relationships suggest that the negative aspects of racialization run strong in health care culture.

Health care's monoculture undermines many aspects of effective care for minority patients. Because of language differences, lack of contextual

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culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanations of sickness, explanations specific to the social positions we occupy and systems of meaning we employ." *Id.* at 252 (footnote omitted). The authors labeled the explanatory model of health care professionals as "a narrow medicocentric orientation." *Id.* at 253. They proposed that "[t]raining modern health professionals to treat both disease and illness routinely and to uncover discrepant views of clinical reality will result in measurable improvement in management and compliance, patient satisfaction, and treatment outcomes." *Id.* at 256.

72. Lisa Cooper-Patrick et al., *Race, Gender, and Partnership in the Patient-Physician Relationship*, 282 JAMA 583, 586 (1999).

73. *Id.* at 587 (data omitted).

74. *Id.* at 588.

75. *Id.*

76. *Id.*



understanding, and/or lack of participatory care, patients may be unable to follow treatment protocols or understand the need for follow-up care.<sup>77</sup> Compliance with treatment protocols and instructions for follow-up care, in turn, affects health outcomes.<sup>78</sup> A study examining language concordance and follow-up care showed that monolingual Spanish-speaking adult Latinos seen by monolingual English-speaking doctors were more likely than Spanish-speaking Latinos with bilingual doctors to miss follow-up appointments, not adhere to medication protocols, and to make emergency room visits.<sup>79</sup>

The study also found that English-speaking Latinos were more dissatisfied with provider communication than English-speaking white patients. As other scholars noted, the difference may reflect contextual, as well as linguistic, barriers to patient-physician communication.<sup>80</sup> Patients who have language or other cultural differences with their providers may not understand medical instructions given in the provider's primary language and cultural framework. They may delay seeking care, clarify confusion about care, or get follow-up care because of the difficulties with provider-patient communication.<sup>81</sup> For example, at an urban primary care clinic, eleven percent of Latina mothers surveyed said that they had deferred a medical appointment for their child because the doctors and nurses did not understand Latino culture.<sup>82</sup>

Perhaps not surprisingly, racial and cultural concordance strongly correlates with patient satisfaction. In the study previously mentioned concerning the role of race and gender in participatory decision-making, "[p]atient satisfaction with both technical and interpersonal aspects of care" correlated closely with high participation in decision-making, which in turn correlated with race and gender concordance.<sup>83</sup> Other studies also show a strong correlation between racial and cultural concordance between the patient and the physician and overall patient satisfaction with the quality of health

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77. Woloshin et al., *supra* note 48, at 725; Flores, *supra* note 61, at 15; Nieli Langer, *Culturally Competent Professionals in Therapeutic Alliances Enhance Patient Compliance*, 10 J. HEALTH CARE FOR POOR AND UNDERSERVED 19, 24 (1999) (concluding that patient participation is necessary for compliance, and that cultural competence in building a therapeutic alliance is the key to patient participation).

78. Joseph R. Betancourt et al., *Hypertension in Multicultural and Minority Populations: Linking Communication to Compliance*, 1 CURRENT HYPERTENSION REP. 482, 483 (1999).

79. Flores, *supra* note 61, at 17 (citing Aaron Manson, *Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma*, 26 MED. CARE 1119 (1988)).

80. Betancourt et al., *Hypertension in Multicultural and Minority Populations*, *supra* note 78, at 484.

81. See Woloshin et al., *supra* note 48, at 725; Flores, *supra* note 61, at 16.

82. Flores, *supra* note 61, at 20 (citing Glenn Flores et al., *Access Barriers to Health Care for Latino Children*, 152 ARCH. PED. ADOLESC. MED. 1119, 1122 (1998)).

83. Cooper-Patrick et al., *supra* note 72, at 587.

care.<sup>84</sup> This evidence is significant for several reasons. First, patient satisfaction is important in itself. Second, patient satisfaction is a good indicator of the quality of health care.<sup>85</sup> Third, the concordance evidence affirms the importance of racial diversity in the medical and health care professions.<sup>86</sup> Finally, as one study concluded, the results indicate that “[i]mproving cultural competence among physicians may enhance the quality of health care for minority populations.”<sup>87</sup>

c. Racist

The institution of health care, and providers in particular, claim the values of science-based objectivity and universalism. They also claim that medicine is acultural, but research has shown that health care contains many portals for cultural bias to enter the system. In some cases, official tools of health care directly introduce the risk of bias into the processes of health care. Those tools include essentialism, racial profiling, universalizing standards, and pathologizing bias. In others, bias simply operates in the judgment of clinicians, but it remains largely undetected because the claims of objectivity and universalism mask it.

1. Essentialism

“Essentialism is a core precept of medicine: focusing on deviations from whatever has been defined as ‘normal.’”<sup>88</sup> For the most part, “‘normal’ was based on studies of men of European descent and generally only a narrow subset of that group.”<sup>89</sup> Women and all persons of color are, by implication, not normal. Biological essentialism as a basic tool of medicine has helped perpetuate patriarchy and racial subordination.<sup>90</sup>

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84. See Somnath Saha et al., *Patient–Physician Racial Concordance and the Perceived Quality and Use of Health Care*, 159 ARCH. INTERNAL MED. 997, 998 (1999); see also Leo S. Morales et al., *Are Latinos Less Satisfied with Communication by Health Care Providers?*, 14 J. GEN. INTERNAL MED. 409 (1999).

85. See Morales, *supra* note 84, at 414.

86. See Saha et al., *supra* note 84, at 1003.

87. *Id.* at 997; see also Cooper-Patrick et al., *supra* note 72, at 589.

88. Kathleen Fuller, *Eradicating Essentialism from Cultural Competency Education*, 77 ACAD. MED. 198, 199 (2002).

89. *Id.*

90. See Nancy Krieger & Elizabeth Fee, *Man-Made Medicine and Women’s Health: The Biopolitics of Sex/Gender and Race/Ethnicity*, in MAN-MADE MEDICINE: WOMEN’S HEALTH, PUBLIC POLICY, AND REFORM 15-21 (Kary L. Moss ed. 1996) (recounting the ways that science and medicine have reinforced the white male as normative); SUE V. ROSSER, *WOMEN’S HEALTH—MISSING FROM U.S. MEDICINE* (1994) (examining the effects of the androcentric focus in clinical practice and research and providing a critique of the tendency to treat women as a monolithic group in practice and research).

Applying the tool of essentialism to culture extends the reach of those forces. For example, the twin claims of physician universalism and medical aculturalism “foster static and essentialist understandings of the ‘cultures’ of patients.”<sup>91</sup> Within this framework, only some patients—the different ones—have culture. This viewpoint also supports a deficit model of culture and difference—the notion that patient culture and race are the problems. It is the exotic patient that disrupts the medical machine. From inside the essentialist understanding of culture, outsider patients are defined by what they lack or how they have failed. For example, the patient’s lack of English language proficiency, the patient’s irrational beliefs, or even the patient’s complicated life or unfounded mistrust of doctors are all deemed barriers to access. And as the discussion above shows, providers respond to the real or assumed problems by imposing the medical gaze ever more strictly.

## 2. Racial profiling

Racial profiling in medicine is an accepted tool. Case studies used to train medical students feature, for example, African-American patients with hypertension and diabetes or working-class Irish-Americans with alcoholism.<sup>92</sup> Population-based incidence rates that show correlations between certain diseases and racial populations make these profiles seem medically sound rather than biased. In a system that uses speed and efficiency as measures of success, medical students and doctors see profiling as a valuable tool.<sup>93</sup> Indeed, even some experts aware of the risks support using race and ethnicity as proxies, but only if the use of the correlation between race or ethnicity on the one hand and disease or condition on the other is contextualized and examined with respect to the individual patient.<sup>94</sup>

The risks that racial profiling in medicine creates are very real. They include reinforcing and perpetuating stereotypes, failing to address “the underlying individual factors,”<sup>95</sup> and misdiagnosing patients of color at excess rates. Scholars have suggested that despite the expectation of physician universalism, “the very nature and context of physicians’ work may enhance the likelihood of stereotype usage.”<sup>96</sup> Evidence shows that the need to make quick judgments in time-pressured encounters, in which cognitive load and

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91. Taylor, *supra* note 20, at 559.

92. DelVecchio Good et al., *supra* note 17, in *UNEQUAL TREATMENT*, *supra* note 2, at 603.

93. Sally Satel, *I Am a Racially Profiling Doctor*, N.Y. TIMES, May 5, 2002, § 6 (Magazine) at 56.

94. Marshall H. Chin & Catherine A. Humikowski, *When Is Risk Stratification by Race or Ethnicity Justified in Medical Care?*, 77 ACAD. MED. 202, 204 (2002).

95. *Id.*

96. Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-economic Status on Physicians’ Perceptions of Patients*, 50 SOC. SCI. & MED. 813, 814 (2000).

task complexity are high, increase a person's use of stereotypes.<sup>97</sup> Others point to the role that clinical uncertainty plays in creating space for stereotyping.<sup>98</sup> Physicians may have more difficulty assessing symptoms and other information from patients of color than they do from white patients.<sup>99</sup> In the absence of certainty, doctors are more likely to use racial profiling.<sup>100</sup> All of these factors characterize the work of providers, making them more vulnerable to stereotyping patients.<sup>101</sup>

Racial profiling can also interfere with the diagnostic process. Consider this account:

A student presented the case of a 68-year-old Latina with longstanding diabetes who was blind from complications of her disease. The complaint of this pleasant woman was that she had nausea. When asked to present the differential of her nausea, the student first presented a psychiatric syndrome that he understood to be an ailment of Latinos.<sup>102</sup>

The patient's actual condition was, in fact, diabetes-induced gastroparesis.<sup>103</sup> The student may have learned racial profiling before medical school, but medical education added the lesson that racial profiling is acceptable.

### 3. Universalizing Standards

Universalized standards result, in part, from essentialism. Universalized standards are based on a normative patient. They are used for diagnosis and for developing treatment plans. Typically, the normative patient is white.<sup>104</sup> When the real patient is non-white, or otherwise culturally different than the normative patient, misdiagnosis and ineffective care can result.

The studies showing that doctors continually misdiagnose and involuntarily commit African-Americans at excess rates illustrate this point. Data in a 2001 report by the Surgeon General documents significant racial

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97. *Id.*

98. See Ana I. Balsa et al., *Clinical Uncertainty and Healthcare Disparities*, 29 AMER. J. L. & MED. 203 (2003); Bloche, *supra* note 13; UNEQUAL TREATMENT, *supra* note 2.

99. See Balsa et al., *supra* note 98, at 204. Balsa observed, "If physicians, as a group, communicate less well with their minority patients than with Whites, greater uncertainty about minority patients' needs and interests results." *Id.*; see also UNEQUAL TREATMENT, *supra* note 2, at 9.

100. Balsa et al., *supra* note 98, at 204. The author noted that "[t]hese sources of uncertainty create wide space for clinical discretion. Subjective influences, including unfavorable stereotypes and attitudes about social groups, shape the exercise of this discretion." *Id.* (citing Bloche, *supra* note 13, at 103-4); see also UNEQUAL TREATMENT, *supra* note 2, at 9.

101. van Ryn & Burke, *supra* note 96, at 814.

102. Ana E. Núñez, *Transforming Cultural Competence into Cross-cultural Efficacy in Women's Health Education*, 75 ACAD. MED. 1071, 1080 (2000).

103. *Id.*

104. See *supra* note 89 and accompanying text.

disparities in the mental health system.<sup>105</sup> The report strongly suggests that “the culture of the clinician and the larger healthcare system” is ethnocentric.<sup>106</sup> The statistics show a high rate of misdiagnoses in immigrant and minority populations.<sup>107</sup> Among the most startling statistics are the over-diagnosis of schizophrenia among African-Americans and the excessive rates of involuntary commitment of African-Americans.<sup>108</sup>

There are at least two possible explanations for these statistics. One is that patients from different populations may experience and report symptoms differently because of cultural variations.<sup>109</sup> Using diagnostic standards derived from studies with white, middle-class patients on patients with different cultural and social norms may lead to misdiagnosis.<sup>110</sup> Those standards appear neutral because the typical patient—white, native-born, middle class—is the societal norm and thus, apparently without race or culture. Like the rest of the medicinal and healthcare industry, however, the standards are embedded in a particular culture and are racially normative. Universalizing the standards may result not only in a higher misdiagnoses rate for immigrants and racial minorities; it also extends the racist-nativism inherent in the prevailing medical culture.

