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Ethics, Cultural Competence, and the Changing Face of America

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Abstract

The population in the United States is increasingly multicultural. So, too, is the U.S. physician workforce. The combination of these diversity dynamics sets up the potential for various types of cultural conflict in the nation's examining rooms, including the relationship between religion and medicine. To address the changing patient-physician landscape, we argue for a broad scale intervention: interdisciplinary bioethics training for physicians and other health professionals. This approach seeks to promote a common procedural expectation and language which can lead to an improved, patient-centered approach resulting in better patient-physician relationships that contribute to better health outcomes across the U.S. population. The authors illustrate their thesis and solution using a well-known case of cross-cultural dynamics taken from religion and medicine —Anne Fadiman's *The Spirit Catches You And You Fall Down*.

Keywords

Bioethics; Patient-physician relationship; Physician workforce diversity; Religion and medicine

Introduction

The image of a mosaic has been a decades-long metaphor for the patchwork of peoples and cultures that make up the American experience. In the 21st century, the metaphor has become reality. Racial and ethnic minorities make up the fastest growing portions of the population in the United States today (Nakamura 1999). The widely discussed forecast is that by the 2050 Census, the population of the United States will become majority minority. In other words, the faces and cultures that make up the nation will have become mostly a collection of persons whose heritage is less European and more Latino, Asian, and African. And for Americans who live in Texas, Hawaii, California, and New Mexico, the future is now; the mosaic was estimated to have been realized by 2010 (Census news release 2005; Census briefs 2010).

Changes in population diversity present challenges and opportunities for an already complex matrix of care sites and types in an arguably over-burdened and inequitable health care system. Cultural competence is one concept which has been advanced as important to the discourse and practices of care delivered within systems; it originated as a means of improving care for emotionally disturbed children (Cross et al. 1989). Cultural competence acknowledges strengths in all cultures, and its goal of service improvement focuses on members of four target minority groups: African American, Asian American, Hispanic American and Native American. Early researchers envisioned the term as a philosophical

framework in which, over time, care givers progressively gained skills in negotiating the cultural differences between themselves and the children they served (Cross et al. 1989). The aim of cultural competence in health care (or any service delivery system) is to utilize its techniques as one means to better understand the targeted patients, and which improves health issues and outcomes which racial and ethnic patients face in the U.S. medical milieu (Betancourt et al. 2005). Less often discussed is the impact that the population diversity of the medical profession itself has on the patient-physician cultural exchange that is inherent in any medical encounter. Bioethicist Leigh Turner observes that “the concept of culture is no longer simply used to explain the ways of life and forms of understanding of distant societies, but . . . refers to the dominant values, symbols, social practices, and interpretive categories of *any* community” (emphasis added) (Turner 2005). Giving attention to culture in this way and connecting it to the demographic trends among us have the potential to mark the art of medicine and to impact patient experiences in U.S. health care in the coming decades (Adelman et al. 2000). Aspects of culture such as beliefs about the cause of diseases, pain relief, truth telling, religious beliefs and practices, the organization of social units, decision making, and moral codes can impact interactions between patients and their treating physicians (Juckett 2005; Turner 2005).

We suggest that physician and patient diversity both may have a profound impact on social organization, stress, and health, at the individual and systemic level and should be addressed in the research and discourse related to the social determinants of health. There are data that give rise to the kind of challenges that may lie ahead in the delivery of health care to all persons regardless of age, race, gender, and socioeconomic status. The discussion in this paper could examine various aspects of the patient-physician relationship; however, here, we focus only on two: the significance of the patient-physician relationship, and the potential to impact the patient-physician relationship through training in bioethics.

We begin with the brief description of a well-known case from religion and medicine.

A case from religion and medicine

The Spirit Catches You And You Fall Down is an oft-used text in the medical humanities and other settings where illustration of cross-cultural medicine is taught. It offers a case study on the failure of members of the biomedical culture and members of the Hmong culture, the Lee family, to find ways to collaborate with each other, even though they both desire to improve the health of the youngest Lee child, Lia.

