Dignified Healthcare for Immigrants: The Need for Cross-Cultural Efficacy in America's Medical Community

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Abstract: The diversification of the American population changes the healthcare landscape. Patients with different cultural belief systems and the increased incidence of tropical diseases in the United States requires reform in the education of medical practitioners in the U.S. In this paper, I will show that successful treatment of minority patients requires cross-cultural efficacy. The American medical community possesses a moral responsibility to develop cross-cultural efficacy because it is necessary to uphold the principle of non-maleficence ("do not harm"), to promote human dignity and capabilities, and to provide just healthcare from a Rawlsian perspective. As such, medical school policymakers should think about cross-cultural efficacy as a vital skill to be developed in students, and they should require medical students to engage in active learning by participating in rotations at clinics serving minority populations.

"I will remember that there is an art to
medicine as well as science, and that
warmth, sympathy, and understanding may
outweigh the surgeon's knife or the
chemist's drug."
-Louis Lasagna,
From the modern Hippocratic Oath

1. Introduction

At least 42 million people in the United States are immigrants, here both legally and unauthorized (National Conference of State Legislators, 2016). The majority of immigrants originate from Latin America (CNN Library, 2017). Even the highest proportion of legal green card holders are from Mexico (NCSL, 2016). Immigrant families from Mexico have higher rates of poverty than all other immigrant families and also all native-born families (Zong & Batalova, 2016). Regardless of political views, immigration is prominent in the United States. As I will show, medical practitioners have a moral obligation to provide the best treatment they can to their patients no matter who they are, and this obligation means that the presence of immigrants in the United States also affects the health care landscape of the country. Since the majority of immigrants in the United States are from Latin America, these immigrants will be the focus of this paper.

The medical profession has a duty to be informed on the current medical environment, which today includes the treatment of a diverse population. Recently, the Center for Disease Control (CDC) identified Chagas Disease as a "neglected" parasitic infection, which is a label applied to diseases that are often associated with marginalized groups and do not receive adequate attention from the medical community despite their gravity (2016). They estimate at least 300,000 people, statistically from Latin America, in

the United States are living with Chagas Disease, and likely do not know it (2016). Importantly, chronic infections often go undiagnosed, leading to complications that can ultimately be fatal. The CDC hopes to increase awareness about this tropical disease so that physicians can diagnose more infections and then properly treat their patients. This is just one example of dangers associated with providing care to a diverse population if physicians are not prepared to encounter such situations.

As I will argue, if the medical community chooses to ignore the changing demographic of America's patient base, they are morally culpable for negative health outcomes of minority populations. Justice from a Rawlsian perspective dictates that physicians uphold their professional responsibilities and encourage positive social determinants of health. Starting with curriculum in medical schools, medical students and professionals alike should be informed on cultural practices relevant to minority patients, as cultural norms impact the care of Latin American patients. This will improve a physician's ability to diagnose diseases like Chagas Disease and incresase the chance of successful treatment for minority patients. Although it can be argued that the majority of doctors practice in areas where the patient base matches their own demographic (Olds, 2016), I contend that not having an understanding of treating diverse patients, here immigrants from Latin America, would make physicians negligent in their medical education. I recognize there are other ways to accomplish this goal, but I am focusing on the role of medical schools because that is where medical professionals begin their education. Aligning with the message of the CDC, practitioners should be exposed to cultural practices of Latino patients and be familiar with diseases that specifically plague the Latin American area to ensure that such circumstances germane to the care of Latino

patients are firmly on the medical community's radar. In the following paragraphs, I elaborate on the issue of Chagas Disease as an illustrative example for problems caused by a current gap in medical education. Then, I provide ethical reasoning for why such an education is required of medical professionals. Next, I review current "cultural competency" requirements created by institutional bodies governing medical school curricula. Finally, I conclude the paper with policy recommendations towards addressing an inadequate medical education in the face of a growing, diversifying American population. Although I acknowledge the role insurance and legal status plays in immigrants' access to health care, I am putting aside that conversation in this discussion to instead focus on the role medical knowledge, cultural awareness, and communication skills play in the success of interactions between diverse patients and medical professionals. In short, however the person comes to arrive in the clinic, doctors have a professional and moral obligation to treat a patient as best they can.

1.1 A note on terminology

Later in the paper, I make a distinction between "cultural competency" and other terms like "cross-cultural efficacy" and "culturally responsive behaviors," the latter of which better communicates the concept of cross-cultural learning as a skill to be developed by physicians. As such, in the following sections I will use terms like "cultural awareness" and "culturally responsive" to reflect the dynamic nature of this quality and I will use "cultural competency" to refer to the current institutional understanding of cross-cultural efficacy that forms the basis of medical organization's recommendations for cultural competency training in medical school curricula.

