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Ethics Opinion: Eliminating Dietetics-Related Inequalities

An Ethics Opinion reflects the interpretations or application of the American Dietetic Association (ADA)/Commission on Dietetic Registration (CDR) Code of Ethics for the Profession of Dietetics by the Ethics Committee in response to a specific ethics issue facing registered dietitians and dietetic technicians, registered, in practice. This opinion was initiated by the Ethics Committee in response to a discussion regarding health disparities and the profession of dietetics by the ADA House of Delegates in fall 2007.

An ethics opinion is an educational guide for practitioner conduct; it is meant to be a comprehensive review of the issue. The situations described are hypothetical.

ifferences in health incidences and outcomes for racial and ethnic minorities are commonly referred to as health disparities (1). When these differences are a result of systemic or unjust distribution of resources, they are considered health inequities that are unfair, unjust, and yet reversible. Outcomes present as variances that include the incidence, prevalence, mortality, and burden of disease among specific population groups in the United States. Health equity requires that everyone have equal opportunity to attain health regardless of his or her social status or circumstance (2).

Diet-related disparities are differences in dietary intake, dietary behaviors, and dietary patterns in different segments of the population as compared to the general population (3). According to Satia, the results are poorer dietary quality and inferior health outcomes. Nutrition-care disparities can be defined as differences in the access, delivery, and health outcomes of dietetic services offered

0002-8223/\$36.00 doi: 10.1016/j.jada.2010.12.010 to people with similar conditions. The results are inadequate access to care and substandard quality of care including variances in treatments, care, sanitation, and overall quality of life as covariants. Together, these terms will be referred to as *dietetics-related inequalities*.

Registered dietitians (RDs) and dietetic technicians, registered (DTRs), in every area of practice have an ethical responsibility to create social, evidence-based, and pragmatic solutions to eliminate dietetics-related inequalities. The result will be the ability for *all* populations to have an equal opportunity to live long, healthy, and productive lives.

A NEW MINDSET

The United States census bureau has predicted that ethnic minority communities will make up more than half of America's national population by 2042 (4). This shift challenges practitioners to adopt the overarching goal to eliminate health disparities within a dietetics context, and is consistent with the American Dietetic Association's (ADA's) values and vision to optimize the nation's health through food and nutrition. RDs and DTRs can:

- recruit and retain diverse students and practitioners:
- train, assess, and recognize practitioner cultural competency;
- facilitate education and research in dietetics-related inequalities;
- utilize culturally appropriate health literacy principles in practice;
- seek practice opportunities with health disparate populations;
- create dissemination channels for shared learning;
- evaluate policies and systems within agencies and organizations that provide food, nutrition, and/or dietetic services;
- develop performance metrics to identify and track progress toward eliminating dietetics-related inequalities

- in work settings and through the professional development portfolio process; and
- advocate for equal access to food, nutrition, and health services.

THE CODE OF ETHICS IN ACTION

The following principles from the Code of Ethics (5) are applicable to the goal of eliminating dietetics-related inequalities.

Principle 3: The dietetics practitioner considers the health, safety, and welfare of the public at all times.

RDs and DTRs have an ethical requirement to practice with knowledge, attitude, aptitude, and understanding of:

- implications of health disparities;
- disparate US high-risk populations and sub-populations;
- dietetics-related inequalities including variations in cultural differences related to food selection and health beliefs; and
- contributors to health inequalities including social factors (eg, socioeconomic status); race/ethnicity, racism, stereotyping; historical trauma; environment; health and language literacy; disability; multi-dimensions of acculturation; geographical influences and residence (urban vs rural).

Principle 4: The dietetics practitioner complies with all laws and regulations applicable or related to the profession or to the practitioner's ethical obligations as described in the Code of Ethics.

RDs and DTRs have an ethical requirement to comply with laws, regulations, and standards. The Office of Civil Rights Act of 1964 (6) and the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care (7) are two key examples. Noncompliance represents an infraction of legal stat-

utes. Congress enacted Title VI of the Civil Rights Act to prevent discrimination based on national origin. According to Title VI, health providers that receive federal funds, including Medicare and Medicaid, must provide language assistance to people who speak little or no English, and may not provide lesser or inferior services to such individuals.

CLAS standards are mandates, guidelines, and recommendations issued by the US Department of Health and Human Services Office of Minority Health. The Standards inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. CLAS are comprised of 14 standards thematically organized as follows:

- Culturally Competent Care: Provides standards for staffing and training to ensure that all levels across all disciplines receive ongoing education and training to assure language access and culturally appropriate services for all clients.
- Language Access Services: Requires provision of language services at no additional costs.
- Organizational Support for Cultural Competence: Provides guidance for strategic planning, assessment, and evaluation.

In August 2008, the Joint Commission began developing accreditation standards for hospitals that will promote, facilitate, and advance the provision of culturally competent patient-centered care with proposed implementation of requirements in 2011, with 16 issues addressed to date (8). The concept of protection against discrimination and linguistic accommodation in dietetics settings, even without the impetus of law or accreditation infringements, is easy to support as an ethically responsible common sense approach to practice.

Principle 5: The dietetics practitioner provides professional services with objectivity and with respect for the unique needs and values of individuals.

