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Carlos A. Sanchez
San Jose State University, carlos.sanchez@sjsu.edu

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Cultural (Incompetence), Justice, and Expectations of Care: An Illustration

Carlos A. Sanchez
San Jose State University
Assistant Professor
Department of Philosophy

Abstract

The health care industry seems prima facie obligated to respond to the demands and expectations of those multicultural communities that make up its stakeholder base. However, as prima facie, this obligation fails to justify "cultural competence" amongst health care professionals or the health care industry. Without some justification, one can only assume that cultural competence is a bilateral process requiring multicultural communities themselves to assume the responsibility for their own care. Relying on a Rawlsian conception of justice, I argue against the view that cultural competence is a bilateral process in this case, and that health care professionals in particular and the health care industry in general have an obligation to attain to cultural competence in order to satisfy a fundamental principle of justice, what Rawls calls the "difference principle."

Keywords: Competence, Multiculturalism, John Rawls, Justice

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INTRODUCTION

We can agree on two critical, and interrelated, propositions right off the bat: the first is that multiculturalism in the United States has created a unique set of challenges to the health care industry that it must address (either for economic or for professional reasons); the second, necessitated by the first, is that some minimal degree of *competence* is required in order to properly recognize and address those challenges as they arise in the patient-physician relationship. The question is: where, or on whom, does the burden of competence lie? *Prima facie*, again either for economic reasons or professional ones, namely, those required by the Hippocratic Oath, it seems that the burden of competence falls squarely on the shoulders of health care professionals as a matter of *duty*. But is this *prima facie* duty assumed by health care professionals? It might be that health care professionals *internalize* the duty to be as competent as possible when dealing with their client base; but this might be a case of simply knowing that something is right but not believing in it enough to do anything about it.[1] In any event, it does not seem that this *prima facie* duty or obligation, the duty or obligation to cultural competence in this multicultural world, is convincing enough to justify the cultural understanding required to deal with those unique set of issues that multiculturalism gives rise to.

My aim in this paper is to speculate about health care access and issues of justice that might arise as a result of the emergence of multiculturalism in our society. Thus, mine is merely a speculative exercise—but I'll give one concrete example so as to illustrate my point throughout. My parents are originally from Mexico…Southern Mexico to be precise. Neither of them speaks

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[1] An example of this might be believing that everyone, regardless of race or class, is entitled to health care but not believing in this enough to be willing to pay higher taxes or support health care reform.

English, although they have tried desperately to learn it over the last thirty-two years. They understand it well enough to survive and prosper—relatively speaking. They understand North American culture. They are well aware, perhaps instinctively by now, of the nature of North American capitalism, its Protestant Ethic, its social hierarchies, the vital importance it places on certain professions, such as police officers, doctors, and lawyers (although judging from representation in the Media this is not self-evident); they understand, finally, their place in the culture and the limits it places on their own (social and cultural) mobility.

A family of eight, they've managed to *stay out of the way*, mostly: thus avoiding the negative aspects of social hierarchies, paying their taxes and keeping up with the demands of capitalism, and, most importantly, they have managed to avoid burdening the "sacred" professions, which means staying out of the court system, jail, and hospitals. With one exception: one of my younger sisters suffers from a severe mental disorder. Over the last 17 years she has been misdiagnosed, over-medicated, and under-treated: we still don't know what her mental disorder is! Every time I ask my mother about it she says: *well, the doctor said she's sick…but I didn't understand him*. So she buys the pills and hopes for the best. Whenever I request to speak to the doctor, nurses remind me that only my mother can speak for or on behalf of my sister.

Without getting too involved in this case, the purely speculative (epistemological) question is: why does my mother not know what is wrong with my sister? My answer is this: there is a breakdown in communication between my mother and the physicians where (a) my mother fails to clearly communicate what she expects from the physician, (b) the physician fails to understand both what my mother says and what she does not say, and (c) the physician stops short of asking the relevant questions in a way that is both clear and culturally sensitive. We can surely blame (a) for this breakdown in communication—my mother fails to clearly communicate what she expects. However, due to cultural factors pertaining to the "sacred" role of the physician,[2] my mother believes, and justifiably so, that her expectations, whether communicated or not, are being understood. She understands, *a priori,* that her ignorance is no match for the physician's superior intellect and advanced training. Again, this is a cultural factor. My claim is that we cannot hold her morally responsible *in this case*. On the other hand, both (b) and (c)—namely, that the physician fails to understand what my mother *does not say* and that he or she stops short of asking the relevant questions, require that we hold the physician morally blameworthy, since we can attribute both (b) and (c) to a certain degree of cultural incompetence. Again, as I said at the beginning, it seems, *prima facie,* that cultural competence is a physician's moral obligation.