2. Chagas Disease as a case study

2.1 Pathology of Chagas Disease

Chagas Disease occurs mostly frequently in Latin America because the insects that serve as the vectors, triatomine bugs, are located in Latin America (CDC, 2016). Known as "kissing bugs," although they belong to a family of "assassin bugs," triatomine bugs transmit the parasite *Trypanosoma cruzi* (*T. cruzi*), which causes Chagas Disease. How can the same insect have two names so different, one sweet and one lethal? Triatomine insects feed on blood and are attracted to water. As such, they typically bite humans on the mouth, seeking moisture (hence, "kissing bugs"). This bite can result in the development of a lethal *T. cruzi* infection.[i] In the acute stage of the infection, there may be a fever or some swelling around the penetration site. However, the symptoms may be so mild they are unnoticeable. Eventually, especially with multiple infections, the infection shifts to a chronic stage. In the chronic stage, patients can develop serious gastrointestinal and cardiac complications. Difficulty swallowing or severe constipation can result from a dilation of the gastrointestinal tract. A chronic infection can also lead to heart dilation, making it harder for the organ to pump blood. Even worse, the heart can also develop rhythmic abnormalities that can lead to sudden death (CDC, 2016). The disease often gets associated with impoverished communities because the bugs tend to live in cracks of houses with roofs, walls, or floors made of mud or palm thatching or in livestock shelters (Rozendaal, 1997).

2.2 Chagas Disease as a public health crisis

The CDC labels *T. cruzi* as a neglected parasitic infection because the organization believes *T. cruzi* needs to receive more attention in the public health arena. Given the influx of Latino immigrants, the CDC estimates at least 300,000 people are

living in the United States with an infection of which they are likely unaware. This poses a public health risk in the United States for three reasons: preventable sudden death of those with the infection, transmission of the infection to others through sharing needles, and transmission from mother to child.

2.2.1 Preventable deaths

In the first, undiagnosed chronic infections of Chagas Disease put patients at risk for sudden death due to unidentified heart complications. If the majority of the people in the United States with a chronic *T. cruzi* infection are unlikely to know about their risk for heart failure due to an undiagnosed infection, resulting sudden deaths could be preventable with the right treatment, but that would require a diagnosis and a medication regimen from a doctor. Without increased awareness of non-native maladies like Chagas Disease and a better understanding of cultural expectations (discussed further in this paper), Latino immigrants may be less likely to seek out treatment from doctors unfamiliar with their needs, and physicians that do treat Latino immigrants may not know to look for certain signs indicative of Chagas Disease.

2.2.2 Transmission through needle sharing

Another public health issue arises from the transmission of *T. cruzi* between people through contact with infected blood. The infection can be passed through blood donations. Until 2007, blood banks were not screening donors for *T. cruzi* infection (CDC, 2016). Although donors are screened now, the lack of awareness among the donors themselves supports the CDC's concern that people are living with undiagnosed infections whom could have their lives saved by treatment. Moreover, unregulated exchanges of blood products face risk of passing infection. Notably, *T. cruzi* can be

transmitted through sharing of needles (Auger et al., 2005; Nijjar & Del Bigio, 2007). Once again, the lack of awareness of *T. cruzi* infections means people are likely to share needles without knowing they are transmitting or receiving a parasite in the process, increasing the number of people living with the infection.

2.2.3 Transmission from mother to child

Since *T. cruzi* circulates in the blood stream, the infection can be passed congenitally (Gürtler, Segura, & Cohen, 2003; Carlier & Torrico, 2003). As an additional route of transmission, congenital infections also demonstrate a need to increase physician familiarity with Chagas Disease. It is imperative that practitioners identify *T. cruzi* infections in women prior to pregnancy, in order to be able to treat the infection before it can be passed to the fetus. Similar to the other public health problems arising from lack of attention to *T. cruzi* infections, the incidence of these infections will continue to rise if the medical community fails to address this gap in medical education.

