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# CULTURAL COMPETENCE IN THEORY AND PRACTICE

by

BRITNI ASHKINAZY

Under the Direction of Steven Black, PhD

## ABSTRACT

Cultural competence has been adopted and required in medical school education to address health disparities, though there is no standard curriculum. This thesis examines theoretical frameworks of cultural competence and its application through an ethnographic study of three practicing physicians and one medical student in the greater Atlanta area. Two of the participants attended medical school before the implementation of this requirement and were unfamiliar with the concept. Methods included semi-structured interviews and participant observation through focal follows, or shadowing, physicians. Questionnaires assessed patients' opinions of provider efforts. Findings investigated if and how distinct models of culture enter into doctors' consultation and decision-making processes, considered the feasibility of incorporating cultural competence practices given structural constraints, and identified doctors' recommendations for learning about culture. Recommendations are offered to improve cultural competence at the institutional and interpersonal level, including expanding existing elements of appointments and structural changes to facilitate time with patients.

INDEX WORDS: Biomedicine, Culture, Doctor-patient communication, Ethnography, Health,  
Medical anthropology

CULTURAL COMPETENCE IN THEORY AND PRACTICE

by

BRITNI ASHKINAZY

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2017

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2017

CULTURAL COMPETENCE IN THEORY AND PRACTICE

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## **DEDICATION**

This thesis is dedicated to the medical professionals who generously offered their time to participate in my study. They work exceptionally hard to save lives and maintain the health of their patients.

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## 1 INTRODUCTION

In the medical field, cultural competence is understood as a set of skills that can be learned and is intended to enhance communication between patients and providers, increase trust and satisfaction, and improve health outcomes of patients in an increasingly diverse country (Cohen et al. 2002; Nickens et al. 2001; Walsh et al. 2016). In the literature, the concept is often intertwined with linguistic competence and framed to reduce racial and ethnic health disparities. Investigating physicians' interactions with patients could provide insight into how the concept of culture is understood and put into practice in routine medical work (Beagan and Kumas-Tan 2009; Harrison and Turner 2011; Truong et al. 2017; Wong et al. 2003). Drawing on existing research on cultural competence, health disparities, and cultural models from public health and medical anthropology, this research aims to contribute to those efforts in the literature. This study investigates what physicians were taught about culture, and in cases of no formal cultural competence training, the ways that they conceptualize its role in medicine and navigate it with patients. It also considers the feasibility of incorporating cultural competence practices given the immense amount of medical knowledge doctors acquire and their time limitations with patients. Additionally, it includes a component to determine whether or not patients deem their providers' efforts successful.

Through an applied medical anthropological perspective, I advocate expanding the concept of cultural competence in required trainings to encompass a broader understanding of culture. Creating a more nuanced and inclusive definition could improve future training and education to avoid the pitfalls of essentialism and othering that often perpetuate health disparities. While the literature is filled with commendable and nuanced conceptualizations and teaching tools for how to accomplish this, the reality of what happens in classrooms and in

practice does not necessarily follow suit. I hope that this contribution provides useful insights and sheds light on some of the structural constraints and opportunities for future research to develop.

### **1.1 Research Questions**

This research examines how physicians understand and incorporate culture in their work with patients as well as the factors that might limit or facilitate its inclusion. It explores if and how distinct models of culture or cultural competence enter into clinical care and physicians' decision-making processes regarding culture and medical practice. What were the physicians taught about the concept of cultural competence, if at all? How important do they think culture is in medicine? In what ways do they integrate it into their practice? Do their patients find their efforts effective? How practical is it for providers to incorporate cultural competence considering the vast amount of medical knowledge they must master and the constraints they face on with time spent with patients?

### **1.2 Purpose of the Study**

I first examined the topic of cultural competence during my ORISE fellowship at the Centers for Disease Control and Prevention (CDC) in the Office of Minority Health and Health Equity's (OMHHE) science team beginning in September 2016 to April 2017. During that time, I researched methods and rationale to monitor diversity in the health and health care workforce as a new indicator to track for social determinants of health. Cultural competence was among the largest justifications for increased diversity in the health and health care workforce to minimize racial and ethnic health disparities.

As part of that project, I examined possible indicators for measuring diversity. The information available in national databases dictates feasibility for measurement. The limitations

necessitate a narrow definition of diversity, which cannot be as inclusive as the one promoted by the Diversity and Inclusion department that encompasses all aspects of personal and professional experiences and background (e.g., nativity, native language/language spoken at home, veteran status, disability status, education, religion, political affiliation, gender identity and sexual orientation, etc.). The United States Office of Management and Budget (OMB) lists minimum standard categories for racial and ethnic data collection by federal agencies<sup>1</sup>, including the Census Bureau. The race categories consist of American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. The ethnicity category includes only Hispanic. The ORISE fellowship project hopes to push the boundaries and expand these definitions as well as further the call to gather intersectional and granular data, particularly in the aggregated categories of Hispanic, Asian, and Pacific Islander, as recommended by the Department of Health and Human Services (U.S. Department of Health and Human Services 2011). For example, the Asian category could be subdivided by nationality (e.g., Vietnamese, Indian, and Filipino). Some have proposed the inclusion of a Middle Eastern/North African or Mediterranean category that could be aggregated into the White category, due to expressed confusion of people from that region on which option to choose (Mathews et al. 2017).