The author of *Spirit*, Anne Fadiman, outlines the aspects of the history of the Hmong people that contribute to what she interprets as their fiercely independent nature. According to Fadiman, in recent history, the Hmong were among the paid mercenaries fighting for the U.S. in the Vietnam War. When the U.S. ended its troop deployment there in the mid-1970s, some members of the displaced mercenary community immigrated to the U.S.; clusters of Hmong settled in Merced, California, and Minneapolis, Minnesota.

Eight-month old Lia had recently been diagnosed with epilepsy. According to Fadiman, the Hmong historically hold fiercely to their culture. One aspect of their culture locates the origin of and solution for epilepsy and other illnesses in spiritual causes. In Hmong culture, the spiritual cause of epilepsy is that something has caused the soul to leave the body (Fadiman 1997). In Lia's case, one day her older sister slammed the front door of the family apartment as she was entering their home. In the parent's purview, the slam of the door was the moment that Lia's soul fled her body. When Lia experienced her first few seizures, her parents took her to the emergency room to seek medical attention. Western medicine would be able to address the physical symptoms, but the parents retained their traditional, culturally-relevant treatment practices, including consultation with a shaman, to address the

spiritual aspects of Lia's illness. In Fadiman's account, Merced-area physicians are experts in biomedical treatments including the use of drugs, but they are ill-informed about Hmong culture and how to work with it to create an optimal patient-physician relationship. The author notes that there are a variety of approaches to care for Lia (and that of other Merced Hmong) by the local medical community, but one physician, the primary pediatrician, finds unacceptable the parents' inability and sometimes resistance to properly administering the anticonvulsants he prescribes. Eventually he reports her parents' failures to the child protective services agency for an investigation of child endangerment. In the book, Fadiman conveys that he wants to send a message to the Lee family as well as to other members of the Hmong culture about acceptable behaviors when they enter the Western biomedical system. Fadiman writes a compelling account of the Lee family's ordeal, Lia's health during foster care, and the various miscommunications. By the end of the book, the reader learns about aspects of Hmong culture, including perspectives on religion and on medicine and how Hmong cultural traditions and Western biomedical traditions can clash. We will return to analyze Fadiman's account of the Lee family below.

Changing demographics and the patient-physician relationship

Changing demographics are affecting the U.S. health care system. First, the U.S. population is coloring *and* it is aging (U.S. Census Bureau 2010; The Federal Interagency Forum on Aging-Related Statistics 2010). Second, by some estimates, international medical graduates and U.S. medical graduates of color are providing a majority of primary and safety net care (AMA-IMG position paper 2010; AAMC 2010). Finally, major changes in physician and population diversity are occurring at a time of health care reform when discussions abound about the need for continuity of care (e.g., electronic medical records, medical homes where patients obtain routine primary and preventative care), and the health care discussion is shifting from access to care to quality and cost of care. The long-term impact of a patient-physician relationship may be not only to prevent the accumulation of further health disparity but may also be to alleviate past inequities and set people on a more advantaged health and life trajectory (Marmot and Wilkinson 1999).

The number of Americans over the age of 65 is projected to double between 2006 and 2030, when it will reach 71.5 million, or nearly 20% of the U.S. population (The Federal Interagency Forum on Aging-Related Statistics 2010). More and more Americans are living past age 65 with fewer functional limitations compared with persons in their age group in previous generations (The Federal Interagency Forum on Aging-Related Statistics 2010). However, older Americans can expect to live with chronic disease such as hypertension, diabetes, and arthritis (The Federal Interagency Forum on Aging-Related Statistics 2010). To manage the costs associated with longer life, including chronic disease, clinical and social science researchers will be challenged to continue to seek to understand the social and intrapersonal nuances of health care as well as the physiologic aspects (Greene et al. 1989).

As mentioned above, the portion of the U.S. population that is aging is growing, and there are special features of the relationship between the older patient and his/her physician. Elderly patients can have multiple medical problems to discuss during an office visit and are more likely to have a companion accompany them during the encounter with their physician (Adelman et al. 2000). Older patients may also face ageist beliefs or false notions about older individuals (Adelman et al. 2000). Ageist beliefs include stereotypes such as beliefs that older patients are senile or preoccupied with death; that they are hypochondriacs or difficult persons; or that their illnesses are difficult to treat (Greene et al. 1989). To be sure, some older patients *do* suffer from dementia; some *are* frail—adding a degree of difficulty to scheduling office visits when they feel well enough to be transported and when a companion is available to attend with them; and other elders have reduced functionality that can provide

challenges to the logistics within the examining room, such as whether a patient can maneuver to climb and sit on the examining table (Adelman et al. 2000). But elder patients are a heterogeneous group, and the range of issues, including sensory deficits such as hearing or vision loss or functional or cognitive limitation, can vary broadly (Adelman et al. 2000). A strategy is needed that effectively and efficiently identifies which of the special issues relates to a particular elder in order to efficiently build rapport and trust between a particular patient-physician pair and to replicate the same process across physicians who treat this portion of the U.S. population.