2.3 The importance of cultural norms, communication, and trust

Communication between physicians and their patients is critical to the success of the relationship, especially because interactions with doctors often affects patients' adherence to their treatments (Ong et al., 1995). Culture relates inextricably to communication, as it affects how messages are formulated, conveyed, received, and interpreted; with communication about topics as important as health, it is therefore vital to understand the role of culture in doctor-patient communication (Rocque & Leanza, 2015). The amount of rapport between doctor and patient established by both verbal and non-verbal communication also influences how much and what type of information Latino patients will disclose to their physicians, especially depending on the demographic

of the physician (Julliard et al., 2008). Latino patients face a larger challenge of obtaining a physician that matches their demographic because Latinos are significantly underrepresented in the health care system given their large presence in the United States (Peterson-Iyer, 2008). Physicians need to understand cultural values held by Latino immigrants in order to communicate effectively with their patients, thereby helping to ensure they are providing their patients with the best care possible. I will discuss the important role of *respeto, familismo, simpatia/personalismo,* and *fatalismo* in physician interactions with Latino patients. Miscomprehension of these values can hinder a physician's ability to diagnosis patients who may have untreated conditions like *T. cruzi* infections. I recognize the importance of speaking the same language or having a reliable translator service, but again, this is not the focus of my discussion and instead will operate under the assumption that the patient and doctor can understand each other literally. My descriptions of these values are generalizations, so they may not hold for every Latino patient, but applying them to the case of a Chagas Disease patient highlights the need for understanding different cultural belief systems.

2.3.1 Respeto

The concept of *respeto,* translating to "respect," means that Latino patients will adapt their behavior to show respect to authority figures, like physicians (Flores, 2000). Because of authority dynamics, Latinos may be less likely to ask questions during appointments because they do not want to appear to be challenging the doctor's authority, and also may nod to show respect, not in agreement, which can be confusing for physicians (Flores, 2000). On the other hand, if a Latino is older than the doctor, they too are coming from a place of authority and therefore expect respect from the doctor. If the

doctor fails to pick up on these cues, and the patient feels disrespected, the patient is less likely to disclose certain information, strictly follow treatment instructions, or even return for a follow-up appointment (Flores, 2000). Using Chagas Disease as an example, a failure with *respeto* may cause patients to withhold information from the doctor, like symptoms that may indicate that they have a *T. cruzi* infection. Or perhaps, they might be diagnosed with *T. cruzi* but not take their antiparasitics because they do not feel respected by the doctor and subsequently do not trust their prescription.

2.3.2 Familismo

Familismo refers to the family dynamics that can affect a patient's decisions, both owing to a hierarchical arrangement within the family or the feeling of the needs of the family outranking the needs of the individual (Flores, 2000). For example, because of *familismo*, a wife may defer to a husband concerning medical decisions. A need to consult with other family members can cause patients to have to put off decisions until thorough discussion with other members of the family, which could be problematic if the patient needs to make a quick decision in an emergency situation (Flores, 2000). In our Chagas Disease scenario, a Latina mother may not take the time to seek out medical attention for odd symptoms because she feels she cannot take that time away from her household, not realizing she is in danger of sudden heart failure. If her doctor understands this concern, he/she may be able to use the mother's own values to persuade her to take care of herself (e.g. "You should return for a follow-up appointment because the time you take out your day to get treatment can ensure that you are there for your family in the long term, but failing to receive treatment can jeopardize your ability to help your family in the future").

2.3.3 Simpatia/personalismo

The values of *simpatia* and *personalismo* work in tandem. *Simpatia* refers to kindness. When Latino patients expect *simpatia* from their health care providers, the typical neutral affect of American clinicians may upset them (Flores, 2000). *Simpatia* also deals with the avoidance of conflict, so if doctor presents a Latino patient with a treatment with which the patient feels uncomfortable, the patient may not voice this discomfort because of *simpatia* (Peterson-Iyer, 2008). Similar to *simpatia*, *personalismo* places value on warm interactions between doctor and patient. American doctors are less likely to engage in physically comforting a patient, as part of their professional, neutral presentation. However, absences of welcoming gestures may cause negative results. For example, if a doctor suspects a Latino patient has Chagas Disease, but fails to communicate this news through comforting gestures like a gentle hand on the shoulder, the Latino patient could interpret this as the doctor not sincerely caring about them, and therefore would be less inclined to return for a follow-up appointment or to accept treatment from them.

2.3.4 Fatalismo

The belief in *fatalismo* means that individuals feel that they have little control over their own fate (Flores, 2000). Because of this belief, Latino patients may be more likely to reject treatment or decline preventative screenings, thinking that their illness is unavoidable. In the case of a Chagas Disease patient, if a doctor succeeds in diagnosing a *T. cruzi* infection, the physician may have a difficult time convincing the patient that treatment with antiparasitics is necessary to avoid a preventable death. However, an understanding of the mindset behind *fatalismo* could help physicians use the patient's

own way of thinking to rationalize treatment (e.g. “If God wanted you to die now, then why would He send you to be diagnosed in my office? Perhaps He wants you to receive treatment because it is in fact too early for you to die.”).