Cultural matters take on a deeper meaning in the context of dieteticsrelated inequalities. Practitioners need to enhance skills to understand the way of life of clients or a target audience. Foods, food preferences, preparation methods, and the significance of foods and beverages need to be understood through a multitude of lenses. Cultural and environmental exposure affects food purchasing decisions and the ability or willingness to follow medical nutrition therapy plans and recommendations. When working with a cultural or racial group other than one's own, the provider needs to respect a host of individual and group norms including spatial distance, body language, inclusion or exclusion of family members, and communication styles. Reliance on traditional cues to indicate understanding may not be relevant. Response to authoritative figures may result in silence or head nods when, in fact, the information communicated is not being understood. Development of culturally and linguistically appropriate methods to determine feedback will be critical. Practitioner incorporation of understood health attitudes, beliefs, and values will be keys to successfully establish and maintain trust. A superficial knowledge of a culturally diverse group will not be sufficient. The new standard of care is to be culturally competent and establish culturally competent systems to meet the unique needs of diverse clients, patients, and community members (9). Practitioners may need to recognize their own cultural preference and identify means to negotiate that preference in interactions with multicultural clients. Cultural competency training and resource materials are available through the American Dietetic Association and a variety of organizations.

Principle 8: The dietetics practitioner recognizes and exercises professional judgment within the limits of his or her qualifications and collaborates with others, seeks counsel, or makes referrals as appropriate.

Clear expression is essential in the communication of ideas, instructions, and practice in the provision of dietetic services. Written and spoken communications for Limited English Proficient (LEP) and Non-English Proficient (NEP) individuals can be a struggle. Language, combined with cultural barriers, can lead to deleterious errors in any area of dietetics

practice. About 49.6 million Americans (18.7% of US residents) speak a language other than English in their homes, and of those, 22.3 million are LEP (10). RDs and DTRs have the potential to do "more harm than good" when practitioners do not recognize the significance of these barriers. Practitioners need to collaborate, refer, and/or use trained interpreters and cultural brokers for communications, whether written or verbal, when practitioner skills are inadequate for safe and effective communication. The New England Journal of Medicine reports that language barriers impede care and that few clinicians receive training in working with interpreters (11). Positive outcomes include improved client/patient satisfaction, resource utilization, and quality care with patient safety addressed (12).

WALK THE WALK

Health disparities and diet-related inequalities are complex opportunities, and there is much to understand. RDs and DTRs should continue to follow and evolve evidence about root causes identifying best practices to close the gaps related to health disparities. Practitioners can begin by addressing dietrelated disparities through self-reflection regarding individual cultural and linguistic readiness, work setting preparedness, and even changing policies and systems that hinder inadequate access to care or delivery of substandard quality of care. Consider:

- Outreach. What struggles and realities exist for racially and ethnically diverse individuals or groups? Will location and time of service delivery support or build barriers to access? Will the community members view images and communications utilized positively? Is the space conducive to building client relationships? Are cultural brokers needed?
- **Prevention services.** Is prevention understood or valued by the client? Will a holistic framework be needed, and will it include culturally appropriate aspects (eg, body, mind, spirit)? How are traditional eating patterns, foods, ceremonies, and celebrations impacted by recommendations?
- **Treatment.** Can the client or client group access the fruits, vegetables,

or services recommended? Is there transportation available or even accessible to a local vendor? Can the plan bring solutions and build sustainable trust, enhancing compliance?

• Chronic disease management. Will the client's cultural belief system affect the long-term treatment plan? Will the lack of health insurance affect the delivery of care? Will policies, practices, and practitioners need to be developed to accommodate health disparate populations afflicted with chronic diseases? How will self-management be addressed?

CONCLUSION

Facing dietetics-related inequalities includes an ongoing commitment that will challenge practitioners and may require adaptation of new perspectives that require moving out of one's comfort zone. Professional development activities may include initiating new skills in client interaction; learning aspects of a new language; completing a review of relevant evidence; or, perhaps, conducting community-based participatory research. Frameworks, models, and resources continue to be developed through a variety of organizations.

The American Dietetic Association is addressing health disparities through key actions including:

- Identification of the issue through the ADA's strategic plan.
- Mobilization of resources through the Association's organizational units, teams, and committees.
- Initiation of evidence-based research on the subject matter.
- Development of print and Web-based practitioner tools and resources.

While less than 10% of ADA members identify themselves as members of racial or ethnic minority groups (13), ADA's Member Interest Groups and the work of the Association's Diversity Committee have recently created new and exciting points of engagement. Yet, more needs to be done to address the profession's pipeline issues to attract and retain ethnically and racially diverse members through a commitment to increasing the number of underrepresented minorities in dietetics education, practice, and leadership.

RDs and DTRs will continue to ad-

just to a more multi-ethnic, multi-racial society in order to be relevant to staff, patients, clients, consumers, and communities. Opportunities abound in research, education, practice, and advocacy in the ethical response to dietetics-related inequalities across all work settings. The benefits to society include decreases in health care costs and opportunities to close the health disparity gap with positive health outcomes (14). Addressing dietetics-related inequalities will provide expanded practice realm opportunities, advance practitioner skill development options, and forward individual cultural competency while building a healthier America for all. Imagine equal access to food, nutrition, and dietetics services as just a few of the benefits to society advanced by dietetics practitioners.

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