#### 4. Pathologizing Bias

The second possible explanation is that the misdiagnoses and excess involuntary commitments are consistent with other patterns of pathologizing bias. Throughout the history of the United States, persons of color, women, immigrants, low-income youth, the elderly, and the mentally disabled have all been unjustifiably deemed particularly susceptible to and dangerous because of specific diseases.<sup>111</sup> Racial profiling that correlates a racial population with a

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105. CENTER FOR MENTAL HEALTH SERVS., U.S. DEP’T OF HEALTH AND HUMAN SERVS., *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY—A SUPPLEMENT TO MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL* (2001), available at <http://www.surgeongeneral.gov/library/mentalhealth/cre/> [hereinafter *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY*].

106. EXECUTIVE SUMMARY: MAIN MESSAGE, in *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY*, *supra* note 105, at <http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-3.html>; see also DelVecchio Good et al., *supra* note 17, in *UNEQUAL TREATMENT*, *supra* note 2, at 612.

107. *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY*, *supra* note 105, at 67; H. Jack Geiger, *Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes*, in *UNEQUAL TREATMENT*, *supra* note 2, at 417.

108. *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY*, *supra* note 105, at 67.

109. DelVecchio Good et al., *supra* note 17, in *UNEQUAL TREATMENT*, *supra* note 2, at 614.

110. *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY*, *supra* note 107, at 35 (noting that clinical trials used to generate professional treatment guidelines used predominantly white populations and provided no ethnic or race-specific outcome data).

111. See, e.g., WENDY KLINE, *BUILDING A BETTER RACE: GENDER, SEXUALITY, AND EUGENICS FROM THE TURN OF THE CENTURY TO THE BABY BOOM* 113-123 (2001) (assessing the

particular disease without examining the correlation may account for some of this pattern. It may also be that broader stereotyping is at work.

A 1988 study asked psychiatrists to make diagnoses based on two case vignettes.<sup>112</sup> Some of the vignettes described the patient's gender as either male or female and race as either black or white. Some vignettes provided no race or gender identification at all.<sup>113</sup> The researchers distributed the vignettes on a randomized basis.<sup>114</sup> Some of the findings support the point that broader stereotyping plays a significant role in healthcare. The psychiatrists provided correct diagnoses most often when the case vignette contained no gender or race identification.<sup>115</sup> They made more severe diagnoses of Black patients, and of Black male patients in particular.<sup>116</sup> Those diagnoses were of conditions characterized by violence, suspiciousness, and dangerousness. The research results strongly suggest that "[c]linicians appear to ascribe violence, suspiciousness, and dangerousness to black [patients] even though the case studies are the same as the case studies for the white clients" in every respect but race.<sup>117</sup>

##### 5. Plain bias

Bias affects perceptions, beliefs, and attitudes toward patients. Bias may affect any aspect of a patient's health care experience from room assignment to

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legal and media discourse in a 1936 case in which the court upheld the eugenic sterilization of a young, wealthy white woman because her "sexual transgressions" indicated she would never make a "desirable" mother); NAYAN SHAH, *CONTAGIOUS DIVIDES: EPIDEMICS AND RACE IN SAN FRANCISCO'S CHINATOWN* 179-203 (2001) (describing involuntary commitment of immigrant girls in the late Nineteenth and early Twentieth centuries and how officials used theories of racial susceptibility and immunity to justify medical screenings of Chinese immigrants for parasitic diseases). See also DeVecchio Good et al., *supra* note 17, in *UNEQUAL TREATMENT*, *supra* note 2, at 614-616; MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY, *supra* note 107, at 67 (noting clinician bias as one explanation for disparate findings and diagnoses).

112. Marti Loring & Brian Powell, *Gender, Race, and DSM-III: A Study of the Objectivity of Psychiatric Diagnostic Behavior*, 29 J. HEALTH & SOC. BEHAV. 1, 8 (1988).

113. *Id.* at 6-7. The authors note that:

While keeping all other information about the client constant, we alter the client's sex and race so that an approximately equal proportion (one-fifth) of the psychiatrists evaluates a white male, a black male, a white female, or a black female. Furthermore, to examine whether the absence of information influences clinical judgments directly, we include an additional category in which one-fifth of the psychiatrists assess a client whose sex and race are not disclosed.

*Id.*

114. *Id.* at 7.

115. *Id.* at 11.

116. *Id.* at 14.

117. Loring & Powell, *supra* note 112, at 18.

recommended treatment.<sup>118</sup> Studies show that race, gender, ethnicity and socioeconomic status affect providers' perceptions of patients.<sup>119</sup> Generally, physicians perceive racial minorities, women, immigrants, and low and middle socioeconomic (SES) groups more negatively. One study sampled 842 patient encounters with 193 physicians.<sup>120</sup> The study showed that race influenced "physicians' assessment of patient intelligence, feelings of affiliation toward the patient, and beliefs about patient's likelihood of risk behavior and adherence with medical advice . . ." <sup>121</sup> It also demonstrated that physicians link patient SES with "patients' personality, abilities, behavioral tendencies and role demands."<sup>122</sup>

Provider bias can directly translate into less effective health care for patients of color.<sup>123</sup> The now-famous Schulman study—*The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*<sup>124</sup>—supplies some detail on how provider bias intervenes in treatment decisions. The study used a computerized survey instrument, which included text and video interviews of actors portraying patients. Seven hundred and twenty primary care physicians took the survey.<sup>125</sup> The "patients" all presented with chest pain and other symptoms. The survey instrument provided other clinical detail, including some test results. Each physician viewed one of eight "patient" video interviews with either a fifty-five year-old Black woman, a fifty-five year-old Black man, a seventy year-old Black woman, a seventy year-old Black man, a fifty-five year-old white woman, a fifty-five year-old white man, a seventy year-old white woman, or a seventy year-old white man.<sup>126</sup> Various analyses of the resulting data consistently revealed that the "race and sex of the patient were significantly associated with the physicians' decisions about whether to make referrals for cardiac catheterization, with men and whites more likely to be referred than women and blacks, respectively."<sup>127</sup> Physicians referred Black women at the lowest rates overall.<sup>128</sup>

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118. Gerald T. Perkoff & Mary Anderson, *Relationship Between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room*, 8 MED. CARE 309, 319 (1970) (finding that despite similar insurance coverage, clerks more often assigned Black patients to wards and white patients to private rooms).

119. See, e.g., van Ryn & Burke, *supra* note 96; Cooper & Roter, *supra* note 40.

120. van Ryn & Burke, *supra* note 96.

121. *Id.* at 813, 821-24.

122. *Id.* at 813, 820-22.

123. UNEQUAL TREATMENT, *supra* note 2, at 9-11.

124. Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618 (1999).

125. *Id.* at 618.

126. *Id.* at 619.

127. *Id.* at 622-23.

128. *Id.* at 623.

Health care's most touted values—objectivity and universalism—do not shield it from the racism, nativism, and ethnocentrism inherent in dominant culture. The claims to objectivity and universalism are claims to colorblindness. Colorblindness, at its most powerful, gives those privileged by racism permission not to see their privilege. It denies to those marked by racism the means of proving that racism exists. Colorblindness shields racism from view. In the guise of objectivity and universalism, racism operates as a set of medically valuable tools—essentialism, racial profiling, universalized standards, and pathology. Sometimes plain bias comes out into the open and appears as the failure to recommend a Black woman for further treatment. At least at first glance, the claims of objectivity and universalism prevent us from seeing this bias.

The larger examination of the health care system's culture shows that its values are the opposites of objectivity and universalism, and many of health care's practices are, in effect, racial sorting devices. These practices limit access to health care, compromise patient rights, and interfere with the quality of care that minority patients receive. The examination shows that racial disparities arise in significant part from health care's culture.

### C. Cultural Competence and Racial Disparities

There are many definitions of cultural competence in health care.<sup>129</sup> For example, some focus on clinician knowledge and skills.<sup>130</sup> Others describe cultural competence as a multi-level issue that requires institutionalizing culturally appropriate care.<sup>131</sup> A recent definition attempts to operationalize the concept of cultural competence in health care.<sup>132</sup>

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129. Brach & Fraser, *supra* note 1, at 182 (noting that “[e]very organization and author define cultural competency somewhat differently”). See BUREAU OF HEALTH PROFESSIONS, U.S. DEP’T OF HEALTH AND HUMAN SERVS., OTHER DEFINITIONS OF CULTURAL COMPETENCE, at <http://bhpr.hrsa.gov/diversity/cultcomp.htm> (providing various definitions of cultural competency) [hereinafter OTHER DEFINITIONS OF CULTURAL COMPETENCE]; THE HENRY J. KAISER FAMILY FOUNDATION, COMPENDIUM OF CULTURAL COMPETENCE INITIATIVES IN HEALTH CARE 6 (2003) [hereinafter COMPENDIUM OF CULTURAL COMPETENCE INITIATIVES IN HEALTH CARE].

130. OTHER DEFINITIONS OF CULTURAL COMPETENCE, *supra* note 129. “Cultural Competence is defined simply as the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group.” *Id.*

131. See JOSEPH R. BETANCOURT, ALEXANDER R. GREEN & J. EMILIO CARRILLO, THE COMMONWEALTH FUND, CULTURAL COMPETENCE IN HEALTH CARE: EMERGING FRAMEWORKS AND PRACTICAL APPROACHES FIELD REPORT (2002). “Cultural Competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.” *Id.* at v.

132. Betancourt et al., *Defining Cultural Competence*, *supra* note 5, at 297. The authors noted:



Despite the variety, most definitions explicitly or implicitly contain at least three common premises. First, most definitions of cultural competence in health care acknowledge that health care has a culture of its own and that cultural competency requires adjusting that culture to provide care for a diverse population of patients.<sup>133</sup> Second, most definitions recognize that “[c]ultural competency goes beyond cultural awareness or sensitivity. It includes not only possession of cultural knowledge and respect for different cultural perspectives but also having skills and being able to use them effectively in cross-cultural situations.”<sup>134</sup> Third, most definitions assume that health care itself is a social construct that consists of different values and beliefs about central concepts such as the body, wellness, illness, and decision-making.<sup>135</sup> Generally, the prime social and political fact behind efforts to implement cultural competence in health care is that the patient population is diverse in the United States, but health care, at the organizational, structural, and clinical levels, is not.

Cultural competence activities are at least as varied as the definitions. For example, a recent compendium catalogued at least eight categories of existing cultural competence activities, including interpreter services, cross-cultural training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family and/or community members in care-giving, immersion into another culture, and

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“Cultural competence” in health care entails: understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations.

*Id.*

133. See OTHER DEFINITIONS OF CULTURAL COMPETENCE, *supra* note 129. Note the following description:

*Cultural competence* is defined as a set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Striving to achieve cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment of time.

TONI BRATHWAITE-FISHER & SUZANNE BRONHEIM, NAT’L CTR. FOR CULTURAL COMPETENCE, U.S. DEP’T OF HEALTH AND HUMAN SERVS., CULTURAL COMPETENCE AND SUDDEN INFANT DEATH SYNDROME AND OTHER INFANT DEATH: A REVIEW OF THE LITERATURE FROM 1990 TO 2000, 4 (2001).

134. Brach & Fraser, *supra* note 1, at 183.

135. See NAT’L STANDARDS FOR CLAS, *supra* note 23, at 4; see also Cooper & Roter, *supra* note 40, at 563-64.

administrative or organizational accommodations.<sup>136</sup> Other activities include efforts to diversify the health care profession<sup>137</sup> and research to determine the efficacy of different cultural competence activities.<sup>138</sup>

An informal survey of the literature documenting current activities indicates that both scholarly and organizational efforts focus largely on the first two categories—interpreter services and cross-cultural training. The proliferation of activities to use and provide interpreter services probably arises from the federal requirement that health care organizations provide language assistance, including interpreter services and written materials, for patients with limited English proficiency.<sup>139</sup> The primacy of cross-cultural training may result from the fact that it can benefit all levels of the health care system.<sup>140</sup> Thus, there is greater demand for cross-cultural training than activities that are only appropriate at the provider or program level. In fact, organization-wide cultural competence may require training as a starting point to setting up other program changes.<sup>141</sup> In addition, cross-cultural training is politically appealing. First, it operates on the premise that cultural barriers result from lack of knowledge rather than the presence of malice. It implicates no one as a racist, nativist, or xenophobe under the standard liberal intent-based definition of bias. Second, using cross-cultural training and/or linguistic access as the sole or primary means to achieve cultural competence assumes that basic communication is the problem. It leaves the structure of the health care system intact.