Research from Stewart, Brown, et al. suggests that there could be a cost reduction impact from patient-centered care (Stewart et al. 2000). Their study of patient-physician communications in adult primary care settings included obtaining clinical symptoms and having the physician seek to understand patients' feelings about their illness, to understand the patient holistically, and to develop a patient-physician management plan agreeable to both parties (Stewart et al. 2000). One result from the study, which included elders as well as patients from younger age groups, was that "patients who perceived that their visit had been patient centered received fewer diagnostic tests" (Stewart et al. 2000). The authors suggest that one possible interpretation for this result is that "increased participation during the visit may have reduced patients' anxiety and their perceived need for investigations and referrals," which go hand-in-hand with insecurities that could have been raised among patients who did not feel understood (Stewart et al. 2000). Adelman et al. (2000) caution against automatically applying patient-physician relationship findings to older patients when a study has included both demographics (Adelman et al. 2000). However, they agree that the interpersonal aspects of the patient-physician exchange are part of the "art of medicine" and that "the science and the art of medicine are interdependent and inextricably bound" (Adelman et al. 2000).

Even as a growing portion of the U.S. population is aging, a growing number of younger faces in the country are coming from nonwhite racial and ethnic groups; in short, America's face is coloring (Population Profile 2010; U.S. Census Bureau 2010). In the last 10 years, the nation has grown fastest among persons who identified their ethnicity as Hispanic or Latino or Asian as well as among persons who completed the Census form by reporting their race as "something other" than "White alone" (U.S. Census Bureau 2010). Between 2000 and 2010, persons who categorize themselves as white experienced a growth rate of only 5% while the fastest growing portions of the population, persons identifying themselves as Hispanic/Latino or Asian, experienced a growth rate of more than 43% (U.S. Census Bureau 2010).

These growth rates, between 5% and 43%, point to the trajectory of the future of the nation. The segment of the population identified as white continues to be the largest racial category in the U.S., even though the growth rate was lowest; whites comprise 72% of the population, compared to 75% in 2000 (U.S. Census Bureau 2010). The next most slowly growing group, persons who identify as black or African American, now represent 12.6% of the population, up slightly from 12.3% in 2000 (U.S. Census Bureau 2010). Nearly 5% of the population now identifies as Asian, up from just over 3.5% in 2000. Latinos or Hispanics now make up 16% of the U.S. population, up from 12.5% in 2000 (U.S. Census Bureau 2010).

Physician workforce demographics

Demographic shifts indicated in the general population are also reflected in changes in the physician workforce. International medical graduates (IMGs) have long been a part of the U.S. physician workforce (AMA-IMG Council 2010). IMGs are so termed in that they attended medical school outside the U.S. and seek entry to residency programs in the United

States (AMA-IMG Council 2010). When the U.S. was a new nation there were only three medical schools in the country (AMA-IMG Council 2010). In the 19th century, U.S. physicians were often trained in France and Germany where the medical education systems were much better established (AMA-IMG Council 2010). In the 20th century, undergraduate medical education in the U.S. was standardized and graduate medical education began to adopt the house assistant training model that had been developed in Germany (AMA-IMG Council 2010). By mid-century when residency training programs came into extensive use, house staff positions sometimes went vacant (AMA-IMG Council 2010). Residency training programs, especially those that were free-standing, that is, unaffiliated with a medical school, began to recruit IMGs to complete their house staffing needs (AMA-IMG Council 2010). The number of IMGs that entered U.S. residency increased fourfold between 1950 and 1959 (AMA-IMG Council 2010). Today, more than one-quarter of trainee-physicians in U.S. residency programs are IMGs; 75% of IMGs were born outside the U.S. (AMA-IMG Council 2010).