2.4 Folk medicine beliefs

A discussion of culturally shaped medical beliefs also requires a conversation about illnesses. Illnesses differ from diseases in that they are personal perceptions of disease influenced by culturally held beliefs as part of a social structure (Kleinmen, Eisenberg, & Good, 1978). The social nature of illnesses affects the responses by patients to their symptoms (Kleinmen et al., 1978). Two major childhood illnesses that pose implications for treating children with *T. cruzi* infections, whether congenital or vector acquired infections, include *empacho* and *mal ojo*. Because of beliefs associated with these folk illnesses, it could be hard for a physician to convince a parent to pursue clinical treatment for a child with Chagas Disease without an understanding of folk illnesses.

2.4.1 Empacho

Empacho occurs, according to ethnic groups that believe in this diagnosis, when food or saliva gets stuck in the stomach as a result of poor eating habits (which can affect adults as well) or teething in infants (Pachter, Bernstein, & Osorio, 1992). The illness can manifest as gastrointestinal problems like bloating, constipation, and diarrhea, as well as fever (Pachter, Bernstein, & Osorio, 1992). In the case of Chagas Disease, a *T. cruzi* infection shares some of the symptoms associated with *empacho*. This folk illness poses some challenges for practitioners who may want to treat for a clinical diagnosis with Western medicine. For treatment of *empacho*, families typically consult folk healers; for

Puerto Rican families, healers are called *santiguadoras*, and Mexican-American families use the terms *sobadera* or *curandero* (Flores, 2000). Even after seeing a clinical physician, 85% of Puerto Rican families surveyed sought out the opinion of a folk healer or pursued a home remedy (Pachter, Bernstein, & Osorio, 1992). As such, it may be necessary for a Western doctor to consult with a traditional healer in order to convince a Latino family to accept a Western treatment such as antiparasitics, perhaps in tandem with a traditional remedy.

2.4.2 Mal ojo

The illness of *mal ojo* literally translates to "evil eye" (Flores, 2000). Ethnic groups that identify this illness believe a person with "strong eyes" heats up the blood o the child, causing fever, diarrhea, stomach pain, vomiting, and crying (Flores, 2000). This has important applications to eye contact with a Latino child. If a health care professional looks too much at a child without physically interacting with the child in some way (a comforting hand on the shoulder, etc.), a believer in *mal ojo* would worry the child would become ill as a result of that interaction (University of Washington Medical Center, 2007). Again, this illness also carries implications for treatment. The child may wear an amulet, or *azabache*, on a necklace or bracelet in order to protect the child from *mal ojo*; as such, doctors should be respectful of the cultural role of the amulet and allow the child to keep the amulet close during examination or else risk upsetting the family (Flores, 2000). By having an understanding of what causes such a folk illness, a physician can avoid behavior that would potentially jeopardize the appointment by distressing a Latino family that believes in certain folk illnesses. Regarding treatment for Chagas Disease, medical practitioners will have an easier time convincing a family to accept a Western

medication if they show respect for the family's wishes and use their understanding of the way of thinking behind *mal ojo*, for example, to convince the family to approve of the antiparasitics. In this section, I used Chagas Disease to highlight how cultural beliefs can significantly impact a doctor's interaction with a patient. Therefore, a lack of cultural awareness creates an array of issues for physicians trying to treat a diverse population.

3. A moral commitment

The medical community possesses a moral responsibility to be prepared to treat a diverse population in America on the grounds of their professional obligations and on the application of John Rawls' justice as fairness.

3.1 Professional obligations of physicians

3.1.1 Do no harm

When patients interact with medical professionals, there is the universal understanding that the practitioner will, as the saying goes, "do no harm," which here I extend to include emotional harm as well as physical harm. At the very minimum, doctors are therefore expected to at least not make their patients worse off than when they arrived. However, if physicians do not take care in their interactions with Latino patients, they may cause more damage than they realize. Perceptions of discrimination are associated with negative physical and emotional health outcomes for minority groups (Williams, Neighbors, & Jackson, 2003). Struggles with acculturation also create disincentives for minorities to seek medical attention (Rocque & Leanza, 2015). With Latino patient populations, a failure by practitioners to understand cultural norms associated with the physician-patient relationship can lead to negative health outcomes of minority patients because these patients are less likely to trust the doctors, which makes

the patients less likely to disclose information in the exchange (Julliard et al., 2008). Moreover, if any patient has a poor experience with a doctor, the patient is less likely to return for a follow-up appointment and may develop a general distaste for clinical medicine. In order for physicians to successfully aid their patients, or at least cause no further harm, they need cross-cultural efficacy.