Different agencies, organizations, and scholars have offered a number of reasons for implementing cultural competence in health care. The National Center for Cultural Competence at Georgetown University has identified the following six reasons to strive to achieve cultural competence: to respond to demographic changes in the United States; to eliminate disparities in health status based on race, ethnicity, and culture;<sup>142</sup> to provide the overall quality of

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136. COMPENDIUM OF CULTURAL COMPETENCE INITIATIVES IN HEALTH CARE, *supra* note 129, at 5.

137. *Id.*; Brach & Fraser, *supra* note 1, at 185.

138. Joseph R. Betancourt, *Cross-cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation*, 78 ACAD. MED. 560 (2003).

139. See OFF. OF MINORITY HEALTH, U.S. DEP'T OF HEALTH AND HUMAN SERVS., ASSURING CULTURAL COMPETENCE IN HEALTH CARE: RECOMMENDATIONS FOR NATIONAL STANDARDS AND AN OUTCOMES-FOCUSED RESEARCH AGENDA 10 (2003), at <http://www.omhrc.gov/clas/cultural1a.htm>; see also *infra* notes 151-206 and accompanying text (Part III discussion of Title VI and limited English proficiency (LEP) guidelines).

140. For a discussion of various approaches to cross-cultural education, see UNEQUAL TREATMENT, *supra* note 2, at 203-209.

141. More cynically, the relative ease (at least to other cultural competence activities) of marketing interpreter services and cross-cultural training may also partially explain the focus on those activities.

142. See also NAT'L STANDARDS FOR CLAS, *supra* note 23, at 3.

services and health outcomes; to comply with legislative, regulatory, and accreditation requirements; to gain a competitive edge with racial and ethnic minorities in the marketplace, and to reduce the risk of potential malpractice liability.<sup>143</sup> Certainly, the reasons vary widely and reflect the various positions of stakeholders in health care.

There are at least three possible frameworks for describing the goal of reducing race- and ethnicity-based gaps in health outcomes. Many frame cultural competence as a matter of providing special accommodations for patients who are culturally and/or racially different from the norm. Within this framework, the white, English-only norm remains largely intact. This framework carries two serious risks. One is that barriers to access and effective care will be attributed to patient difference, not institutional practices. A deficit model of cultural competence may, in turn, perpetuate racial and ethnic disparities. For example, cultural competency education that describes a set body of “facts” about the exotic other can reinscribe existing stereotypes,<sup>144</sup> thus increasing the risk of race-based misdiagnoses.

A second approach to cultural competence recognizes the racism embedded in health care culture, but it assumes that changing certain cultural practices and skills will be sufficient. Within this framework, health care culture, not patient difference, is the problem. But because this approach does not include direct anti-racism efforts, it leaves those racial disparities that result from provider bias untouched.

This Article proposes a third framework. In this alternative framework, as in the second framework, cultural competence is a matter of countering racially and ethnically exclusive health care. This framework explicitly identifies racism as the problem, and includes tools that can be used both proactively and reactively against the creation and implementation of racially exclusive rules and practices in the bureaucratic and medical aspects of health care, as well as against provider bias. This third framing, therefore, is more likely than the first two to result in normative changes to health care. The risk this approach carries is political. This approach is more likely to raise political resistance precisely because it requires acknowledging the deep roots of the problem and, in some instances, direct action against racism.

As suggested, cultural competence that defines organizational values, beliefs and practices as the problem can effect change on two levels. The first level is normative. For example, several cultural competence activities, when implemented from an anti-racist perspective make the relevance of social context obvious. The relevance of social context arises from “an awareness of

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143. Nat'l Ctr. for Cultural Competence, Georgetown Univ. Ctr. for Child and Human Development, *Frequently Asked Questions*, at <http://www.georgetown.edu/research/gucdc/nccc/faqs.html> (last visited Oct. 3, 2003) [hereinafter Nat'l Ctr. for Cultural Competence].

144. See Fuller, *supra* note 88, at 201; see also Núñez, *supra* note 102, at 1072.

the integration and interaction of health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes for different patient populations.”<sup>145</sup> That, in turn, can change the definition of “medically relevant” and thus broaden the medical gaze. Medical care might come to include examining the root causes of illness. A second example focuses on cross-cultural training. Cultural competency education can create self-awareness about both individual and organizational values, beliefs, and practices and their interaction with those of patients. Thus, cultural competence holds the potential to undermine the claims to universalism and objectivity within the health care system. Within the third framework, the more appropriate term for such education is cross-cultural training or cross-cultural efficacy.<sup>146</sup> The result of cross-cultural efficacy or training is, hopefully, a norm that expresses no preference for the organization’s, the provider’s, or the patient’s culture.<sup>147</sup>

Cultural competence efforts can also achieve change in the basic quality of services. For example, one study describes how interpreter services could improve health status by providing eight specific benefits.<sup>148</sup> For example, language assistance would improve patient education. That, in turn, would reduce patient risk-producing behavior and exposure to risk of certain diseases.<sup>149</sup> Other benefits would result in increased access, utilization, and quality of care. For example, interpreter services would enable providers to obtain more information on medical history and symptoms. Such information would improve accuracy of diagnosis, and hence, the quality of care.<sup>150</sup> The overall effect of a cultural competency effort that includes a variety of activities could be lower disease incidence rates for all, particularly for patients of color, and improved access, use, and quality of care.

Implementing a full array of cultural competency activities can reduce race- and ethnicity-based gaps in health outcomes, but their effect on the problem of racism in health care is indirect. Racism, nativism, and ethnocentrism in health care and in our society are deeply rooted in and constitutive of dominant culture. Implementing cultural competency activities within a framework that does not seek broader normative change will not close the portals for bias. Efforts aimed at normative change, in combination with efforts aimed at changes in practices and skills, hold more potential to close those portals.

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145. See Betancourt et al., *Defining Cultural Competence*, *supra* note 5, at 294.

146. Núñez, *supra* note 102, at 1072 (noting a focus that shifts curriculum “from a philosophy of ethnocentrism to one of ethno-relativism”).

147. *Id.*

148. Brach & Fraser, *supra* note 1, at 189-94 (focusing on the benefits of interpreter services but including analysis of the potential benefits of nine cultural competency activities).

149. *Id.* at 190.

150. *Id.* at 191.

### III. LAWS ADDRESSING CULTURAL COMPETENCY IN HEALTH CARE

There are relatively few laws that directly implement cultural competency in health care. Title VI of the Civil Rights Act is the key federal law in this area. Title VI provides significant protection for patients who have limited English proficiency, but it also contains serious limitations. The federal government has published model standards that provide a starting point for implementing broader cultural competency efforts, but they are not currently adopted as law. Recently, several state legislatures have expressed a willingness to consider statutory requirements that implement various aspects of cultural competency. The laws and standards have not passed without comment. Primary objections include free-market arguments and concerns about the intangibility of culture.

#### A. *Title VI of the Civil Rights Act of 1964*<sup>151</sup>

Title VI of the Civil Rights Act of 1964 prevents federal money from being used to support activities and programs that discriminate on the basis of race, color, or national origin.<sup>152</sup> Section 601 of Title VI states that no person shall “on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”<sup>153</sup> Section 602 says that federal agencies with the power to provide Federal financial assistance have the authority and obligation to issue “rules, regulations, or orders of general applicability” to carry out the provisions of section 601.<sup>154</sup>

Under section 602, the Department of Health and Human Services (HHS) has issued regulations that say recipients cannot:

[U]tilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.<sup>155</sup>

In 1970, the Department of Health, Education, and Welfare, the predecessor of HHS, issued a memorandum that asserted, “[w]here inability to speak and

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151. Pub. L. No. 88-352, Title VI, 78 Stat. 241, 252 (1964) (codified as amended at 42 U.S.C. §§ 2000d–2000d-7 (2000)).

152. See 110 CONG. REC. 6543 (1964). Sen. Humphrey, quoting from President Kennedy’s message to Congress delivered on June 19, 1963, stated, “Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes, or results in racial discrimination.” *Id.*

153. Pub. L. No. 88-352, Title VI, § 601, 78 Stat. 241, 252 (1964) (codified as amended at 42 U.S.C. § 2000d (2000)).

154. Pub. L. No. 88-352, Title VI, § 602, 78 Stat. 241, 252 (1964) (codified as amended at 42 U.S.C. § 2000d-1 (2000)).

155. 45 C.F.R. § 80.3(b)(2) (2000).

understand the English language excludes national origin-minority group children from effective participation in the educational program offered by a school district, the district must take affirmative steps to rectify the language deficiency in order to open its instructional program to these students.”<sup>156</sup> Although those regulations remained largely unenforced,<sup>157</sup> they did make the first connection between the denial of language assistance and discrimination on the basis of national origin.

In 1974, the Supreme Court affirmed the 1970 regulations in *Lau v. Nichols*.<sup>158</sup> *Lau* originated when the San Francisco, California school district desegregated under court order in 1971.<sup>159</sup> The desegregation process left 1,800 Chinese-American students who did not speak English or who had limited English proficiency (LEP) skills in schools without supplemental English language courses.<sup>160</sup> The Court recognized that “there is no equality of treatment merely by providing students with the same facilities, textbooks, teachers, and curriculum; for students who do not understand English are effectively foreclosed from any meaningful education.”<sup>161</sup> The Court held that the school district’s failure to take affirmative steps to provide language assistance constituted national origin discrimination.<sup>162</sup>

With *Lau* as a foundation case, HHS has enforced Title VI against health care and related social services that have failed to provide language assistance to LEP patients. The rationale for doing so is virtually the same as the Supreme Court’s analysis in *Lau*. There is no equality of treatment merely by providing all patients with health care and accompanying social services in English; patients who do not understand English are substantially foreclosed from effective health care. In effect, separate but equal monolingual health care is national origin discrimination and results in no equality at all.

The most recent events regarding HHS’s role in requiring language assistance in health care started in 2000. On August 11, 2000, President Clinton issued Executive Order 13,166, entitled *Improving Access to Services for Persons with Limited English Proficiency*.<sup>163</sup> Executive Order 13,166 required every federal agency that provides federal assistance, including HHS, to publish a Title VI guidance to explain to recipients of federal funds how to provide access to LEP persons and achieve compliance with Title VI

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156. Identification of Discrimination and Denial of Services on the Basis of National Origin, 35 Fed. Reg. 11,595 (July 18, 1970).

157. Rachel F. Moran, *The Politics of Discretion: Federal Intervention in Bilingual Education*, 76 CAL. L. REV. 1249, 1267-68 (1988).

158. *Lau v. Nichols*, 414 U.S. 563 (1974).

159. *Id.* at 564.

160. *Id.*

161. *Id.* at 566.

162. *Id.* at 568-69.

163. Exec. Order No. 13,166, 65 Fed. Reg. 50,121 (Aug. 16, 2000).

regulations, which say that recipients shall not “[u]tilize criteria or methods of administration which have the effect of subjecting individuals to discrimination’ or have ‘the effect of defeating or substantially impairing accomplishment of the objectives of the program as respects individuals of a particular race, color, or national origin.’”<sup>164</sup>

On the same day, August 11, 2000, the Department of Justice also issued its policy guidance for federal agencies.<sup>165</sup> The policy guidance described four factors to use in developing guidance documents under Executive Order 13,166.<sup>166</sup> The HHS Office of Civil Rights issued its guidance on August 30, 2000 (2000 HHS LEP Policy Guidance),<sup>167</sup> and shortly after that, the Supreme Court decided *Alexander v. Sandoval*.<sup>168</sup>

The *Sandoval* decision raised questions about the enforceability of the LEP policy guidances, including the HHS LEP Policy Guidance. In *Sandoval*, the plaintiff challenged the Alabama Department of Public Safety’s refusal to give the driver’s examination in Spanish, Martha Sandoval’s primary language.<sup>169</sup> Sandoval argued that the English-only rule as applied to the driver’s examination imposed national origin discrimination on LEP persons and thus violated Title VI regulations.<sup>170</sup> A bare majority of the Supreme Court held that private individuals have no right of action to enforce Title VI disparate impact claims.<sup>171</sup>

Justice Scalia’s opinion for the court rejected the longstanding reading of *Lau v. Nichols* and *Cannon v. University of Chicago*<sup>172</sup> that said that there was a private right action to enforce Title VI regulations.<sup>173</sup> Scalia’s analysis stated, “[T]hree aspects of Title VI must be taken as given.”<sup>174</sup> The first is that there is a private right of action to enforce section 601 of Title VI.<sup>175</sup> The

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164. Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons with Limited English Proficiency; Policy Guidance, 65 Fed. Reg. 50,123 (Aug. 16, 2000) [hereinafter 2000 LEP Policy Guidance]. Note that the Executive Order also requires federal agencies to comply with the standards for federal assistance recipients regarding language access for LEP persons. Exec. Order No. 13,166, 65 Fed. Reg. at 50,121.