IMGs help to inject cultural and ethnic diversity into the U.S. physician workforce (AMA-IMG Council 2010). In 2010, the Association of American Medical Colleges compiled a report of the diversity among physicians who had attended medical school between 1978 and 2008 (AAMC 2010). Of U.S. medical school graduates, more than 400,000 were estimated to be providing patient care (AAMC 2010). Of U.S. medical school graduates practicing medicine, 75% racially identify as white, nearly 13% identify as Asian, 6% as black or African American, 5.5% as Hispanic or Latino, and less than 1% as Native American or Native Alaskan (AAMC 2010).

Primary care practitioners, the physicians who some expect to coordinate care, are a more diverse group than the general physician workforce (Nutting, Miller, et al. 2009; Sia et al. 2004; Fisher 2008; Davis et al. 2005; AMA-IMG 2010). International medical graduates and African American and Latino U.S. medical graduates are more likely to practice in primary care than whites (AAMC 2010). They are also providing care in underserved areas (Shomaker 2010). IMG members of the American Medical Association estimate that they now provide the majority of primary care in the U.S.—nearly 60% between the 28% in pediatrics and the 37% across various adult primary care specialties (AMA-IMG Section position paper 2010). IMGs hail from 127 countries. (AMA-IMG Section 2010). The top four countries where IMGs physicians completed their medical education are India, the Philippines, Mexico, and Pakistan (AMA-IMG Council 2010). The AMA-IMG Council estimates that 75% of IMGs remain in the U.S. after completing residency in the U.S. (AMA-IMG Council 2010). IMGs are men and women of color who bring with them a cultural background that is often grounded in Eastern sensibilities (Miyasaka et al. 1999).

The transfer of technical competency is not of concern here. Academic requirements that help to standardize the preparation of IMGs who wish to gain entry into U.S. residency programs are set by the Educational Council for Foreign Medical Graduates (ECFMG) (AMA-IMG Section Council 2010). To gain entry into a US residency training program, IMGs complete a number of requirements including an English language skills test. Another primary requirement is the passing of a clinical skills assessment (Whelan et al. 2005). This assessment includes an interpersonal section in which graduates should be able to demonstrate communication skills needed in the medical encounter, including rapport, expression of empathy, and listening. The clinical skills assessment is evaluated across ten standardized patient encounters (Whelan et al. 2005). Standardized patients are specially trained to interact with potential residents to help them learn how to obtain a clinical history and how to perform a physical examination (Ainsworth et al. 1991). Failure to pass the doctor-patient communications skills section can result in failure of the clinical skills assessment (Whelan et al. 2005). The simulated examining room encounters, as well as

those experienced in professional practice, present the opportunity for the emergence of the science *and* art of medicine to converge in order to create a satisfactory patient-physician encounter.

Kaplan et al. (1989) acknowledge that “patient satisfaction is by far the most recognized and widely used measure for gauging the effectiveness of physician-patient communication.” Efforts to conduct and experience a satisfactory encounter between doctor and patient also must meet the challenge of cultural exchanges.

A study conducted by Chen et al. (2005) concluded that some patients express greatest satisfaction in their physician relationship with a doctor who is racially or ethnically concordant with themselves. Racial or ethnic concordant preference has been found to be related to a shared language, shared social experiences, and shared cultural beliefs (Chen et al. 2005). A majority of participants in Chen et al.’s national telephone survey stated that if they had the freedom to choose, they had no preference as to the race or ethnicity of their physician (Chen et al. 2005). However, when patients had a preference, many of them selected physicians that met their preference, and among African Americans and whites, patients were more likely to express satisfaction in racially concordant relationships—by rating the treating physician as excellent—by considerable margins (Chen et al. 2005). Twenty-two percent of African Americans, for example, preferred to have an African American physician, and of this group, 39% reported that their personal physician was African American. Thirty-four percent of Latinos preferred a Latino physician, and 47% of this group matched their preference by choosing a Latino physician (Chen et al. 2005). The goal of their study on racial beliefs, preferences, and satisfaction was to gauge black and Latino preferences for race-concordant physician relationships, so although whites were included, the analysis regarding whites’ attitudes concentrated on whether a race discordant relationship made a difference in their satisfaction with their personal physician. Importantly, satisfaction with their physician was highest among blacks and whites who held race-concordant preferences and had a personal physician whose race or ethnicity corresponded with their in-group preference. African Americans with race-concordant preference were three times as likely to rate their physician as excellent than were African Americans for whom concordance did not matter or who had a preference but did not have a racially concordant physician relationship (Chen et al. 2005). Whites rated satisfaction as excellent twice as often when they and their personal physician were racially concordant (Chen et al. 2005). Only among Latinos did there appear to be no bearing on level of satisfaction: neither ethnic preference nor ethnic concordance had an effect on whether Latino respondents rated their personal physician as excellent (Chen et al. 2005).