WHAT IS CULTURAL COMPETENCE?

In a recent study published in the *Journal of General Internal Medicine*, researchers found that "Racial and ethnic minorities are more likely to perceive bias and lack of cultural competence in the health system" (Johnson, R., et. al., 2004, p. 106). In fact, minorities were 15 times more likely to hold this opinion than whites (p. 107). This lack of cultural competence, the researchers concluded, is in fact "a structural and clinical barrier to care" (p. 102). Indeed, since feeling misunderstood and being misunderstood coincide in this case—my sister's case—cultural incompetence *is* a barrier to care.

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[2] By and large, Latin Americans greatly admire and respect the opinion of the medical community. Philosophically, we can speculate as to the primary reason for this: an intimate, in fact, religious relationship with death and mortality. Doctors are not preventing the inevitable—as we are apt to think from our Western perspective; rather, doctors make the transition into death more tolerable, more welcoming, we can even say, easier. Doctors *know* death. This knowledge makes them unique amongst the living. As such, they *deserve* the respect and reverence which they get.

Broadly defined, cultural competence can be understood as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations” (Cross et al., 1989). Moreover, without cultural competence, “the *ability* of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter” is lacking (Johnson, R., et al., 2004, p. 102). And here we hit upon that aspect of cultural competence that lends it moral weight: it is an “ability” required by “health care professionals” to do their job!

In the example cited above, my claim is that cultural competence is completely lacking. It may be argued, however, that the multicultural landscape in which we live is so varied as to prevent something like a *multi*-cultural competence, that if cultural understanding is possible—through education or exposure, for instance—it will make one competent in *one* or two cultures, at most, but not all—it will not be *multi*cultural competence. While this is a fair objection, the point with cultural competence is that one is able to *be open* to the other’s difference and to be aggressive in the pursuit of that information required to make rational, informed, and professional decisions regarding a patient with a completely different set of expectations regarding his, hers or another’s care.

PRIMA FACIE DUTIES: WHAT ARE THEY?

At the start, I said that cultural competence was a *prima facie* duty which health care professionals must assume. What I didn’t explain was the nature *prima facie* duties and the reason why they might be difficult to assume.

In *The Right and the Good* (1952), his landmark ethical treatise, the English philosopher W.D. Ross argues in favor of a deontological moral theory grounded on what he calls "*prima facie* duties." *Prima facie* duties are duties that morally bind one to perform certain (morally significant) acts in certain (morally demanding) situations. Thus one has a *prima facie* duty to keep one's promises, to be grateful, to be just, to be benevolent, to self improve, and to refrain from causing harm to others.[3] The question arises: What if one recognizes multiple *prima facie* duties at the same time, for instance, one's duty to benevolence and one's duty to not cause harm? Ross suggests that here we see the virtue of this theory: namely, that some duties can and will often override other duties, depending, of course, on the circumstance, so that one's duty not to cause harm is, Ross says (1952), "of a more stringent characteristic" than one's duty to be good (p. 178). But just because *prima facie* duties are binding in different ways depending on the situation, it does not mean that these duties are arbitrary. In fact, Ross argues, "There's nothing arbitrary about these *prima facie* duties. Each rests on a definite circumstance which cannot seriously be held to be without moral significance" (p. 177).

When it comes to access to care, two *prima facie* duties are immediately intuited: duties of benevolence and duties of justice. Duties of benevolence, says Ross (1952), "rest on the mere fact that there are other beings in the world whose condition we can make better in respect of virtue, or of intelligence, or of pleasure," while duties of justice "rest on the fact or possibility of a distribution of pleasure or happiness (or the means thereto) which is not in accordance with the merit of the persons concerned" (p. 178). Thus, access to medical care is a duty that rests on the "mere fact" that a person's physical or mental condition *obviously* needs improvement. But it also rests on the recognition that *people in general* should have an opportunity to be happy or

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[3] This is a quick summary of the tentative "list" Ross provides. According to Ross, there may be other *prima facie* moral duties not included in the list.

free from pain. Whichever one of these two duties one determines as taking priority in cases dealing with access to health care is not important. On the one hand, the physician should act simply because of the “mere fact” that a patient’s physical or mental condition is in a state of need or, on the other hand, he or she should act from a general duty to alleviate pain in his or her fellows.