3.1.2 Human dignity and autonomy

The American Medical Association's *Code of Medical Ethics* defines a guiding set of basic principles for physicians. The first and last are especially relevant to this conversation; "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights," and "A physician shall support access to medical care for all people." (2016) These principles echo the message of the modern Hippocratic Oath communicating the humanity and artistry of an otherwise strictly scientific profession. The values reflected in these principles demonstrate the professional duty of physicians to treat all current and prospective patients with respect and dignity. Refusing to recognize, respect, and respond to a patient's cultural belief system violates their human dignity. This may pose a challenge for physicians who are indignant about traditional healers. However, respecting a patient's views does not mean a physician has to accept the medical validity of a folk healer's treatments. Rather, showing respect for the views of the patient and understanding why a patient values the opinion of a traditional folk healer can inform a doctor on how to approach a conversation with a patient involving Western treatments. This maintains the dignity of the patient while helping the doctor tailor their discussion to best reflect the individual case of the patient.

Not every health professional accepts the concept of human dignity, preferring to think about patient autonomy. Ruth Macklin, in an article for the British Medical Journal (BMJ), dismissed the concept of dignity as an empty term no different than respecting a person's autonomy (Macklin, 2003). In response to the criticisms of dignity by Macklin and others, Doris Schroeder attempted to clarify the concept of dignity in bioethics by delineating four different uses of dignity on context (Schroeder, 2008). Then, Suzy Killmister built upon Schroeder's work by paring it down to two definitions that connect to each other: Kantian dignity, the inherent self-legislating quality possessed by all creatures of reason (approximately autonomy), and aspirational dignity, the capacity of a person to realize one's standards and avoid humiliation (Killmister, 2010). She claims Macklin made a shortsighted claim against dignity, as aspirational dignity matters in medicine since the actions of doctors can either promote or undermine such dignity (Killmister, 2010). Regardless of the preferred conception of dignity, culturally unresponsive physicians can impinge on both of these uses of dignity.

In the first, doctors may undermine Kantian dignity, roughly autonomy, by dismissing patients' abilities to determine the best course of action for their particular values. For instance, say a physician diagnoses a Mexicana patient with Chagas Disease. The physician wishes to treat her with an antiparasitic, but the patient expresses wanting to consult a *curandero*. A culturally unresponsive doctor may flippantly dismiss the views of the patient as wrong, removing the patient's autonomy, and taking control of the power dynamic. On the other hand, if the doctor listens to the Latina patient's reasoning, the doctor can present the different options for treatment and, while respectfully acknowledging the patient's beliefs, share the risks and benefits of the different options to

enable the patient to make an informed decision for herself. The doctor may also be able to convince the patient to consider clinical antiparasitic treatment in tandem with *curandero* treatment. In the second use of dignity, aspirational dignity, a physician who is ignorant of certain cultural expectations may violate the dignity of a patient by causing them shame. New diagnoses of Chagas Disease often entail follow-up appointments, as it is recommended physicians assess the cardiac condition and gastrointestinal health of the patient (Bern, et al., 2007). Perhaps our Latina patient with Chagas Disease worries about taking the time away from her family to return for follow-up appointments because of *familismo*. If her doctor accuses her of failing to take care of herself, because the doctor doesn't understand her concern for taking care of her family, she may experience shame and the doctor won't be able to use culturally responsive reasoning to persuade her to return (e.g. "It will be harder for you to take care of your family if you feel sick, so the time you spend on another follow-up will actually ensure that you are better able to help your family."). Human dignity and autonomy therefore can have separate meanings but also can be understood as connected concepts, with both having important implications for the conduct of medical professionals.

3.1.3 Dignity and human capability

A discussion of human dignity (and autonomy) also necessitates the introduction of human capability theory. Championed by Amartya Sen and Martha Nussbaum, the human capabilities approach refers to a person's collective abilities to achieve basic life outcomes and states of being (known as functionings) if one chooses to exercise one's capabilities (Sen, 1993). Martha Nussbaum expands this discussion by conceptualizing a list of central (basic) capabilities a person ought to have (though it is up to the individual

whether or not to exercise said capabilities) because without these central capabilities, a person cannot be considered to lead a dignified life (Nussbaum, 2011). Relevant to our discussion of health are the central capabilities of life and bodily health. The capability of life refers to the ability to avoid premature death and the capability of bodily health means to be in good health, including being properly nourished and adequately sheltered (Nussbaum, 2011). In order for doctor to ensure a patients' dignity, they must work to promote bodily health and life capabilities, as they are requirements for leading a dignified life. Without good health, time spent being sick takes away from time spent being productive, hindering a person's capacity to fulfill other capabilities. Therefore, since doctors have a professional obligation to encourage human dignity, they also have a professional responsibility to promote human capabilities.