Race and ethnicity concordance-satisfaction results are important in at least two ways. Cooper et al. (2003) found that race-concordant patient-physician encounters were over 2 min longer than were encounters of discordant pairs; patients more often rated these visits as positive interactions and were more likely to have seen physicians engaging in a participatory manner (Cooper et al. 2003). Although Cooper et al. (2003) did not link concordance with satisfaction, patients and physicians interpreted the duration of their visit as an important indicator of the quality of care. The length of time was connected to comfort with decision making as well as whether the decision making was a shared process between physician and patient. Satisfaction, thus defined, has been linked to perceived health status and to improved health outcomes. Past research has documented that socioeconomic status is a primary predictor of health status and health disparity (Marmot and Wilkinson 1999). However, an unanswered research question is whether concordant relationships also produce measurable improved health outcomes among groups with health disparities.

Thus far, we have seen that concordant relationships can facilitate communication and result in a patient who expresses greater satisfaction. A more satisfied patient may, in turn, result in a patient reporting better health status, upon follow up, as measured by functional status and subjective evaluation of one's own health (Kaplan et al. 1989). Concordant relationships also produce more free-flowing patient-physician interviews that elicit more lifestyle discussion as well as more medical information, thus contributing more information that will help the patient and physician manage illness (Eamranond et al. 2009; Greene et al. 1989). It is not possible, however, to achieve racial or ethnically concordant patient-physician relationships across the U.S. healthcare system. The racial and ethnic diversity of the U.S. physician workforce matched against the demographics of the patient population will not support racially and ethnically concordant matches—even as both of these agent populations are in the midst of shifting in the coming decades. Furthermore, there is less research available on other factors of patient and physician diversity that may be of equal or greater interest for concordance, such as gender, sexual orientation, or religious values and beliefs. The question of concordance is one factor in the patient-centered care model, and the patient-physician relationship at the heart of this model is an issue for U.S. medical graduates and international medical graduates alike.

Data from a study conducted in Houston, Texas, suggest that the interpersonal skills and characteristics needed to enter medical school can be sidetracked during preparation and socialization into the profession (Haidet et al. 2002.) In their study, Haidet and his associate researchers measured empathetic attitudes and other indicators of patient centeredness among classes of first-year medical students. Patient centeredness was reported in sub-scores called “caring” and “sharing.” The caring subscore was represented by empathetic attitudes; sharing included the shared power in the encounter between patient and physician and the sharing of information with the patient by the doctor. Female students in their first year tended to have the highest levels of patient centeredness. Patient centeredness in male students reached its peak as the students left the theory of the classroom and entered the examining rooms filled with actual patients. The statistically significant finding in the authors' study was in the interaction between gender and year in medical school. By their fourth year, the average class score was lower than when students began their first year. Beyond gender, the authors hypothesized that results may also indicate potential links between ethnic identity and a tendency toward patient centeredness. The authors hypothesized that there may be cultural differences in the manner of conveying empathy as well as in the degree of empathetic expressions. The researchers suggested that some students may come from cultural backgrounds in which the physician role is seen as more paternalistic or authoritative and that the medical students enter their training with this idealized doctor-centered role already formed. In this study, approximately 50% of the fourth-year students were of Euro-American descent; more than 60% of the non-Euro-American students self-reported Asian ethnicity, nearly one quarter self-reported Hispanic ethnicity, and 9% African American. Although scores were not provided for each ethnic group, non-Euro-American students scored lower on the total score as well as caring and sharing subscores. Findings from these researchers suggest that during the medical school learning process, students gain clinical knowledge and skills and often learn to deemphasize their sense of patient centeredness and that the medical students' cultural background could also be a factor in how patient-centeredness may be demonstrated.