165. 2000 LEP Policy Guidance, *supra* note 164.

166. *Id.* at 50,124-50,125.

167. 2000 HHS LEP Policy Guidance, *supra* note 4.

168. 532 U.S. 275 (2001).

169. *Id.* at 279. The Department of Public Safety made this decision after the State of Alabama amended its Constitution to declare English “the official language of the state of Alabama.” *Id.* at 278-79 (citations omitted).

170. *Id.* at 279.

171. *Id.* at 293.

172. 441 U.S. 677 (1979).

173. *Sandoval*, 532 U.S. at 282-285.

174. *Id.* at 279.

175. *Id.*

second is that section 601 prohibits intentional discrimination only.<sup>176</sup> The third is that for purposes of the case, regulations that prohibit disparate impact discrimination under section 602 are presumed valid.<sup>177</sup> Scalia used a strict textual analysis that focused solely on section 602 and determined that section 602 displayed no congressional intent to create new rights.<sup>178</sup>

As a result of *Sandoval*, LEP patients cannot sue recipients of federal funds who fail to provide appropriate language assistance.<sup>179</sup> The *Sandoval* decision leaves individuals who have disparate impact claims with only one remedy—filing an administrative complaint with the Office of Civil Rights.<sup>180</sup> The Office of Civil Rights has considerable power to enforce rules by terminating funding to violators or to use any other means authorized by law,<sup>181</sup> but investigations, monitoring and enforcement take substantial funding and staffing, which the Office of Civil Rights persistently lacks.<sup>182</sup>

The *Sandoval* decision also raised the question of whether Title VI regulations were still valid, given the fact that they prohibit disparate impacts on the ground of race, color, or national origin.<sup>183</sup> In particular, though the *Sandoval* decision did not address the validity of Executive Order 13,166, it did raise questions about the LEP policy guidances issued under the order.<sup>184</sup> On October 26, 2001, the Department of Justice issued a memorandum to the federal agencies that addressed these questions.<sup>185</sup> In the memorandum, the Department of Justice disagreed with the argument that the *Sandoval* decision

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176. *Id.* at 280.

177. *Id.* at 281.

178. *Sandoval*, 532 U.S. at 288-89.

179. For an example of the efficacy of the private right of action, see, for example, *Resolution Agreement between the Office of Civil Rights, U.S. Dep't of HHS Region I and Maine Medical Center*, 01-98-3025, at <http://www.hhs.gov/ocr/mmc07172000.html> (July 17, 2000) (comprehensive settlement of a complaint filed on behalf of limited English speaking patients who claimed that Maine Medical Center's failure to provide language services denied claimants equal access to the hospital's facilities and services). The settlement includes Maine Medical Center's agreement to provide qualified oral interpreter services, thresholds for providing written translations and subject matter for translations, distribution of information about translation services, and monitoring of activities). *Id.*

180. Individuals with intentional discrimination claims have two remedies—through the administrative enforcement process or through the courts. *Sandoval*, 532 U.S. at 279-282.

181. Procedure for Effecting Compliance, 45 C.F.R. § 80.8 (2003).

182. See Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647, 1669 (1993).

183. See Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311 (Aug. 8, 2003), available at <http://www.hhs.gov/ocr/lep/revisedlep.html> (last revised Nov. 20, 2003) [hereinafter 2003 LEP Policy Guidance].

184. *Id.* at 47,312.

185. *Id.*



impliedly invalidated disparate impact regulations.<sup>186</sup> The memorandum pointed to the fact that the Court did not expressly address the validity of the regulations, Executive Order 13,166, or the authority of federal grant agencies to enforce existing regulations.<sup>187</sup>

The same memorandum instructed HHS and other federal agencies to republish the LEP policy guidances for public comment. HHS did so on February 1, 2002.<sup>188</sup> The 2000 HHS LEP Policy Guidance received nearly 200 public comments.<sup>189</sup> In July 2002, the Department of Justice sent another memorandum to emphasize the need for uniformity among the guidances.<sup>190</sup> The memorandum identified the Department of Justice LEP guidance as a model and requested that other agencies revise their guidances accordingly.<sup>191</sup> HHS then revised its guidance in response to the public comments and the Department of Justice request. On August 4, 2003, HHS published the revised *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (2003 HHS LEP Policy Guidance).<sup>192</sup>

The substantive provisions of the 2003 HHS LEP Policy Guidance are in five parts: Who is Covered?; Who is a Limited English Proficient Individual?; How Does a Recipient Determine the Extent of Its Obligation to Provide LEP Services?; Selecting Language Assistance Services; and Elements of Effective Plan on Language Assistance for LEP Persons.<sup>193</sup> The part entitled “Who is Covered?” lists examples of recipients, including: hospitals, nursing homes, home health agencies, managed care organizations, universities, state, county and local health agencies, state Medicaid agencies, state, county and local welfare agencies, programs for families, youth, and children, Head Start programs, public and private contractors, subcontractors and vendors, and physicians and other providers who receive federal financial assistance from HHS.<sup>194</sup> The Title VI regulations apply to a recipient’s entire program or activity, even if federal assistance only funds one part of it.<sup>195</sup>

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186. *See id.*

187. *Id.* In May 2003, the Fourth Circuit Court of Appeals dismissed the case *ProEnglish v. Bush*. *ProEnglish v. Bush*, No. 02-2044 (4th Cir. May 15, 2003) (unpublished opinion). *ProEnglish*, an organization that advocates state “English-only” laws, challenged both the 2003 HHS LEP Policy Guidance and the Department of Justice’s 2003 LEP Policy Guidance, which were issued under Executive Order 13,166, as they applied to two physicians. The Fourth Circuit dismissed without prejudice for lack of subject matter jurisdiction. *Id.*

188. 2003 LEP Policy Guidance, *supra* note 183, at 47,312.

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.*

193. *See* 2003 LEP Policy Guidance, *supra* note 183, at 47,313-21.

194. *Id.* at 47,313.

195. *Id.*

The section headed “How Does a Recipient Determine the Extent of Its Obligation to Provide LEP Services?” sets out the 2003 HHS LEP Policy Guidance’s analytical framework. The framework is “designed to be a flexible and fact-dependent standard” that balances four factors:

- (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people’s lives; and (4) the resources available to the grantee/recipient and costs.<sup>196</sup>

The 2003 HHS LEP Policy Guidance makes it clear that recipients can comply with Title VI regulations by using a “mix” of LEP services.<sup>197</sup> Those services include a variety of oral interpretation services such as professional interpreters, bilingual staff, telephone interpreter services, and written translation.<sup>198</sup> The mix that brings the recipient into compliance is the one that is reasonable and necessary in light of the four-factor analysis.<sup>199</sup>

Title VI is the only federal law that directly supports any aspect of cultural competency in health care. As currently applied, Title VI only requires language assistance for LEP patients. Reasonable and necessary efforts to provide language assistance can address some of the most fundamental communication problems for LEP patients. Basic language assistance can enable access, more accurate diagnosis, patient education, and safe and appropriate use of prescription medication and other forms of care. Appropriate language assistance can also help reduce the toll on patient status and patients’ rights. Informed consent and confidentiality are more likely to be protected. Title VI helps address some causes of racial disparities in health care.

Of the racial disparities the cultural incompetence of health care causes, language assistance does not prevent all. In that sense, while Title VI and the 2003 HHS LEP Policy Guidance are valuable tools, they are limited tools. The 2003 HHS LEP Policy Guidance is, in fact, carefully limited to language assistance. For example, in the discussion of “considerations relating to competency of interpreters and translators,” the 2003 HHS LEP Policy Guidance notes that “many languages have ‘regionalisms,’ or differences in usage.”<sup>200</sup> But there are no other references to the need for contextual knowledge.

The 2000 HHS LEP Policy Guidance provides an interesting point of comparison. It was substantially limited to language assistance, but it did

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196. *Id.* at 47,314.

197. *Id.* at 47,315.

198. 2003 LEP Policy Guidance, *supra* note 183, at 47,315-16.

199. *Id.*

200. *Id.* at 47,316 n.8.

acknowledge the importance of contextual knowledge to effective communication. For example, the 2000 HHS LEP Policy Guidance discussion of interpreter competency requirements included “sensitivity to the LEP person’s culture and a demonstrated ability to convey information in both languages, accurately.”<sup>201</sup> In addition, a list of “Promising Practices” described a Multicultural Delivery Project using community outreach workers that “can be used by employees in solving cultural and language issues.”<sup>202</sup>

The possibility of using Title VI to implement broader cultural competency efforts exists. In fact, many health care advocates, civil rights organizations, medical and research organizations, and interpreter organizations endorsed the 2000 HHS LEP Policy Guidance.<sup>203</sup> That endorsement has recognized the 2000 HHS LEP Policy Guidance’s potential to improve the quality of care for LEP individuals and prevent harm to LEP patients.<sup>204</sup> At the same time, those advocates and organizations strongly encouraged the Office of Civil Rights to adopt additional recommendations.<sup>205</sup> Those recommendations included issuing guidance on cultural competence.<sup>206</sup> In very general terms, the argument for a Title VI requirement of broader cultural competency efforts might go something like this: Both race and national origin strongly correlate with culture. Arguably, the Title VI prohibitions on race and national origin discrimination apply to the denial of, participation in, benefits of, and other discrimination in health care arising from race and national origin-related cultural differences. More specifically, HHS, using Title VI, should require broader cultural competency requirements than language assistance to enable full access to effective health care and accompanying social services.

*B. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care*

In fact, HHS has already developed standards for culturally and linguistically appropriate services. The Office of Minority Health began the process of developing national standards in 1997. The purpose of proposing national standards was “to provide a much-needed alternative to the current patchwork of independently developed definitions, practices, and requirements concerning CLAS.”<sup>207</sup> In December 2000, the Office of Minority Health published the *National Standards for Culturally and Linguistically*

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201. See 2000 LEP Policy Guidance, *supra* note 164, at 52,770.

202. *Id.*

203. See NHeLP Letter, *supra* note 58, at 2-3 (listing of 67 organizations that signed the letter to the Office of Civil Rights, HHS, expressing enthusiasm for the LEP Guidance and encouraging the adoption of additional recommendations).

204. *Id.* at 3-4.

205. *Id.* at 1.

206. *Id.* at 15.

207. NAT’L STANDARDS FOR CLAS, *supra* note 23, at 1.

*Appropriate Services in Health Care: Final Report (CLAS Report).*<sup>208</sup> The CLAS Report states that the standards “are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. . . . [and] to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.”<sup>209</sup>

The CLAS national standards are independent of the Department of Justice and Office of Civil Rights guidances, but the CLAS Standards incorporate the requirements for language assistance to LEP patients. The CLAS Standards include “mandates.” The mandates are the language assistance requirements that the 2003 HHP LEP Policy Guidance addresses.<sup>210</sup>

The CLAS Standards also include “guidelines” and “recommendations.”<sup>211</sup> The guidelines are activities the Office of Minority Health recommended for adoption by federal, state, and national accrediting agencies.<sup>212</sup> The recommendations are suggestions the Office of Minority Health made for voluntary adoption by health care organizations.<sup>213</sup> The guidelines and recommendations are, in short, not legally enforceable at this time, but they provide a roadmap for addressing some of the causes of ethnic disparities in health care.