In addition to a lack of diversity in the medical field, particularly at administrative and specialized levels, there is a shortage of doctors that leaves a significant portion of the population underserved (Valentine, et al. 2016). These health professional shortage areas primarily affect minorities and people of low socioeconomic status in both rural and urban spaces across the country. Numerous educational pipeline programs have been and continue to be developed to

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<sup>1</sup> United States Census Bureau. "About Race." Accessed February 24, 2017. <https://www.census.gov/topics/population/race/about.html>.

increase minority presence in the medical field. These efforts aim to increase minority representation, which can in turn reduce health disparities by (1) improving doctor-patient concordance for improved communication, trust, and satisfaction, (2) increasing cultural competence through diverse experiences that benefit the whole system, and can (3) help fill in service gaps because minority doctors are more likely to serve in underserved areas (Cohen, et al. 2002; McDougle et al. 2015; Nickens, et al. 2001; Smedley et al. 2004; U.S. Department of Health and Human Services 2006; Valentine, et al. 2016; Williams, et al. 2016).

Two aspects of the ORISE fellowship research influenced this thesis topic and research design. First, many students shadow doctors to become more competitive applicants for medical schools and, once enrolled, follow doctors for clinical rounds in their third and fourth years. This means that shadowing physicians could provide a sense of doctors' early biomedical socialization processes. It also means that the presence of a student observer would not be unusual in a medical office setting. Secondly, I noticed that ethnographies on cultural competence largely focus on patient perspectives. These ethnographies often identify a particular patient population from a foreign or minority culture and examine its experiences with doctors. This makes sense because patients (usually minorities) are the intended beneficiaries of cultural competence training as it is promoted in public health. Patient needs and experiences help shape the training doctors receive. However, equally beneficial knowledge could be gained from examining the providers' experiences in practice with various patients (Beagan and Kumas-Tan 2009; Harrison and Turner 2011; Truong et al. 2017; Wong et al. 2003).

Understanding the ways that providers conceptualize and practice cultural competence can help fine-tune and improve training curricula as much as the research into patients has contributed, leading to improved health outcomes. Studying providers can also serve to uncover

barriers to culturally competent care such as time constraints, financial constraints, and the lack of exposure to cultural training—for example, the absence of required continuing education in cultural competence despite its presence in medical schools. To understand both sides of the medical interaction between doctors and patients holistically, this thesis includes patient perspectives via questionnaire while concentrating primarily on the physicians. This ethnography focuses on one medical student and three practicing physicians in three different offices in the greater Atlanta, Georgia area and the surrounding cities of Marietta and Austell. I conducted four interviews and participant observation in two offices with the contributing medical professionals by gaining access either through personal association or mutual connections who reached out on my behalf.

As the birthplace of the Civil Rights movement, Atlanta is a fitting city to study cultural competence. Civil rights are often related to social determinants of health and framed in terms of equal access to quality healthcare and treatment for minority groups. Metropolitan Atlanta boasts the second fastest growing foreign-born population in the nation (after Baltimore from 2000-2010) and has a broad immigrant and refugee community. Between 2000-2012, the City's foreign-born population grew by nearly 22%, from 27,352 to 33,358 people<sup>2</sup>. Health treatments and interventions are not just found in the clinical medical encounter, but in various interconnected networks and systems—from small community services and organizations to large governmental, private, or non-profit public health institutions, and every level in between. Nevertheless, doctor-patient encounters remain a vital point of contact that can serve either as a facilitator or barrier to patient health. Atlanta's growing population and diversity could have implications for worsening health disparities if care does not encompass culture.

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<sup>2</sup> Welcoming Atlanta Initiative, Mayor's Office of Immigrant Affairs. Accessed February 24, 2017. <http://www.welcomingatlanta.com>.

### 1.3 Chapter Summaries

Following this introduction, the second chapter of this thesis is the literature review. The first section begins by discussing health disparities as the frame and rationale for medical cultural competence education. The second section introduces the concept of cultural competence and its origins. Additionally, it covers related concepts in the literature that can be taught in tandem. Following that is a review of various educational approaches to teaching cultural competence and a brief overview of some cultural competence models for practice. There is then a discussion of cultural competency at the broader institutional level and an examination of the reasons that learners may be resistant to cultural competence. The third section considers the anthropological origins of cultural competence and compares classic and poststructural cultural models. It also discusses elements of the culture of medicine and how doctors can turn the medical interview into an ethnographic interview. Lastly, this section reviews different biocommunicable models, which frame the broader ways that health is discussed.

The third chapter covers the research methods. Included in this chapter is the study design. There is an overview of the four core participants, the two field sites of the participant observation portion of this research, the data collection methods employed, and the techniques utilized to analyze the gathered data. Subsequently, there is a discussion of the ethical considerations involved in observing patients in a clinical setting and the limitations of this study.

