

Looking Out for Voodoo 101 (or the Case against “Cultural Competence” in Medicine)

by Patricia Hausman

Few terms have as much cachet in academic medicine these days as "cultural competence" (CC). Foundations are funding it, professional organizations are endorsing it, and medical schools are changing their curriculums to accommodate it.

Admittedly, it is an inherently appealing notion. But dispassionate analysis is all the more important when ideas have an intrinsic attraction—and even more so when the nation's health is at stake. Yet, the cultural competence movement seems disinclined to engage in such analysis, relying instead on an odd mixture of assumptions, wishful thinking, and inattention to hard questions. Odder still is how readily this mix has been accepted among those charged with educating future physicians.

I should emphasize that my misgivings are not with cross-cultural medicine—the study of physiological differences among populations. Their importance to research and teaching could not be clearer. My concern is with the "fuzzy" stuff—the differences in customs, beliefs, and behaviors that, according to the CC movement, are derived from culture and need to be a central theme around which medical education is structured.

The CC movement is based on the notion that people vary dramatically in certain beliefs, customs, behaviors, and attitudes that profoundly influence health. With that much, I agree. What troubles me is its certainty that educating physicians to show positive regard for these differences—and incorporate them into their practices—will eliminate disparities in health outcomes.

If certain behaviors and attitudes have profound effects on health, and the goal is

equal outcomes among particular groups, what is more likely to achieve that goal? Doing what one can to make groups more similar in behavior and attitudes—or taking pains to keep them different? I can find nothing in the CC literature that explains why the latter would be expected to yield greater success than the former. Nor evidence that patient outcomes are improved when physicians are schooled in the ways of the CC movement. Why the CC movement feels no obligation to present such evidence before demanding an overhaul of the medical school curriculum is puzzling. Even more mysterious is the willingness of medical organizations to embrace CC with nary a word about the thorny issues underlying its benign-sounding principles.

Policies regarding disclosure and consent are a case in point. CC advocates make much of cultural differences in attitudes toward fully informing patients about their medical condition. They cite cultures where family members (or others) make decisions about health care on behalf of the patient—and where terminal diagnoses, in particular, are concealed. The not-even-subtle message is that "cultural competence" requires the physician to honor such traditions for those from such cultures now living in the U.S.

But surely CC advocates realize what this would mean in practice. Patients classified as members of some cultures would have to consent to treatment, while others would receive whatever treatment (if any) chosen for them by relatives or others. Similarly, family members of some groups could terminate life support without an advance directive from the patient. Others would not have the same right—and would be forced to incur huge legal fees in pursuit of the right granted to others by virtue of "cultural difference." Before medical educators suggest to their students that cultural competence will bring peace and harmony to healthcare, they ought to ponder such scenarios and their potential to bring chaos and litigation instead.

They might also explain their enthusiasm for a movement whose notion of the relationship between patient and physician comes down to "ethnocentricity for me, but not for thee." The rhetoric of the CC movement demands that students be taught to celebrate the ethnocentricity of their patients—while cleansing themselves of their own. Somehow, egalitarian movements always seem to excel at this sort of hypocrisy.

But at what price do medical schools tolerate this sort of thing? It would be nothing short of tragic to lose sight of just what can be at stake here: human lives. Platitudes about honoring the belief systems of patients and their families sound marvelous until a child's life is in danger because its parents will not authorize medical treatment on cultural or religious grounds. When the rhetoric of cultural competence meets this sort of medical reality, what is ethnocentric starts

to look just plain eccentric. Ditto for the notion that Western medicine has no more validity than any other approach to health and disease. If medical educators truly believe this, it can't be long before voodoo becomes part of the medical school curriculum—and physicians face discipline for refusing to incorporate it into the treatment plans of patients who believe in it.

It is sobering enough that the sophomoric gibberish so familiar to the social sciences and humanities has now found a home in medical school. But to teach physicians in training that medical care should be guided by what patients believe rather than what science shows is beyond the pale.

When physicians feel obligated to hold that treatments based on empirical evidence are no better than witchcraft, science has been reduced to farce—and medical education to yet another example of the decay of rational thought in today's academy.

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