It is the last issue about patient centeredness that advances the argument of cultural exchange. As these students continued in medical school, they were acculturated into more doctor centeredness, accruing greater potential to miss cues during communication with patients. Although the theory of patient centeredness began in pediatrics, it has been extended to primary care more generally (Sia et al. 2004). In the Haidet and colleagues' study, medical students considering primary care already have a greater tendency toward

patient centeredness. The ability to retain this tendency is a challenge in a culture that, rightly so, values technical competence. This research supports that one goal in graduate medical education and professional development will need to shift to mechanisms that encourage its retention at the highest levels, especially given that discordant race, ethnic, cultural and socioeconomic backgrounds of patients and practitioners is growing in the U.S.

Patient-physician relationship: Social determinants of health

The societal conditions that affect health and that have the potential to be altered by social and health policy programs are included in three broad categories of the social determinants of health (Anderson et al. 2003). At the community and individual level, social institutions, social relationships, and physical surroundings have more than a fleeting impact on patterns of health and illness (Anderson et al. 2003). Despite the recognition that social conditions can impact health, patterns of health and well-being, and illness, a systematic response to address and alleviate social conditions in micro-systems can be challenging, and in macro-systems, it can be almost impossible. During the past century, a proportional decline in health behaviors has resulted as the social determinants of health and the medical system have become more complex (Bunker et al. 1989).

It is in the hypothesized mechanism by which social or societal factors influence population health that the patient-physician relationship can be included. While population health effects are mediated by different factors at each stage of life, the health impact of individual health behavior remains a constant across the lifespan. Included in the literature is a plethora of data on the physician's role as a primary participant and trusted source of health information, as a referral resource to various prevention resources, as a necessary partner of the treatment team, and as an information resource at the end of life (Gerber and Eiser 2001; Murray et al. 2003; Metsch et al. 1998; Deber 1994). In short, physicians remain the primary entry point across the life cycle to the numerous resources in the health care system (The Segmentation Company a division of Yankelovich Inc. 2007; U.S. Department of Health and Human Services 2011). The quality of the physician-patient relationship can be an important mediating factor and—play a positive or negative—role as a social determinant of health.

Discussion

A return to the case of Lia Lee is a helpful way to understand how these various factors—patient demographics, cultural values, and the patient-physician relationship—can converge.

Spiritual beliefs are one key to understanding the cultural disconnect between the Lee family and the treating physician who decided that he needed the assistance of the local child protective agency to enforce his medical orders. According to Fadiman's narrative of this real-life drama, for the Hmong, everything is related to spirituality (Fadiman 1997). Patients who have strong spiritual beliefs or who maintain a sense of spiritual causes of illness may need additional support from a religious specialist such as a hospital chaplain or a personal spiritual counselor who can work alongside or as a member of the medical care team. However, even without this specific cultural knowledge, consideration for the family using the bioethical principle of autonomy could have met with a more dialogical relationship between the family and the reporting physician.

In the brief decade since *Spirit* was published, its human sciences approach and the increasing empirical research in the areas of bioethics, cultural competence, and religion-and-medicine have helped to broaden the potential to better understand how these aspects of clinical encounters impact individual cases as well as those of population groups. The Merced medical community has since offered a series of community education

opportunities, including training Hmong shaman, about medical procedures. These measures have been intended to increase trust between members of the Hmong community and local hospital staff. In addition, the hospital staff has reconsidered points during care where Hmong shamans may be included and they now conduct some 85 interventions and rituals (Mochel et al. 2007). This cross-cultural partnership—marrying cultural beliefs with biomedical technology—can help build case-by-case relationships and trust between communities, the social units where culture resides.

Relationships between doctors and patients are built on layers of trust (Pilgrim et al. 2010). Pilgrim et al. (2010) note in their book, *Examining Trust in Healthcare*, that trust in the competence of health care professionals is assumed. Patients take it for granted that professionals (health care and otherwise) have gained the knowledge and skills they need to work in the capacity and role for which they are being consulted. A patient enters relationship with a physician with competence as the minimal level of trust. Although the competence aspect of trust does not usually need to be earned, it can be lost, such as in the event of a consequential error, according to the authors. The expectation of technical competence is supported by codes of ethics, institutional mechanisms, and laws governing roles and responsibilities of professionals. Since this is the minimal level of trust, it becomes evident that building a relationship between a physician and a patient that helps to generate good health involves more than the clinical knowledge and skill: it must involve something in their interpersonal exchange.