Beyond the capabilities obviously related to health care, other capabilities necessary to lead a dignified life connect to patient care as well. The capability of practical reason refers to, "Being able to form a conception of the good and engage in critical reflection about planning of one's life" (Nussbaum, 2011). This reflects the ideas conveyed in Kantian dignity and in autonomy, which we already discussed as far as their implications in physician-patient interactions. Furthermore, the central capability of affiliation deals with "having the social bases of self-respect and nonhumiliation . . ." (Nussbaum, 2011). This capability echoes the values communicated through aspiration dignity, also covered above in regards to its impact on a doctor's behavior towards a patient. Thus, we can understand a physician's ability to engage in effective cross-cultural communication as promoting dignity, autonomy, and human capabilities.

3.2 Rawlsian unbiased conception of justice

3.2.1 Justice as fairness

Imagine you and some friends are playing a game of LIFE. Going into the game, before you spin the wheel, before you draw your cards, you have no idea what type of "life" you are going to have; it is impossible to know if you will have a high paying job, or decent insurance, or adequate housing. Now imagine you had to establish guiding principles to govern this imaginary land in your imaginary life, without knowing what hand you would be dealt. This is the concept of philosopher John Rawls' thought experiment referred to as the "veil of ignorance." He argues that behind the veil, everyone would lobby for equal basic liberties with the understanding that if they tried to favor one group, they could disadvantage themselves later since they could not know who they would be (what characteristics they have, what skills they possess, etc.) once the veil is lifted (Rawls, 1971). People would agree to fair equality of opportunity behind the veil. Fair equality of opportunity does not mean that everyone receives the same benefits, because some disparities in income are necessary to maintain incentives to work. It simply means that irrelevant characteristics (factors that are not based on talent and effort) could not disadvantage certain groups (Rawls, 1971). As unbiased contractors behind the veil, people would reach a consensus about basic rights afforded to everyone because it is what justice would require (Rawls, 1971). Thus, even if the contractors were acting in their own self-interest, i.e. hedging their bets, instead of considering what would be fair to all of humanity, the contractors would agree to certain basic liberties for all people in a society. Applying this logic, unbiased contractors behind the veil would agree that doctors should be prepared to provide the best care they can to their patients no matter who they were, because there is the chance that any of the contractors could be a

minority or disadvantaged member of society once the veil is removed. As demonstrated previously, doctors would need a cultural understanding of the norms determined by the patient's society in order to achieve the best care possible. Principles agreed to by unbiased contractors under fair conditions are therefore considered just, as suggested by Rawls' concept of "justice as fairness" (Rawls, 1971). Thus, since unbiased contractors would agree to the principle of adequate health care, adequate health care is a just principle.

3.2.2 Applied Rawls: Daniels and social determinants of health

Ethicist Norman Daniels and colleagues Bruce Kennedy and Ichiro Kawachi employ Rawls' justice as fairness specifically to health care. In their essay "Justice, Health, and Health Policy," they add to the dialogue of social determinants of health. Social determinants of health are conceived as social structures that contribute to individual and group health outcomes, separate from purely financial access to health care. Empirical evidence indicates that "the greater degree of socioeconomic inequality that exists within a society, the steeper the gradient of health inequality" (Daniels et al., 2002). In fact, middle income groups in a country with greater economic inequality have worse health outcomes than groups of a lower class in a more egalitarian society (Daniels et al., 2002). An analysis of the distribution of income within developed countries predicts the health outcomes of its citizens, showing a correlation between greater inequality in society and poorer overall health outcomes (Wilkinson, 1992). These patterns concerning relative socioeconomic status confirm the presence of social determinants of health. The existence of negative social determinants of health provides implications for our discussion of moral responsibility.