But, as we know, contemporary health care is essentially bureaucratic. There are forms to fill out, HMO’s to bill, superiors to answer to, etc. It is a business in a capitalist world. What this means is that as *prima facie*, as immediately recognized obligations, prima facie duties are *not mediated* through decision procedures that one can appeal to and thus use to justify one’s actions. Put another way, it would go against bureaucratic dogma to care for someone simply because that person is in pain—there have to be other reasons, for instance, that the person is a patient with insurance, that the person is recognized by the doctor as someone who she/he’s treated, that the person meets all the required qualifications for personhood (rational, not an animal), etc. Hence, while cultural competence is a *prima facie* duty related to both benevolence and justice, not many people would justify re-education in cultural understanding on the basis of the obvious, *prima facie*, necessity to do so. A doctor, for instance, who thinks it more important to keep up on the latest medical techniques might dedicate his time and resources to this endeavor instead of attending a seminar in cultural competence although, simultaneously, he recognizes that he *ought to* attend such a seminar for the sake of his patient roster. However, it would be easier to justify the first of these than the second.

RAWLS AND A DECISION PROCEDURE

The weakness of *prima facie* duties is that their recognition is immediate, so acting on them would require only that recognition. Most people, however, require more elaborate reasons to justify their actions. The more advanced the particular practice, for instance medicine and the business of medicine, the more elaborate the justifications required. Even though dealing with others is not such an advanced practice, the context is, namely, the health industry. Practitioners here require elaborate reasons for doing things, either because of “rules or regulations” or because of professional arrogance. In either case, reasons always satisfy some rule or other (either a professional or a persona rule); a decision procedure is, therefore, necessary.

If the basic *ethical problem* deals with the *inability* to attain to cultural competence, then the basic ethical problem is one of treating or not treating *everyone*, every stakeholder, fairly. Moreover, if, as I’ve suggested, this ethical problem is exacerbated by an unwillingness to act on *prima facie* moral duties due to their immediacy and lack of rational support, then what is needed in order to deal with this ethical problem is a decision procedure that both justifies one’s actions and fulfills some external requirement.

I want to suggest that the work of American philosopher John Rawls offers a decision procedure meant to be both justificatory and just. In his *A Theory of Justice*, Rawls argues that all social arrangements should be structured so as to benefit the least advantaged members of society. This is known as the *Difference Principle*, and Rawls (1999) puts it in the following way: “Social and economic inequalities are…to be to the greatest expected benefit of the least advantaged members of society” (p. 53). As an integral element of any egalitarian decision procedure, the “difference principle” lays out a plan of action meant for us to ensure that everyone has equal access to opportunities, whatever these may be. However, because people will generally find themselves either advantaged or disadvantaged with respect to those opportunities as a result of economic, physical, mental, linguistic, or cultural barriers, to name a few, access to those opportunities made *available to all* must be biased so as to guarantee the greatest probability of access to those who are least likely, or least capable, of taking advantage of them. In our case, when it comes to health care access, health care professionals are required to attain to cultural competence even at the expense of disadvantaging (we could even say, inconveniencing) bureaucratic economics and efficiency as well as certain sectors of their client base who would consider cultural education as a waste of valuable, and most times scarce, resources that could be best used for technological or scientific upgrades.

LET ME CONCLUDE…

Cultural expectations, which any member of an alien culture brings with him or her to the doctor-patient relationship, are barriers to proper medical care if and when these expectations are neither understood nor addressed. Of these expectations, examples abound: these may be religious, as when a patient expects not to be undergo a particular procedure because of reasons pertaining to religious dogma; these may be social, as when a patient expects her doctor to *know* the source of aches and pains without communicating these aches and pains to the doctor; or these can be cultural-linguistic, as when the patient expects a minimal degree of understanding and acknowledgement from her doctor. Ultimately, at the risk of inconveniencing a certain population, or of inconveniencing themselves, physicians must, as a matter of justice, attain to cultural competence. It is a duty justified through reason, compassion, and a sense of justice. As Rawls (1999) puts it: “Thus we are led to the difference principle if we wish to set up the social system so that no one gains or loses from his arbitrary place in the distribution of natural assets or his initial position in society without giving or receiving compensating advantages in return" (p. 87). Indeed, as a decision procedure the difference principle asks us to consider our actions, those who will be affected by those actions, and whether or not they will be advantaged by our actions. If our action is to attain to cultural competence for the sake of individuals who by historical accident do not speak our language or have a different set of expectations when they deal with us, then these folks will be advantaged by our actions and our actions are—whether or not it contributes to the bottom line—just. Again, mine is merely a speculative exercise motivated by a genuine wish to *know* the extent of my sister's illness and a sincere belief that cultural incompetence is what is keeping many of us in the dark.

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