LaVera Crawley credits D. E. Cooper with adding two more dimensions of trust beyond the competency expected in the patient-physician relationship: fiduciary trust and trustworthiness (Crawley 2001). The fiduciary dimension of trust acknowledges that there is an inherent power differential between the patient and the physician, and that this reality requires that patients choose to extend a level of trust believing that physicians and the institutions within which they work will do the right thing with regard to providing effective medical care. In the third dimension of trust, Crawley suggests that providers and institutions should reframe the discussion of mistrust on the part of patients to one that reflects on and explores the ways that the trustworthiness of physicians and their institutions is evident. Trustworthiness is demonstrated in what she refers to as “humanistic qualities”—virtues such as “compassion, altruism, empathy, credibility, honesty and reliability.” Crawley observes that race, ethnicity and culture complicate developing trust. However, according to Crawley, a communication style that uses language that the patient understands is a primary means of demonstrating these virtues. These qualities are important markers which patients use to determine whether they should enter a relationship that allows a physician to exercise all of his/her medical competencies on behalf of the patient.

Thus far, we have noted that the U.S. population is becoming more diverse and is projected to be majority minority nationwide by the middle of the twenty-first century, just as some cities and four states already are. We have noted that the U.S. physician workforce is becoming less white and more international and that primary care physicians may be among the most diverse medical practitioners because greater percentages of men and women of color from the U.S. and beyond practice primary care. We have cited research that social, specifically, racial concordance between a patient and his/her physician can improve patient satisfaction with the medical encounter and produce measurably enhanced communication. Finally, we have noted that trusting relationships can be built through communication despite discordant social factors in the patient and the physician. Most importantly, we have shown that the literature indicates learned interventions that increase communication between patients and their physicians, especially where chronic disease is being managed within that relationship, can lead to better health outcomes—both as perceived by the patient and as measured physiologically (Kaplan et al. 1989). Researchers also indicate that patient-

centered communication may produce more efficient patient visits, an effect that can translate to reducing diagnostic tests and referrals (Stewart et al. 2000).

The demographic trends and patient-physician communications research described here point toward other potential research questions. One of our ongoing research questions is whether there are training mechanisms that can help to retain the patient centeredness that medical students, especially those who desire to practice in primary care, possess when they begin pursuit of a medical career. Further, we indicate that the aspect that research in patient centeredness ought to help address is the coming demographic shift in the U.S. physician workforce and patient population through mid-century and beyond. We suggest here that bioethics training offers one solution, and that through content that incorporates various features of diversity, it can be an efficient solution.

Bioethics training moves beyond the professional medical ethics curriculum (Carrese and Sugarman 2006; Lehmann et al. 2004). Patients may assume their physicians obtain a certain level of technical skill and professionalism, the latter often being the focus of medical ethics curriculum. A survey of 141 medical school deans in the U.S. and Canada indicated that 54 of the schools, 38%, provided no funding for curriculum development and 20% provided no funding for ethics teaching (Lehmann et al. 2004). Besides too little funding, inhibitors to improving the ethics education includes a “lack of time in the curriculum, the [lack of] availability of qualified teachers, and a lack of time in medical school faculty schedules” (Lehmann et al. 2004). There are no easy solutions to these intractable issues, but a curriculum funded and developed from external sources can help address some aspects of the problem. Guest lecturers, while not ideal, can help to supplement faculty (Lehmann et al. 2004).