Rawls' idea of justice requires fair equality of opportunity, which, as a reminder, declares that factors irrelevant for talent and effort should not play a role in advantaging or disadvantaging specific groups. Daniels et al. argue that poor health caused by negative social determinants of health hinders an individual's capacity for fair equality of opportunity (2002). Therefore, justice necessitates that societies provide positive social determinants of health to ensure fair equality of opportunity (Daniels et al., 2002). In the case of immigrant health, society has a duty to aim to evenly distribute positive social determinants of health regardless of personal characteristics like immigration status or cultural background, because that is what justice would require. Physicians participate in the allocation of social determinants of health. As a result, physicians posses an obligation to be well informed on the needs and expectations of a diverse patient in order to effectively promote positive social determinants of health. Positive social determinants of health in this case refer to culturally responsive care, while negative social determinants of health mean culturally insensitive care. As my capstone suggests, justice requires the medical community to ensure its own education on cultural practices and international maladies necessary to develop cross-cultural efficacy skills required for the proper care of Latin American immigrants, recognizing the humanity of all individuals.

4. A review of current cultural competency training recommendations

4.1 What is cultural competency?

The American Psychological Association defines cultural competency as "the ability to understand, appreciate, and interact with people from cultures or belief systems different from one's own" (DeAngelis, 2015). This concept can be extended to health care specifically, resulting in a definition like cultural competence as the ability of health

care providers to successfully care for patients with diverse social norms and cultural backgrounds by effectively adjusting care to address patients' specific belief systems and social needs (Betancourt, Green, & Carrillo, 2002). However, the phrase itself has some complications, criticized for the word "competence" implying a fixed amount of knowledge (Association of American Medical Colleges, 2015). Others have proposed alternative conceptualizations, like cross-cultural efficacy as a dynamic, on-going process of developing effective interactions with patients' of a different culture (Nuñez, 2000). I prefer the dynamic nature of phrases like "cross-cultural efficacy" or "culturally responsive," and the adoption of such conventions would help medical educators and students alike better understand the goals of developing such a skill. In this section, I will review the medical school curriculum requirements around "cultural competence" as set forth by various institutions that dictate curricula.

4.2 Curriculum requirements and suggestions by governing bodies

4.21. Liaison Committee on Medical Education

In 2000, the Liaison Committee on Medical Education (LCME), the institution that accredits medical schools, added a standard for cultural competences in their policy on content required for the Medical Doctorate degree (Association of American Medical Colleges, 2005). The section reads as follows:

> "(ED-21) The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on their health. To demonstrate compliance with this standard, schools should be able to document objectives relating to the development of skills in cultural competence, indicate where in the curriculum students are exposed to such material,

> and demonstrate the extent to which the objectives are being achieved." (International Association of Medical Colleges, 2017).

Thus began a wave of reforms by various medical schools in order add curriculum that addressed this directive of culturally competent medical students.

4.2.2. Association of American Medical Colleges

In 2005, the Association of American Medical Colleges (AAMC) published a report aimed at describing a protocol for assessing cultural competency in medical school curricula. It opened by listing institutional requirements of effective cultural competence curricula: support across the board from faculty and students, commitment to such a curriculum by community leaders and their subsequent involvement in establishing a program, integrated learning approaches appropriate to the students' levels in medical school, and evaluative protocols for assessing the success of cultural competence curricula (AAMC, 2005). The last requirement was the main concern for this publishing. The report elaborated on the proper utilization of the Tool for Assessing Cultural Competence Training (TACCT), a protocol developed by the AAMC, in order to analyze the efficacy of cultural competence education choices. The AAMC designed the TACCT to meet the requirements of the LCME's education directive, ED-21, that requires medical schools to include cultural competency training. This tool was essentially a self-administered survey/checklist consisting of 67 different items categorized into five domains (AAMC, 2005). The goal of the tool was to show medical schools, based on the responses of their faculty and students, where in the curricula the education was occurring and which learning objectives of cultural competence education were and were not being met (AAMC, 2005). However, this process proved to be bulky to administer.

So in 2008, a panel reformulated the TACCT itself, consolidating it to a 47-item revised tool to create easier assessment of cultural competence learning (Lie, et al., 2008).

A few years later, the AAMC revisited its evaluation of cultural competency education. In 2015, the organization issued a report creating recommendations for medical schools on how to implement cultural competency training in their curricula after having a over a decade after the initial wave of curriculum changes to evaluate and determine best practices. The report, titled "Assessing Change: Evaluating Cultural Competence Education and Training," largely focused on detailing four suggestions for how to foster successful cultural competency education programs in medical schools (AAMC, 2015). First, as with any field, high standards of "scientific rigor" need to be applied to studies assessing the general efficacy of cultural competence training, so the AAMC panel established the Cultural Competence Education and Training Assessment Inventory (CCETAI) (AAMC, 2015). The CCETAI compares studies about cultural competence training across the domains delineated by the TACCT, which allows institutions to see which areas are covered the strongest across the nation, and which areas need more attention. Second, important to curriculum design theory, medical school curricula boards should choose specific, quantifiable goals for student learning in cultural competence education (AAMC, 2015). Next, the method for evaluating the efficacy of the curriculum needs to be taken into account when designing the curriculum (AAMC, 2015). Also important in this section is the notion of the dynamic nature of curriculum development. From Kern et al.'s book on developing medical school curricula, the AAMC stressed their attention to the importance of evaluating curricula, as the curricula cannot continue to develop over time if it is not regularly assessed (AAMC, 2015). The