If adopted and consistently enforced as legal requirements for health care and social service organizations, the CLAS guidelines and recommendations would effect substantial change throughout the health care system. In addition to language assistance services, the CLAS Standards provide for culturally competent care and organizational supports. They use a multi-level approach. For example, they would integrate cultural competence training into academic and functional education<sup>214</sup> and implement accountability systems throughout health organizations, not just at the direct service level.<sup>215</sup> The standards

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208. *Id.*

209. *Id.* at 3.

210. *Id.* at 65-82 (Standards 4-7).

211. The “guidelines” are Standards 1-3, 8, and 10-13. *Id.* at 49-64, 83-87, 92-108. The sole “recommendation” is Standard 14. *Id.* at 109. Standard 9 is listed as both a “guideline” and a “recommendation.” *Id.* at 88.

212. NAT'L STANDARDS FOR CLAS, *supra* note 23, at 3 (Standards 1-3 and 8-13).

213. *Id.* at 3 (Standards 9 and 14).

214. *Id.* at 49-52 (Standard 1: Culturally Competent Health Care). The Standard states: “Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.” *Id.* at 49.

215. *Id.* at 83-87 (Standard 8: Organizational Framework for Cultural Competence). The guideline suggests: “Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.” *Id.* at 83.

would require organizations to fit and adapt CLAS efforts to changing patient and community needs.<sup>216</sup> Accordingly, the standards would impose data collection requirements for patient race, ethnicity, and spoken and written language,<sup>217</sup> cultural profile information about the community,<sup>218</sup> and would also require partnerships with communities.<sup>219</sup>

If implemented, the CLAS Standards could go further than existing Title VI requirements in reducing racial disparities in health care within the health care system. The standards could enhance the accuracy of communication with LEP patients by adding contextual knowledge to the communication process. Effective cross-cultural training could result in greater patient participation in decision-making, greater trust of providers and other staff, and less reluctance to seek both initial and follow-up care.

Despite the stated goal of contributing to the elimination of racial and ethnic health disparities, the standards seldom mention either racism or ethnocentrism. Standard 3, which would require ongoing education and training in culturally and linguistically appropriate service delivery for care providers, lists training topics that should be included.<sup>220</sup> Only two of the ten training topics would specifically provide opportunity to examine the role of racism within the health care organization.<sup>221</sup> Standard 13 would require that conflict and grievance resolution processes are culturally and linguistically sensitive.<sup>222</sup> The discussion of Standard 13 acknowledges the possibility of

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216. *Id.* at 88-91 (Standard 9: Organizational Self-Assessment). The Standard notes: “Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities . . .” *Id.* at 88.

217. NAT’L STANDARDS FOR CLAS, *supra* note 23, at 92-97 (Standard 10: Collection of Data on Individual Patients/Consumers). The Standard notes: “Health care organizations should ensure that data on the individual patient’s/consumer’s race, ethnicity, and spoken and written language are collected in health records, integrated into the organization’s management information systems, and periodically updated.” *Id.* at 92.

218. *Id.* at 98-101 (Standard 11: Collection of Data on Communities). “Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.” *Id.* at 98.

219. *Id.* at 102-05 (Standard 12: Community Partnerships for CLAS). “Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.” *Id.* at 102.

220. *Id.* at 59 (Standard 3: Staff Education & Training).

221. *Id.* The two topics that expressly address the role of racism in health care are “strategies and techniques for the resolution of racial, ethnic, or cultural conflicts between staff and patients/consumers” and the “impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service utilization, quality of care, and health outcomes.” *Id.*

222. NAT’L STANDARDS FOR CLAS, *supra* note 23, at 106 (Standard 13: Complaint and Grievance Resolution).

racism within the organization and its impact on patients, which could help protect patient status.<sup>223</sup> Standard 2 would require health care organizations to implement strategies to recruit, retain, and promote a diverse staff and leadership.<sup>224</sup> This requirement constitutes the most significant systemic anti-racist measure among the CLAS Standards; however, the report, does not describe it as such.<sup>225</sup>

### C. State Law

Patients whose access and care are compromised by health care's cultural incompetence can use state laws. Almost all of the existing state laws require some type of language assistance for LEP patients,<sup>226</sup> but, like both the LEP Policy Guidances and the CLAS Standards, the state laws say little or nothing about racism or anti-racism measures. The number of state laws available to patients, however, has increased in the past few years.<sup>227</sup> This increase suggests that state legislatures and agencies have begun to recognize the need to require at least some cultural competency efforts in health care. According to a National Health Law Program survey, thirty-three states have laws that address language access in health-related settings.<sup>228</sup> Several states impose a general responsibility on health care facilities to provide interpreters, bilingual staff and translation to LEP patients. For example, California statutes require interpreters or bilingual staff at general acute care hospitals,<sup>229</sup> county mental health programs,<sup>230</sup> and intermediate care facilities.<sup>231</sup> Some of these laws serve a role similar to the suggestions found in HHS LEP Policy Guidances.

223. *Id.* The Standard's text states:

Patients/consumers who bring racial, cultural, religious, or linguistic differences to the health care setting are particularly vulnerable to experiencing situations where those differences are not accommodated or respected by the health care institution or its staff. These situations may range from differences related to informed consent and advanced directives, to difficulty in accessing services or denial of services, to outright discriminatory treatment.

*Id.*

224. *Id.* at 54-58 (Standard 2: Staff Diversity).

225. *Id.*

226. See NHeLP Letter, *supra* note 58, Appendix C ("Summary of State Law Requirements Addressing Language and Cultural Needs in Health Care").

227. See *id.*; see also JANE PERKINS, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: AN OVERVIEW OF CURRENT LEGAL RIGHTS AND RESPONSIBILITIES (2003), available at <http://www.kff.org/content/2003/4131/4131.pdf> (last viewed Oct. 14, 2003).

228. NHeLP Letter, *supra* note 58, Appendix C; see also PERKINS, *supra* note 227, at 16-18, available at <http://www.kff.org/content/2003/4131/4131.pdf> (last viewed Oct. 14, 2003).

229. CAL. HEALTH & SAFETY CODE § 1259 (West 2000).

230. CAL. WELF. & INST. CODE § 5868 (West 1998).

231. CAL. CODE REGS. tit. 22, § 73501(f) (2003).

They describe what providers must do to comply with state requirements.<sup>232</sup> California law also requires that state and local agencies provide “bilingual services” to non-English speaking persons.<sup>233</sup> California regulations prohibit discrimination by recipients of state funds, including the failure to provide language assistance, interpreter services or written materials to LEP persons.<sup>234</sup> In addition, California statutes require hiring racially or linguistically diverse staff members<sup>235</sup> and posting or distributing patient rights, informed consent forms, or other important information in languages other than English.<sup>236</sup>

Many of the other states with such laws have more limited provisions. Arizona, a state with a significant Spanish-speaking population, has one regulation that requires the Department of Health Services case management staff to assess the language and communication skills of mentally-ill clients.<sup>237</sup> Idaho requires interpreters for the purpose of obtaining consent from patients in the state’s Medical Assistance Program.<sup>238</sup> Hawaii laws establish a state bilingual health education aid program and require the Department of Health to provide outreach and education on mental health issues.<sup>239</sup>

In the past few years, state legislatures and agencies have been active in proposing and creating new law. For example, a 2003 California bill would “prohibit a state or local governmental agency, or a public or private agency, organization, entity, or program that receives state funding, from using any child . . . as an interpreter . . . .”<sup>240</sup> The bill uses the risk of the loss of state funding or state contracts as an enforcement mechanism.<sup>241</sup> In other states, recent laws condition initial and continued licensing on interpreter services requirements. For example, Massachusetts enacted the “Emergency Room Interpreter Bill,” effective as of July 1, 2001.<sup>242</sup> The law requires all public and private acute care hospitals to provide “competent interpreter services” for

232. *E.g.*, CAL. HEALTH & SAFETY CODE § 1259(c) (West 2000); 210 ILL. COMP. STAT. 87/5–87/15 (2002); ILL. ADMIN. CODE tit. 77, § 250.265 (1996) (providing guidance, but giving the health care facility the choice of the process of compliance).

233. CAL. GOV’T CODE §§ 7290, 7291 (West 1998).

234. CAL. CODE REGS. tit. 22, § 98211(c) (2003).

235. CAL. WELF. & INST. CODE § 14552(e) (West Supp. 2003); CAL. CODE REGS. tit. 22, § 54401 (2003).

236. CAL. CODE REGS. tit. 22, § 79111 (2003); CAL. CODE REGS. tit. 22, § 72528(h) (2003); CAL. CODE REGS. tit. 17, § 6824(b)(3)(B) (2003); CAL. WELF. & INST. CODE § 4503 (West 2001).

237. ARIZ. ADMIN. CODE R9-21-305(C)(1)(o) (2003).

238. IDAHO ADMIN. CODE 16.03.09.090.03(c) (2003).

239. HAW. REV. STAT. ANN. §§ 321-301, 334-12 (Michie Supp. 2000).

240. A.B. 292, 2003-04 Leg. Assem., Reg. Sess. (Cal. 2003) (to be enacted in CAL. BUS. & PROF. CODE § 36 (West 2004)).

241. *Id.*

242. Act of Apr. 14, 2000, No. 4917, ch. 66, §§ 1, 6 (codified as amended at MASS. ANN. LAWS ch. 111, § 25J (Law Co-op. Supp. 2002)).

all emergency room services.<sup>243</sup> The law authorizes the Departments of Public Health and Mental Health to evaluate the adequacy of the services at the initial and continued licensing process.<sup>244</sup> Rhode Island uses the licensing process as the enforcement mechanism for a broader interpreter services requirement. Rhode Island requires hospitals to provide a qualified interpreter when a bilingual clinician is unavailable for all services given to every non-English speaking patient.<sup>245</sup> This law became effective January 1, 2002.<sup>246</sup>

Scant few states have used the law to implement broader cultural competency efforts. Recently, California law has acknowledged the need for cultural competency by adding state administrative support for efforts. A 1999 statute established an Office of Multicultural Health.<sup>247</sup> The Office's duties included performing "an internal assessment of cultural competency, and training of health care professionals to ensure more linguistically and culturally competent care."<sup>248</sup> A 2000 law established "The Task Force on Culturally and Linguistically Competent Physicians and Dentists."<sup>249</sup> The Task Force's work has already generated at least two bills. The most recent work cites to findings from the Institute of Medicine report.<sup>250</sup> It would establish a "Licensed Physicians and Dentists from Mexico Pilot Program" to increase the pool of culturally competent providers for Latinos,<sup>251</sup> and it would enact the "Cultural and Linguistic Competency of Physicians Act of 2003" to provide language and cross-cultural training to California physicians.<sup>252</sup>

Other state approaches to cultural competency vary widely. Some laws use linguistic access and cultural competency program requirements as licensing conditions.<sup>253</sup> Some require managed care organizations to develop written cultural competency plans to provide effective health care services to

243. MASS. ANN. LAWS ch. 111, § 25J(b) (Law. Co-op. Supp. 2002).

244. *Id.* § 25J(d).

245. R.I. GEN. LAWS § 23-17-54 (2001).

246. An Act Relating to Health and Safety—Licensing of Health Care Facilities, ch. 88, §§ 2, 3, 2001 R.I. Pub. Laws 651, 654-55 (July 6, 2001); An Act Relating to Health and Safety—Licensing of Health Care Facilities, ch. 253, §§ 2, 3, 2001 R.I. Pub. Laws 1324, 1327-28 (July 13, 2001) (identical versions passed in both legislative chambers) (codified as amended at R.I. GEN. LAWS § 23-17-54 (2001)).

247. CAL. HEALTH & SAFETY CODE § 151 (West 2003); *see also* CAL. HEALTH & SAFETY CODE § 150 (West 2002) (making findings about racial and ethnic health disparities in California).

248. CAL. HEALTH & SAFETY CODE § 152(a)(6) (West 2003).

249. CAL. BUS. & PROF. CODE § 852 (West 2003).

250. Cal. A.B. 801 sec. 1(d) (2003) (citing UNEQUAL TREATMENT, *supra* note 2).

251. Cal. A.B. 801 sec. 2 (2003); *see also* CAL. BUS. & PROF. CODE § 1970 (West 2002) (establishing loan repayment and outreach programs to increase the number of physicians and dentists in low-income, minority, and rural areas).