There is no ideal medical ethics curriculum in Western or Eastern medical schools (DuBois and Burkemper 2002; Miyasaka et al. 1999). One study of U.S. medical school ethics syllabi found that typical elements of what could be an ideal curriculum would include approaches to the examination of ethical dilemmas; development of the professional ethos; patients’ autonomy and clinical dilemmas; and social issues in health care, such as the allocation of resources, among others (DuBois and Burkemper 2002). These valuable topical areas do not necessarily address the complicating demographic issues that we have injected here. A broader program in bioethics, staged throughout the classroom and clinical preparation and practice could help to serve additional, multiple purposes (Lehmann et al. 2004; Carrese and Sugarman 2006). A bioethics curriculum would address moral obligations of the practitioner as well as the value system of the patient, the family, and the physician (Carrese and Sugarman 2006). A bioethics curriculum would make the important connection to culture wherein values, preferences, and perspectives are formed (Carrese and Sugarman 2006). Bioethics provides a means of understanding the patients’ perspective as they experience health care encounters, including how and how much they weigh decision making and their participation in their own health (Beach et al. 2005). As argued by Engelhardt (1996), bioethics offers a “content-less secular ethics” since the plurality of canonical and secular moral systems would make it impossible to discover and establish a singular ethical system. Likewise, bioethics training provides a principled, procedural, and methodological approach to rationally address issues that can inhibit trust in the patient-physician relationship; it can operate effectively even when the ideals of concordance and cultural competency are absent. Concordance is not the *only* factor of the patient-physician relationship, but it is an important one about which we are continuing to learn, especially as it contributes to patient satisfaction, a key measure of health outcomes. Given that the demographics of the U.S. patient population and its physician workforce do not match, system-wide concordant pairings are not achievable. Therefore, the short-term focus ought to be on the proximate replication of whatever it is that occurs in concordant pairs.

Limitations

As a solution that seeks to transcend demographic shifts among patient and physician populations, bioethics training is not without criticism. All cultural products point to dominant values within a group. Dominant values are a beginning place that takes into account a broad understanding (Juckett 2005). Catherine Myser has criticized the values identified as normative in bioethics, both for *what* has become termed as normative as well as *how* it has been selected as normative. She argues that which persons and what perspectives would be considered be central to “American-ness” were established from the beginnings of the social and legal history of the nation. The cultural norms created from this American-ness are inherent in bioethics in the U.S. context. As a cultural product, bioethics, she asserts, is heavily weighted as individualistic with an overemphasis on valuing autonomy (Myser 2003). Myser’s critique is worthy of reflection.

Implications

Myser’s critique acknowledges that normative values represent the values of the dominant group, and this understanding of normative provides an opportunity for bioethics to see the places where it can be reshaped. Where necessary, values within bioethics may be re-formed to match the dynamic demographics taking place in U.S. patient demographics and the physician workforce. In the places where humans experience encounter, cultural products such as language, food, religion, and health care practices can be reformulated. It reminds us that the experience of context can produce cultural types which are not pure. This admixture is the quintessential American experience.

Immigrants from around the world have come to the U.S. bringing their language, their foods, and their customs with them. Sometimes, they have opened restaurants serving foods from their native region. To appeal to customers beyond their ethnic compatriots, owners often adapted those foods to fit the palates of their American customers. When Africans, from varieties of tribes with structurally related, but different deities and religious practices found themselves living together in enslavement in the New World, they formed a religious system that merged some of the commonalities of their systems, some of the elements of their captors, and new elements for the new context to create African American religious expressions (Smith 1994.) Finally, we saw in our case study of the Hmong in Merced, California, that cross-cultural failure does not absolve us of the need to continue to try to reshape norms. In the 21st century, health care in Merced can include intervention from the physician and the shaman. In all these examples, cultural production adapted to meet human needs.

A study with racially and ethnically diverse patients concluded that, ultimately, patients desire to be treated with dignity (Beach et al. 2005). Practices that seek to observe patient dignity also show regard for the principle of respect for persons, one of the original Belmont bioethics principles (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Patient dignity is broader than honoring patient autonomy and including patients in decision making about their care (Beach et al. 2005). The dominant values within bioethics principles and procedures, today, and that can get passed on in bioethics training can themselves be reshaped or modified by the sexual orientation or gender and the varied cultural, racial, and ethnic backgrounds of the persons who enter the training. This process of re-forming bioethics was begun by feminist bioethicists and by social scientists entering the field (Myser 2003). This re-forming process will continue with new ethnic and cultural groups entering the gateway of bioethics through training, and shaping the field and its procedural approaches, and expanding the diversity of

its norms and values. In the end, one of the primary objectives of bioethics is to provide respect for persons, regardless of who they are.

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