dynamic nature of curricula is crucial because it is therefore responsive to the changing health care landscape, like the diversifying America population. Finally, the last recommendation for curricula-makers ties into this notion that successful curricula require thorough, regular assessment (AAMC, 2015). The LCME laid the foundational requirement of cultural competency training in medical education and the AAMC developed ways to evaluate such programs and made recommendations for continuous improvement of the cultural competence training of medical students.

5. Conclusion and future recommendations

5.1 Policy recommendations

5.1.1 A shift in the mindset of policymakers

In the previous section, I reviewed the institutional forces providing guidelines for the development of cultural competency education in medical school curricula. Allow me to briefly discuss now the future implications of their research and the assertions I make in this paper. The institutions governing medical schools demonstrate their awareness of the vital role culture plays in physician-patient interactions. However, by using the terminology of cultural competence, I worry, like Nuñez, that these institutions fail to conceptualize culturally responsive behavior as a crucial *skill* to be developed by medical practitioners in an ongoing learning experience. It is not a fixed set of knowledge that can be conveyed in a three-hour workshop; rather, it is an ability developed through experiences such as working directly with minority patients. The first step towards the development of this skill set is for institutions to reform their thinking and the language they employ in curriculum requirements. “Cultural competency” misguides educators because it implies a static step in learning, gaining a specific set of knowledge.

Conversely, utilizing a framework of "cross-cultural efficacy" or "culturally responsive behaviors" emphasizes providing medical school students the opportunity to develop a skill necessary to treat diverse patients.

5.1.2 Medical school curricula requirement

In order to foster the development of cross-cultural efficacy, policymakers should require medical school curricula to include a specific mandatory clinical rotation. The rotation should be in a clinic serving a minority population. In this way, students can engage in active learning by shadowing physicians in appointments, observing the interactions between physicians and patients, and then discuss their thoughts with the experienced physicians at the clinic. As a result, the students would see how cross-cultural efficacy in practice plays a vital role in positive health outcomes of minority patients. The duration of this rotation can depend on the individual school's schedule, but should last at least two weeks so that the students get a more extensive experience than a weekend workshop would provide. Medical students seeing the impacts of culturally responsive care (or lack thereof) on real patients and having conversations with physicians in these clinics will reinforce the necessity of cross-cultural efficacy in care of America's diverse population.

5.2 Recap of argument

Whether one views the United States as a melting pot, a salad bowl, or some other food related item, we must acknowledge that the uptick in immigration has altered the demographic of America and has therefore also changed the landscape of its healthcare. For critics who argue against the rights of undocumented immigrants, excluding unauthorized immigrants from positive social determinants of health goes against the

principles outlined by Rawlsian justice as fairness because immigrants are more firmly intergrated into society than transient tourists just traveling through a country, thus making them part of the society for which the principles of justice were decided. In this capstone, I used Chagas Disease and some cultural norms that may be held by Latino groups in order to illustrate the negative impacts a physician's lack of cross-cultural efficacy can have on a minority patient's health outcomes. Medical communities possess a moral responsibility to educate its practitioners by connecting the professional obligations of non-maleficence ("do no harm") and the promotion of human dignity or autonomy (and their relation to the realization of human capabilities) to the necessity of cross-cultural efficacy in medicine. Furthermore, a failure to provide culturally responsive care would be considered unjust from a Rawlsian perspective. Culturally insensitive care distributes negative social determinants of health to minority patients. In order to provide positive social determinants of health, and therefore promote fair equality of opportunity in a just healthcare system, doctors need to be prepared to give culturally responsive care. Thus, due to the diversification of America's patient base, doctors have a moral obligation to engage in developing cross-cultural efficacy because of the expectations of their profession and Rawlsian conceptions of justice.

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[i] The bite itself does not lead to infection; the parasite is found in the fecal matter of the bug, so it actually requires that the bug defecates near the bite wound and an unsuspecting victim accidentally rubs the fecal matter into the wound (CDC, 2016).