252. Cal. A.B. 801 sec. 3 (2003).

253. *See, e.g.*, CAL. WELF. & INST. CODE §. 4080(e)(1)(T) (West 2003) (concerning psychiatric health facilities).



members.<sup>254</sup> Others establish service standards,<sup>255</sup> pilot programs,<sup>256</sup> and research priorities.<sup>257</sup> As noted previously, most of the state laws focus solely on interpreter services. Again, these services may reduce some racial disparities for LEP patients, but the scope of these laws varies greatly. In addition, most of the state laws provide patients with the sole remedy of administrative complaints.<sup>258</sup> In states that have a general requirement of language assistance for health care services, however, the state laws provide a great number of patients with an alternative to the federal administrative process. The laws that use licensing as a condition of compliance provide no individual remedy, but they do give state officials the duty and opportunity to review cultural competency efforts on a regular basis.

None of the state laws would implement broader cultural competency efforts using the system-wide approach described in the CLAS Standards. The California Task Force duties, for example, do not appear to allow for that approach. Texas law allows for system-wide cultural competency activities, but it sets the required minimum effort much lower, thereby making system-wide change unlikely. As yet, state laws show no immediate promise of ushering in broader cultural competency in health care, but the recent activity among state legislatures and administrative agencies might indicate a trend toward using the law to require broader cultural competency activities in health care. It may also suggest that in the end, state law will provide the vehicle to remedy this crisis.

#### *D. Primary Objections to Using Legally Required Cultural Competency Efforts*

As noted previously, when the 2000 HHS LEP Policy Guidance was published for comment, HHS received nearly 200 public comments from individuals and organizations.<sup>259</sup> Most of the comments endorsed the 2000 HHS LEP Policy Guidance.<sup>260</sup> Similarly, when the CLAS Standards were

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254. *See, e.g.*, 1 TEX. ADMIN. CODE § 353.411(j) (West 2002); CAL. WELF. & INST. CODE § 14684 (West 2003).

255. *See, e.g.*, CAL. WELF. & INST. CODE § 5806(a)(2) & (9) (West 2003) (State Department of Mental Health service standards).

256. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 11756.5 (West 2003) (establishing three pilot projects aimed at the prevention and nonresidential treatment of alcohol and drug abuse in Asian and Pacific Islander communities).

257. *See e.g.*, CAL. HEALTH & SAFETY CODE § 104145(b)(8) (West 2003) (establishing the Breast Cancer Research Program with priorities including research regarding the cultural, economic, and legal barriers to accessing the health care system for early detection and treatment of breast cancer).

258. *But see, e.g.*, MASS. ANN. LAWS ch. 111, § 25J(e) (Law. Co-op. Supp. 2002) (allowing a right of action in the state superior court).

259. 2000 LEP Policy Guidance, *supra* note 164, at 3.

260. *Id.*

discussed at public comment sessions in San Francisco, Chicago, and Baltimore, most speakers supported the idea and basic substance of the standards.<sup>261</sup> But, the LEP Policy Guidances, the CLAS Standards, and other discussions about using law to require cultural competency have generated some objections to making them legally enforceable. The most forceful objections have been framed in free-market terms or have denied that health care has a culture that causes harm.

### 1. The Marketplace Argument

Objectors raising marketplace concerns have made two logically linked arguments against using law to require cultural competency in health care. The first argument says that mandating cultural competency efforts could cause more harm than benefit. Objectors identified the particular harm as the financial cost of interpreter services, cross-cultural training, and other cultural competency activities.<sup>262</sup> The second argument is that implementing cultural competency should be left to the private sector.<sup>263</sup> This argument also claims that the cost is too great, but in this argument, the cost is the burden on free-market individualism. Not surprisingly, the most powerful voices raising these arguments have been the medical associations, especially the American Medical Association.

Most objectors emphasized the potential harm—the financial cost of implementing cultural competency in health care. This objection has prompted two different responses. Many cultural competency advocates have responded to marketplace concerns with the “business case.”<sup>264</sup> The “business case” presents the financial reasons for implementing cultural competency in health care. In fact, several participants at the Chicago session on the CLAS Standards argued that framing cultural competency in marketplace terms was vital to gaining support from health care organizations. “You need to talk about this as a cost-effective way of delivering healthcare,” said one participant.<sup>265</sup> Another participant is recorded as saying:

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261. See generally *Assuring Cultural Competence in Health Care: Office of Minority Health, CLAS Standards Meetings, San Francisco, January 21, 2000*, [www.omhrc.gov/clas/SFcommentsstaff.htm](http://www.omhrc.gov/clas/SFcommentsstaff.htm) (last viewed Sept. 26, 2003); *Assuring Cultural Competence in Health Care: Office of Minority Health, CLAS Standards Meetings, Baltimore, MD, March 10, 2000*, [www.omhrc.gov/clas/Baltgeneralcomments.htm](http://www.omhrc.gov/clas/Baltgeneralcomments.htm) (last viewed Sept. 26, 2003); *Assuring Cultural Competence in Health Care: Office of Minority Health, CLAS Standards Meetings, Chicago, April 5, 2000*, [www.omhrc.gov/clas/chigeneralcomments.htm](http://www.omhrc.gov/clas/chigeneralcomments.htm) (last viewed Sept. 26, 2003) [hereinafter *CLAS Standards Meetings, San Francisco, Baltimore or Chicago*].

262. See 2003 LEP Policy Guidance, *supra* note 183, at 47,314-15; *CLAS Standards Meetings, Baltimore*, *supra* note 261, at 5-6; *CLAS Standards Meetings, Chicago*, *supra* note 261, 3-5; *CLAS Standards Meetings, San Francisco*, *supra* note 261, at 14-15.

263. See *CLAS Standards Meetings, Chicago*, *supra* note 261, at 7-8.

264. See NHeLP Letter, *supra* note 58, at 5-6.

265. *CLAS Standards Meetings, Chicago*, *supra* note 261, at 4.

To get organizations to “buy in” with more than lip service to cultural competency, we have to wave the flag of the dollar sign and stress they will more than get back the cost of the training, the interpreting, or all of these other things, by potential growth in their future.<sup>266</sup>

The National Center for Cultural Competence (National Center) is among the cultural competency advocates who agree with that argument. The National Center has a list of “six overarching reasons why cultural competence is important to health care providers.”<sup>267</sup> Reason number five is “[t]o gain a competitive edge in the market place.”<sup>268</sup> A long list of cultural competency advocates sent extensive written comments in response to the 2000 HHS LEP Policy Guidance that included a section titled “The Business Case for Ensuring Linguistic Access.”<sup>269</sup> The discussion in that section provides examples of health care providers or organizations that have implemented linguistic access to increase business and financial stability.<sup>270</sup>

HHS has made a more concrete response to the cost argument than did advocates who made the business case. The 2003 HHS LEP Policy Guidance very clearly took cost into account. The history and background section of the 2003 HHS LEP Policy Guidance acknowledged that commentators on the 2000 LEP Policy Guidance raised concerns about compliance costs and then identified the need to reduce the costs of compliance as one of two principles that HHS must balance.<sup>271</sup> The other principle asserts that federally assisted programs aimed at the American public should leave no LEP person behind.<sup>272</sup> The 2003 HHS LEP Policy Guidance includes costs as one of the four factors HHS will use to determine what efforts recipients must make to comply with Title VI. In this four-factor analysis, costs will usually lower Title VI requirements for recipients.<sup>273</sup>

Objections based on marketplace concerns have been taken seriously. Advocates of legally required cultural competency efforts and federal law have accommodated these concerns. Supporters have responded by developing the “business case,” while HHS has responded by incorporating cost concerns directly into its LEP Policy Guidance priorities and standards for determining compliance.

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266. *Id.* at 5.

267. Nat’l Ctr. for Cultural Competence, *supra* note 143, at <http://www.georgetown.edu/research/gucdc/nccc/faqs.html>.

268. *Id.*

269. NHeLP Letter, *supra* note 58, at 5.

270. *Id.*

271. 2000 LEP Policy Guidance, *supra* note 164, at 4.

272. *Id.*

273. *See* 2000 HHS LEP Policy Guidance, *supra* note 4, at 52,766.

## 2. The Denial of Health Care's Cultural Incompetence

A second major obstacle to requiring cultural competency in health care is a denial of culture's significance. This objection takes two forms. The first was discussed in Part II—the belief that health care does not have a culture, or that health care does have a culture but that it is science-based and therefore neutral. The second form of the objection is that culture is too intangible and not measurable enough to regulate. Many objectors who make this claim acknowledge that language is tangible enough to regulate and that the problems that language differences create are measurable. These objectors assert, however, that other cultural beliefs, practices and norms are so subtle that developing enforceable standards for changing them is just not possible without doing violence to reasonable health care practices or to those subject to the standards.

One response to this claim about the intangibility of culture is direct opposition. The Office of Minority Health's development of the CLAS Standards seems to insist that health care does have a culture that does cause harm. In addition, the CLAS Standards purport to provide the possibility of replacing the current scattershot approach to cultural incompetency with a consistent, comprehensive approach by modeling a feasible implementation and enforcement scheme. Several organizations and institutions have, in fact, adopted the CLAS Standards. For example, the George Washington University Center for Health Services Research and Policy has developed model cultural competence purchasing specifications for Medicaid managed care based on the CLAS Standards.<sup>274</sup> In practice, the CLAS Standards show that cultural norms and practices, not culture in the abstract, are at issue.

On the other hand, it may be that the dearth of laws requiring cultural competency activities other than language assistance signifies the political success of the objections. Advocates' focus on bare language assistance may express agreement with the claim that health care culture is neutral at best or at the least too amorphous to regulate. The recent focus on language assistance, however, may reflect only political pragmatism—a temporary concession to the political weight of that claim. If so, then the fact that Title VI protections are limited to language and that few state and local governments have addressed that limitation suggest that the intangibility argument is currently very powerful.

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274. PERKINS, *supra* note 227, at 14.

## IV. PRESERVING THE PROMISE OF CULTURAL COMPETENCE

The dominant political discourse is as important to the problem of racial disparities in health care as is the incompetence of dominant health care culture. Political discourse defines the problem for purposes of determining whether and how government will respond to it by “fram[ing] its goals in language that will be broadly acceptable to politicians and their constituents.”<sup>275</sup> The issue framing and the shape of the debate also say something about the role that advocates for legally required cultural competency efforts are playing. The shape of the debate probably reflects the level of influence the debate participants have. More importantly, for purposes of this discussion, it reflects the competing visions of health and racial equality the participants hold.

A. *Marketplace Concerns*

Certainly, concerns about financial cost to health care organizations and providers are legitimate concerns, but many objectors to legal regulation have cast their arguments in terms that disregard the goals of cultural competency. For example, a participant in the San Francisco CLAS Standards Meeting argued:

[I]t will be impossible to influence organizations to provide training because of the cost of lost clinic time. Physicians need to be convinced the [sic] that 1 day of training will help reduce each patient encounter to 15 minutes, and organizations need to be convinced that 1 hour of interpreter services will save them an hour of care in the future.<sup>276</sup>

While this argument illuminates the time pressures that providers face, it also fails to acknowledge patient needs, particularly those of outsider patients. The goal of reducing racial disparities in health care disappears in this argument.

Perhaps even more disturbing is the argument for free-market individualism. A participant in the Chicago CLAS Standards Meeting stated, “Please consider a product and process that encourages, not stifles, the provision of culturally competent care.”<sup>277</sup> This argument suggests, without promising, that health care organizations and providers might voluntarily implement cultural competence activities. It suggests that a cost-benefit analysis leads to one conclusion—no legal regulation. The use of the cost-benefit analysis is deceiving. Couching the argument in cost-benefit terms gives it the appearance of objectivity, but the argument is really made as a list of pros and cons from the perspective of health care organizations and

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275. Scott Burris, *The Invisibility of Public Health: Population-Level Measures in a Politics of Market Individualism*, 87 AM. J. PUB. HEALTH 1607, 1607 (1997).

276. *CLAS Standards Meetings, San Francisco*, *supra* note 261, at 14.

277. *CLAS Standards Meetings, Chicago*, *supra* note 261, at 7.

providers. Actually, the argument is even narrower than that. It is made as a list of financial pros and cons for health care organizations and providers. The cons are the financial costs of paying for interpreter services, written translation, cross-cultural training, and so on. The pros of cultural competency activities are reduced by the suggestion that health care organizations and providers might voluntarily adopt cultural competency measures. The resulting cost-benefit equation looks something like this: the costs of cultural competence activities  $>$  (the benefits of mandated cultural competence activities *minus* the benefits of voluntarily assumed cultural competence activities).

