LETTER TO THE EDITOR

To the Editor:—The recent *JGIM* issue on health disparities contained a number of thought-provoking articles. Many of those articles pointed to the role of culture and cross-cultural miscommunication in the perpetuation of disparities. As a medical anthropologist and a physician, I am encouraged by the increasing recognition in the medical and public health communities of the role that culture may play in health and health-related behaviors. At the same time, I am also concerned by the tendency in the cultural competency literature to present cultural competency as a panacea against racism and health care inequality.

For example, in the article by Johnson et al.,¹ the authors studied whether “racial and ethnic differences exist in patient perceptions of: (1) individual physicians’ bias and cultural competence; and (2) bias and cultural competence experienced at health care system-wide levels.” They found that once demographics, source of care, and self-rated health status were controlled for, there were virtually no differences by race or ethnicity in patient perceptions of the degree to which their physicians respected and understood them. By contrast, when they looked at experiences in the health care system in general, minority patients were much more likely than white patients to feel that they were disrespected and received poorer care due to their race/ethnicity and language. The authors conclude that minority patients “are more likely to perceive bias and a lack of cultural competence in the health system overall than are whites.”

That is a problematic conclusion. Questions to patients about feeling disrespected and mistreated due to race and language cannot and should not be glossed over as questions about “cultural competence.” They are questions about racial bias—questions about disrespect and lack of care based on how a person looks and sounds. That said, the authors are certainly not alone in considering racism an element to be addressed under the rubric of cultural

competency. In fact, they point out that the design of their study reflects well-recognized definitions of cultural competence that consider racism and stereotyping (along with socioeconomic status, lack of access, and cultural issues) to be central issues for cultural competence programs. Presumably, the encompassing nature of these definitions reflects the understanding that health care disparities will not be solved only through attention to cultural differences. Thus the definitions suggest that cultural competency should address other elements, like racism, that contribute to those disparities.

But race is not culture and racism is not simply a lack of cultural competence, and to present racial bias as a lack of cultural competence dilutes the terrible importance of racism in perpetuating disparities. Furthermore, this thinking ultimately shifts responsibility for bias away from biomedical institutions, by suggesting that the central problem arises from cultural dissonance. Therefore, although it is the institution that is called upon to become more competent, the unspoken locus of the problem lies in the patient’s cultural difference, and not in the institution’s generally unconscious bias.

Thus, while it is clearly true that to effectively address health care disparities we must also consider the impact of race, poverty, and access, it is also true that these problems are large and important enough that they need to stand alone. If we lump them together and label them as problems of cultural competence, they become much more palatable and, unfortunately, much easier to ignore.—**JESSICA GREGG, MD, PhD**, *Tulane University Medical Center, New Orleans, La.*

Reference

1. Johnson RL, Saha S, Arbelaez JJ, Beach MC, Cooper LA. Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *J Gen Intern Med.* 2004;19:101–10.