Perhaps more disturbing is that the cost-benefit analysis leaves causation and responsibility out of the picture. The role that the medical profession and professional culture play in racial disparities in health care remains undiscussed. The claim that the industry or the profession will provide the solution omits the fact that the industry and the profession have been and still are part of the problem. The claim also denies that free-market individualism enables and promotes cultural incompetence in health care.

Legal regulation advocates who respond to cost concerns with the “business case” do so at a great risk. Actually, there are at least three risks. The first risk is that the “business case” will become the primary justification for legal regulation. The business case is appealing because it responds directly to cost concerns. In that sense, the argument displays adroit political pragmatism. In reality, advocates have offered the “business case” as one of several reasons for cultural competency, but, in the fray of political discourse, the “business case” may emerge as the best and most persuasive reason to providers. This possibility creates the risk that cultural competency will be seen primarily as a means of increasing business for health care organizations and providers. Any resulting legal regulations may focus on that purpose, and the goal of reducing racial disparities in health care will fall by the wayside.

The second risk follows closely from the first. The risk is that framing the “business case” in the same narrow terms as marketplace concerns will reinforce the current dominance of market individualism in the broader discourse about health and community. The resulting predominance of market individualism will, in turn, increase the difficulty of asserting that private, market-sheltered choices, both corporate and individual, cause racial disparities in health care.

The third risk arises from the fact that the “business case” is tailor-made to appeal to health care organizations and providers because the argument reflects only their perspective and not that of patients. Perhaps more accurately, the argument reflects their presumed perspective, for the business case assumes that health care organizations and providers have no better, broader perspective, such as one that takes patients, including outsider patients, into account. In that sense, the business case expresses cynicism about the role of

organizations and providers in changing health care's culture. Cynicism can be dangerous; it may undermine those organizations and providers who do take a broader, more inclusive perspective.

*B. The Claim of Neutrality*

The claim that health culture is nonexistent, neutral, or too amorphous and insignificant to regulate is eerily familiar. The same premise supports the very narrow legal definition of discrimination. The primary legal definition of discrimination requires intent. Hence, anti-discrimination law defines racism as a problem caused by a few bad actors in a predominantly neutral world. The claim of neutrality in health care culture suggests that forces unauthorized or external to health care are solely responsible for racial disparities.

The intent-based definition of discrimination has at least two effects. First, it leaves institutional racism untouched and largely hidden from view. The definition limits scrutiny of discrimination to the level of gross individual behavior. That limitation makes it harder to attribute racism to more subtle social and institutional norms, processes, and practices. In addition, the intent-based standard proscribes our understanding of the pervasive nature of the harm. The identification of a single perpetrator often results in identifying only the direct targets—a single person or small group of persons—as victims. Under this standard, racism is perceived as a discrete problem.

The claims of non-existence, neutrality, or intangibility have effects similar to the intent-based definition of discrimination. The claim of neutrality, if accepted, would remove health care culture from scrutiny. Gross individual behavior would be noted and subject to censure, but unconscious racism expressed in the creation and application of institutional standards, norms, and practices that have a disparate impact on minorities would remain intact. The claims would also shrink the understanding of racial disparities in health care by eliminating one cause. Eliminating health care's standards, norms, and practices as a cause may shift the blame to the patients. While examining the role of patient behavior in racial disparities is a valuable line of inquiry, the claim of neutrality leaves too much space for blaming the victim.

The CLAS Standards operate, in part, as a response to the claims of health care's cultural neutrality. As a response, the CLAS Standards take an oppositional approach. To the extent they are voluntarily implemented as internal rules, adopted as accreditation standards, or even enacted as law, the CLAS Standards may replace the claims that health care culture is non-existent and too intangible to regulate. The CLAS Standards may be less successful at replacing the claim of neutrality. The Standards are race-conscious and value diversity, but they do not prioritize direct anti-racism efforts and thus do not directly address the possibility that neutrality may mask racist choices.

### C. Competing Visions of Health and Racial Equality

#### 1. The Colorblind, Free-Market Individualism Model

These two threads of discourse offer a narrow vision of health, equality, and the role of health care in society. A vision based on free-market individualism would protect the market players above all else. It would protect the professional autonomy and financial interests of providers and health care organizations, and in doing so, this vision would minimize their accountability. If this vision dominates the political discourse, then cultural competency efforts would remain only voluntarily assumed professional or institutional standards. If enacted or promulgated at all, cultural competency requirements might even include among its goals the use of cultural competency for financial gain. Such requirements would also pay deference to cost concerns at the expense of patients, especially patients of color. That deference would limit the requirements imposed on health care and social service providers and organizations. The revision of the HHS LEP Policy Guidance serves as an example of this process.

The 2003 HHS LEP Policy Guidance gives significant weight to concerns about compliance costs, particularly for small businesses, small local governments, and small non-profits.<sup>278</sup> The cost concerns are appropriate, but the 2003 HHS LEP Policy Guidance is notable for the weight that it gives to cost concerns relative to the weight that the 2000 HHS LEP Policy Guidance gave to cost concerns. Perhaps not surprisingly, the 2000 HHS LEP Policy Guidance's relative emphasis on the mandate to provide the language assistance necessary to afford LEP persons meaningful access to their services was greater than that in the 2003 HHS LEP Policy Guidance.<sup>279</sup> The 2003 HHS LEP Policy Guidance reduces the anti-discrimination and equality goals of Title VI.<sup>280</sup>

The vision of health, equality, and health care based on the neutrality discourse is a companion to the vision based on free-market individualism.

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278. 2003 LEP Policy Guidance, *supra* note 183, at 44,312-13 (citing the guidance principles of the Department of Justice).

279. See 2000 HHS LEP Policy Guidance, *supra* note 4, at 52,766, 52,771 (providing an extensive description of a model language assistance program and asserting that effective programs usually have the following four elements: assessment, development of a comprehensive written policy on language access, training of staff, and vigilant monitoring). For a thorough comparison of the 2000 and 2003 LEP Policy Guidances, see Mara Youdelman, NATIONAL HEALTH LAW PROGRAM, SIDE-BY-SIDE: COMPARISON OF HHS AUG. 2000/FEB. 2003 LEP GUIDANCE TO DOJ JUNE 2002 AND HHS AUG. 2003 GUIDANCE (2003).

280. For a thorough evaluation of the 2003 LEP Policy Guidance, see Letter from National Health Law Program, to Deean Jang, Senior Civil Rights Analyst for the Office of Civil Rights, U.S. Dep't of Health and Human Servs. (Dec. 8, 2003), available at <http://www.healthlaw.org/pubs/200312.lepcomments.html>.



The claim of neutrality is, after all, a time-tested means of forestalling regulation and maintaining the sphere of private free-market individualism. In the health care context, the claim of neutrality reinforces the cost concerns argument in opposing legally mandated cultural competency efforts.

The neutrality discourse shrinks the promise of cultural competency. Arguably, cultural competence in health care could substantially transform health care culture into a set of inclusive standards, practices, and norms that result in quality care for patients (at least, privately and publicly insured patients). To the extent the claim of neutrality prevails in the discourse, however, the proposal of requiring cultural competency efforts at law fails. Even the contested version of this discourse—the version the CLAS Standards inform—seems to shrink the promise of cultural competency to reduce racial disparities in health care. While the CLAS Standards avoid the harms of apparent neutrality, they may not fully address racial disparities in health care that provider bias causes because of some underlying assumptions consistent with the neutrality discourse. If implemented, the CLAS Standards might fall short of the goal of reducing those racial disparities that health care’s cultural incompetence causes.

In reality, cultural competency advocates have launched effective responses to objectors’ concerns. HHS has taken cost concerns into account in revising the LEP Policy Guidances, but it has also retained the principle of ensuring that “federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English.”<sup>281</sup> The CLAS Standards contain few direct anti-racism measures, but they do use race-consciousness and diversity efforts to address racial disparities in health care. The resulting discourses, however, shrink the potential of cultural competency to reduce racial disparities in health care. A broader alternative vision is needed to support the greater promise of cultural competency.

## 2. An Anti-Racist, Culturally Competent Vision of Health Care

A broader vision of health care would be explicitly anti-racist. The claim that health care culture is neutral or an insignificant determinant would have no place in this vision. In a broader vision of health care, patient access and quality of care would not depend on market share. Indeed, the vision requires acknowledging that while free-market individualism protects physician autonomy and the potential for financial gain by institutional players, it also protects choices and activities that contribute to racial disparities in health care. Instead, the principles of equality and inclusion would govern the norms, practices, and standards used to provide access and determine quality of care.

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281. 2003 LEP Policy Guidance, *supra* note 183, at 47,312.

The law plays a significant and constructive role in this vision. Despite the claims made for the “business case,” there do not appear to be any market forces strong enough to restrict racist free-market choices. Implementing a broader vision of health care requires legally enforceable rules and standards that intervene, undermine, and counter racism in health care culture. This vision does not reject existing cultural competency efforts, but would back up at least some of those efforts with legal enforcement mechanisms. In addition, a broad vision of health care backed by an array of explicitly anti-racist laws leaves less room for claiming that health care norms are neutral and its practices non-exclusionary. Finally, an array of explicitly anti-racist laws that includes rules with patient rights of action might begin to reallocate some institutional power to those most likely to be locked out of the market—patients of color.

a. Using Proactive Legal Rules

Existing laws that can be used to counter the effects of health care’s monoculture are both limited and retrospective.<sup>282</sup> That is, they operate only after racism has caused harm, and they do so only in narrow circumstances. The discussion of Title VI in Part III, *supra*, illustrates this point. The best proposals to enable more effective use of existing law include reshaping strategies to improve Title VI monitoring efforts<sup>283</sup> and institutional report cards to provide information necessary for proving racial disparities.<sup>284</sup> By themselves, these proposals cannot overcome the limitations on disparate impact claims that *Sandoval* has created. Nor do they directly supply all of the resources that OCR needs to fully investigate and enforce Title VI. In addition, as Professor Mary Crossley has pointed out, existing law does little to nothing to directly remedy provider bias.<sup>285</sup>

While efforts to use and strengthen retrospective legal rules should continue, cultural competency efforts are primarily proactive. Cross-cultural training, for example, would ideally prevent racism from affecting access and

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282. Marianne L. Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOK. L. REV. 239, 259-68 (1994); Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135, 157-70 (1998).

283. David Barton Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, 23 J. HEALTH POL., POL’Y & L. 75 (1998).

284. *Id.*; Rene Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 125-32 (2001); *see also* Michael S. Shin, *Redressing Wounds: Finding a Legal Framework to Remedy Racial Disparities in Medical Care*, 90 CAL. L. REV. 2047 (2002) (proposing a reworking of Title VI that uses Title VII and the ADEA as a starting point).

285. Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195 (2003).

quality of care. The legal rules used to implement cultural competence should also take a proactive approach. Professor Barbara Noah has proposed a list of prospective solutions to racial disparities in health care that include changing medical education, using institutional mechanisms to create professional awareness, and getting both accreditation and government regulatory agencies involved in monitoring health care organizations for racial disparities.<sup>286</sup> Each of these proposals does or could include components premised on cultural competency.

This author's proposals, *infra*, are also proactive. They operate by directly requiring institutional change rather than by depending on the deterrence effect of retrospective enforcement. They are not meant to be exhaustive, but rather merely suggestive of a greater array of rules and standards that could effect both normative and practical change in health care culture. Finally, the proposals are not innovative. Two proposals are currently practiced as part of existing cultural competency efforts. Innovation is desirable, but what should be emphasized at this point is that cultural competency should be explicitly anti-racist. So the initial efforts to implement laws to support cultural competency should focus on the already existing explicitly anti-racist aspects of cultural competence activities.

b. Implementing Multi-Level Change

The broader vision would yield laws directed at multi-level change. A recent article provides a framework for implementing cultural competence measures at the organizational, structural, and clinical levels of the health care system.<sup>287</sup> The authors described organizational issues as arising from the leadership and workforce because “[h]ealth care systems and structural processes of care are shaped by the leadership that designs them and the workforce that carries them out.”<sup>288</sup> Structural barriers arise from “systems that are complex, underfunded, bureaucratic, or archaic in design,”<sup>289</sup> and also, “[c]linical barriers have to do with the interaction between the health care provider and the patient or family.”<sup>290</sup> This framework takes into account how social and cultural influences on patients’ beliefs and behavior “interact at multiple levels of the health care delivery system.”<sup>291</sup> A multi-level approach that includes an array of anti-racism tools can more fully address access, patient participation, and quality of care issues for patients of color.

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286. Noah, *supra* note 282, at 169-76.

287. Betancourt et al., *supra* note 5, at 293. The CLAS Standards include multi-level, organization-wide change in their analysis.

288. *Id.* at 295.

289. *Id.* at 296.

290. *Id.* at 297.

291. *Id.*

c. Valuing Diversity

Affirmative action programs in professional schools, hospitals, and other health care and social service organizations are anti-racist interventions at the organizational level.<sup>292</sup> Affirmative action should be a central component of cultural competency requirements. In fact, the CLAS Standards and many cultural competency proponents include staff diversity requirements in their proposals.<sup>293</sup> Such laws can help redefine the meaning of race. For one thing, they counter color-blindness—the neutrality claim that narrows the law’s aim to intentional discrimination. Staff diversity also increases the likelihood of effective communication with patients, patient participation in decision-making, and patient satisfaction with services. The approach and goals of affirmative action also take a value-based approach to diversity.<sup>294</sup> Thus, affirmative action decreases the risk that cultural competency requirements will be implemented with a deficit approach to cultural difference.<sup>295</sup>

d. Consciousness Raising

On the other hand, increasing staff diversity may not, by itself, effect substantial change in health care culture.<sup>296</sup> Other transformative tools are needed. One of the most common cultural competence activities—cross-cultural training—can be and is used to counter unconscious racism, nativism, and ethnocentrism. Consciousness-raising may be a dated term, but both the means used and the goal sought fit the term. Assuming that staff at all levels of health care and social service organizations participate in training aimed at

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292. Betancourt et al., *supra* note 5, at 298.

293. NAT’L STANDARDS FOR CLAS, *supra* note 23, at 8. CLAS Standard 2 states that “[h]ealth care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.” *Id.* Note that Standard 2 would not address the fact that some hospitals and other health care organizations have taken advantage of racial segregation in housing by moving to service areas with little racial diversity. See DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 220-21 (1999).

294. See generally Grutter v. Bollinger, 123 S. Ct. 2325 (2003); Gratz v. Bollinger, 123 S. Ct. 2411 (2003).

295. An example of the deficit approach to cultural difference is treating the patient’s language, beliefs, practices, or way of knowing as a barrier instead of taking a positive approach to the patient’s cultural belief system to better understand his or her needs. See Fuller, *supra* note 88; Joe Kai et al., *Learning to Value Ethnic Diversity—What, Why and How?*, 33 MED. EDUC. 616 (1999).

296. See generally DeVecchio Good et al., *supra* note 17, in UNEQUAL TREATMENT, *supra* note 2, at 594 (located on the CD-ROM attached to the inside back cover of the book).

developing a critical understanding of health care culture and each person's role in it, this intervention can effect multi-level change.<sup>297</sup>

Experts have already developed approaches and curricula for teaching the skills of evaluating one's own attitudes about race and ethnicity and appreciating structural influences on health and health care.<sup>298</sup> Including the effective approaches in cross-cultural training might decrease the role of stereotyping and other forms of bias, thus reducing racial disparities in health care. It might also counter the risk that cross-cultural training, especially training that tokenizes racial and ethnic identity and concentrates on "difference," might actually result in transmitting or reinforcing essentialized understandings of outsider patients.<sup>299</sup>

e. Promoting Equality and Protecting Patient Status

If cultural competency efforts are to achieve the goal of reducing disparities in health care, the rules implementing those efforts should include some means of protecting patient status and promoting equality. Oddly enough, despite the stated goal of reducing racial disparities, few, if any, cultural competency proposals include such means. It may be that advocates have deemed such provisions unnecessary, politically immoderate, or beyond the scope of cultural competence. However, cultural competence should include a vigorous equality principle backed up by measures to directly enforce equality in access to, participation in, and quality of health care.

Existing laws that patients might use to enforce equality and protect patient status include Title VI and the doctrine of informed consent. Both laws, in their current state, have serious limitations. As discussed *supra*, while the Title

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297. NAT'L STANDARDS FOR CLAS, *supra* note 23, at 3 (requiring that "staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.").

298. *See, e.g.,* Kai et al., *supra* note 295 (concluding that medical school curriculum development should include training that promotes valuing diversity but avoids a narrow focus on cultural difference alone, promotes examination of learners' own attitudes and their appreciation of structural influences upon health and health care, provides training and support for teachers, links learning to assessment and professional accreditation, and integrates these components throughout the general curriculum); Delese Wear, *Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education*, 78 ACAD. MED. 549, 551 (2003) (using Giroux's concept of "insurgent multiculturalism" to shift attention away from a focus on minority groups to a study of how "unequal distributions of power . . . allow some groups, but not others, to acquire and keep resources," including the intangible and tangible resources of medical institutions).

299. *See* Fuller, *supra* note 88 (asserting that cross-cultural training that simply lists traits about other groups reinforces stereotypes). "Instead, this education must expose and eradicate the existing essentialist biases in medicine" and replace the essentialist viewpoint with one that recognizes that groups, cultures, and the individuals within them are fluid and complex in their identities and relationships. *See id.*; *see also* Kai et al., *supra* note 295, at 619-20.

VI prohibition on national origin discrimination provides important protections for LEP persons, Title VI protections have not yet reached their potential to address fully health care's cultural incompetence.<sup>300</sup> The prohibition on national origin discrimination has not been extended to other aspects of cultural competence nor has the Title VI prohibition on racial discrimination been used to require any aspect of cultural competence. In addition, the Supreme Court's decision in *Sandoval* contracts the concept of equal rights by eliminating the direct right of action for disparate impact claims.<sup>301</sup> Finally, civil rights experts have observed that in the process of evaluating civil rights claims by outsiders, courts devalue denials of access by either increasing the standard of proof or treating plaintiff's proof dismissively.<sup>302</sup> None of the evaluation of civil rights claims by outsiders means that Title VI cannot be used more expansively to address patient discrimination claims in health care, as Congress could amend the statute or courts may expand the scope. In particular, Title VI could address access problems at the structural level and barriers to participation in and quality of health care at the clinical level. Unfortunately, that may not happen any time soon.

In some ways, the doctrine of informed consent seems ideally suited to address patient status and related quality of care issues at the clinical level.<sup>303</sup> Informed consent has already played a significant role in improving patient status within the doctor-patient relationship. The doctrine has transformed the model of medical decision-making from physician paternalism to patient autonomy.<sup>304</sup> If language or other cultural differences interfere with provider-patient communication and prevent the patient from making a decision based on knowing and comprehending the relevant information, there is no informed consent. Any subsequent treatment may be actionable. Also, if provider bias results in a lower quality of care, the patient may have an action for negligence, or, arguably, for battery. Finally, as a tort doctrine, informed consent would provide patients with a direct right of action.

The doctrine of informed consent has at least three limitations that restrict its ability to provide sufficient protection of patient status and equal care for patients of color. First, in applying the doctrine, courts have focused almost

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300. See *supra* notes 153-209 and accompanying text.

301. See *Alexander v. Sandoval*, 532 U.S. 275 (2001).

302. See *Lado*, *supra* note 282, at 257-260.

303. Cultural competency materials and advocates regularly cite risk of liability as a reason to implement cultural competency. See, e.g., Nat'l Ctr. for Cultural Competence, *supra* note 143; see also Woloshin et al., *supra* note 48, at 725.

304. See JAY KATZ ET AL., *THE SILENT WORLD OF DOCTOR AND PATIENT* 48-80 (1984); see also RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 125-38 (1986).

exclusively on the content of the physician's risk disclosures.<sup>305</sup> The emphasis on disclosure keeps the authority and focus on the physician. It fails to provide a place for substantive patient participation. The patient's role is to say yes or no. So, despite its promise, the doctrine of informed consent currently does not provide a significant basis for protecting patient status vis à vis the physician. In addition, the emphasis on risk disclosure might narrow the opportunity for showing that cultural differences (other than language) accounted for the communication difference.

The second limitation of the doctrine of informed consent is the problem of proving causation when a cultural difference other than language or provider bias interferes with provider-patient communication or quality of care.<sup>306</sup> Proving that cultural differences caused the breach may suffer from the claim that culture is intangible or an insignificant determinant. The narrow intent-based definition of discrimination should not be used as the standard of proof for causation of breach, but, the dominance of the definition may preclude the court from considering or even seeing unconscious bias as sufficient proof.

The third limitation on the doctrine's potential to protect patient status and equality is that the doctrine contains no equality standard. In fact, the two primary standards for disclosure—the medical community standard and the reasonable patient standard—may undercut the goal of equality because neither standard takes the particular patient's needs into account. They are, in a sense, colorblind rules. They assume racial neutrality and an "equal playing field" for patients. Those notions, however, deny the possibility that institutional standards, cultural assumptions and norms express bias.

The limitations on the doctrine of informed consent do not nullify it. In its current state, the doctrine probably proves most useful for LEP patients who did not have language assistance (assuming they have access to the judicial system). The doctrine has the potential to evolve so that it provides greater protection for patient status, and to some extent, so that it ensures rights to equal care exists.

Perhaps one means of implementing the principle of equality at the clinical level is to enact legislation that realizes the potential of informed consent to protect patient self-determination and a right to equal care. A statutory doctrine could be process-oriented, rather than continue the focus on risk disclosure. It would recognize that proving the existence and causative role of institutional norms is no more difficult than establishing a medical community's standard of care. It would allow disparate impact, social science, and other race-conscious evidence to prove provider bias. And it would reject the prevailing standards for disclosure and use a subjective patient standard

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305. Katz, *supra* note 304, at 82-83 ("such disclosures do little to expand opportunities for meaningful consent").

306. See Crossley, *supra* note 285, at 248-49.

that expressly requires the court to take notice of race and other community-based cultural differences.

A more direct approach or one more clearly intended to express equality goals in cultural competence might be a statutory patient bill of rights. Recent efforts to enact a patient bill of rights have attempted to limit the discretion of managed care organizations in health care decisions.<sup>307</sup> This bill of rights would instead address the effects of nativism, ethnocentrism, and racism on access to and delivery of health care. Rather than focusing on the interests of the middle class, as does the recently proposed patient bill of rights in Congress,<sup>308</sup> this bill of rights would attempt to provide full access, participation and quality of care to currently disenfranchised patients. To achieve this goal, the bill should, above all, contain an equal protection clause—one based on disparate impact, as well as intentional discrimination.<sup>309</sup>

Political pragmatists may caution that a less obvious, more gradual approach to implementing cultural competence in health care is desirable. Pragmatists may note that bold ideas are less likely to survive the political fray, less likely to shape the political discourse, and therefore, less likely to emerge as law and effect real change. But if the idea of legally required cultural competence with express anti-racism and equality provisions seems bold, it is because the increasingly conservative political discourse, and the process it reflects, has confined civil rights and social justice work to maintenance and small improvements. The proposals discussed here are small. They accept, for now, the current health care financing scheme. They support existing proposals, use existing law, and adapt existing ideas. The vision is bolder than the proposals, but only because racial minorities have lived with so much less for so long. The vision described here needs expanding, not shrinking. Including a few more anti-racist tools and an equal protection clause are the minimum necessary to prevent the vision from shrinking.

## V. CONCLUSION

The current system of health care is incompetent. It contributes to and exacerbates racial disparities in health care and quality. Cultural competency efforts may expand access to, enable participation in, and improve quality of health care and related social services for minority patients. At best, those achievements will reduce, but not eliminate, racial disparities in health care and quality. The most significant determinants of racial disparities lie outside the health care system, but the harms are so pernicious that the effort to

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307. Dean M. Hashimoto, *The Proposed Patients' Bill of Rights: The Case of the Missing Equal Protection Clause*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 77, 77-78 (2001).

308. *Id.* at 80.

309. *Id.* at 88-90 (proposing the addition of an equal protection clause to the patient bill of rights that would impose limits on the discretion of managed care organizations).



implement cultural competency is essential. Placing hope in this effort requires optimism about the role of law in addressing institutional racism and in the dynamics of political discourse. That optimism may lead to overreaching, but the same optimism leads this author to hope that reaching for an anti-racist, equality-based vision of culturally competent health care cannot be wholly misplaced.