The fourth chapter includes the findings and discussion. It contains a summary and analysis of the four key themes identified in the fieldwork: structural constraints that affect the doctors' practice, time spent with patients, doctors' conceptualizations of culture and the dialectic of its role in practice, and first hand experience as a learning tool for managing cultural



diversity. Finally, there is a review and analysis of the patient questionnaires. This thesis concludes with recommendations and opportunities for future research.

## 2 LITERATURE REVIEW

Anthropologists often work with underserved communities and have a responsibility to those they study. Anthropological praxis is the study of planned change for good, meaning that critical thinking and interpretation are necessary to avoid unintended harm. It is theory “integrated with practice at the point of intervention” (Warry 1992: 156). Praxis goes beyond practice as it “requires an ethical objective, one that is often defined as activity that supports the self-determination of peoples and the actualization of human potential” (Baba 2000: 33). The praxis paradigm within anthropology has a number of core features. Any intervention guided by praxis should be communicative, collaborative, cooperative, agentive, theoretically informed, planned, dialogic, participatory, and responsible. Cultural competence is a core principal and practice in anthropological praxis, which incorporates and tailors interventions to the culture of the intended beneficiaries. In medicine, it was adopted as an intervention to address the ethical issue of health inequity (Betancourt, et al. 2014; Smedley, et al. 2003). This research is influenced by praxis principles and engaged in issues of social justice, aiming to contribute to a body of knowledge that could be used by doctors or in future medical education training or policy to improve health care for underserved groups. I aspire to make the knowledge generated from this ethnography available for use to those who participated or any who are interested.

The first rule of medicine is ‘do no harm.’ Cultural competence has been widely promoted in the medical field to decrease health disparities for minority groups by improving trust, communication, satisfaction, and compliance. In this section I discuss how anthropologists influenced the emergence of the concept and demonstrated the important role that culture plays in clinical outcomes. I also examine how cultural competence has the potential to mediate medical problems that stem from cross-cultural misunderstanding, but only if it is taught and

utilized in a nuanced way in line with poststructural models of culture. If it is not conceptualized and practiced correctly, it could, in fact, do harm.

## **2.1 Health Disparities**

Health is defined not only in terms of morbidity and mortality, but “functional status or disability, suffering, and quality of life,” which includes mental as well as physical health (Braveman 2006: 182). Numerous health disparities have been well documented. Notable health inequities for racial, ethnic, and sexual minority populations exist in cardiovascular care, cancer, cerebrovascular disease, renal transplantation, HIV/AIDS, asthma, diabetes, analgesia, rehabilitative services, maternal and child health, children’s health services, mental health services, and other clinical hospital-based services (Braveman et al. 2010; Smedley, et al. 2003; Williams and Mohammed 2009). Research shows that minority patients consistently receive poorer quality health care and have higher mortality rates than their counterparts, even when educational or socioeconomic differences and access related factors are controlled (Smedley et al. 2003; Smedley et al. 2004; Walsh et al. 2016). Many minority patients also disproportionately lack access to quality health services and opportunities to be treated by providers who share their culture, race/ethnicity, or speak their native language—a lack of which can lead to mistrust, miscommunication, and negative health outcomes (Oh et al. 2015; Nickens et al. 2001; Smedley et al. 2003). For LGBTQ patients, fear of being stigmatized and perceived or actual discrimination and hostility from providers can influence whether or not such patients disclose their sexuality, which can result in “receiving inappropriate health care, including misdiagnosis, under-diagnosis, and delays in seeking medical intervention” (Baker and Beagan 2014: 580). If patients do disclose their sexuality, providers may view it as irrelevant or hold stereotypes and misinformation that can negatively affect their patient’s treatment and health outcomes (Baker

and Beagan 2014). In this case, it is better for physicians to assume difference and acknowledge that their patients may not be straight in order to make them comfortable enough to disclose their sexuality.

These differences in health outcomes are not due to biological or genetic factors, but a combination of social, economic, and environmental causes as well as historical and structural inequalities. Race is a cultural construct and it is the lived experience of being a social, marginalized minority that contributes to health disparities, rather than heritability of genetic populations (Brown and Armelagos 2001; Kawachi et al. 2005). Health disparities are not limited to racial and ethnic categories as defined by the government,<sup>3</sup> but the United States commonly measures and compares disparities by race. In contrast, the United Kingdom primarily uses class to measure disparities (Adler and Rehkopf 2008; Braveman et al. 2010) This is due in part to America's history of slavery and the systems that evolved from it, which currently make racial information easier to obtain as it is more commonly collected and available in national databases than is socioeconomic status (Adler and Rehkopf, 2008). Race and class are distinct but intersecting social categories that influence each other to affect disparities and should be cross-analyzed for meaningful insight. Because race is often intertwined with class, both their independent and intersectional effects must simultaneously be accounted for in producing health disparities (Kawachi et al. 2005). The concepts cannot be separated in attempts to intervene in disparities due to their interlaced history and overlapping influence. To focus on correcting one and not the other through policy results in groups left behind (Kawachi et al. 2005). This imbues health disparities with a social justice component that inspires interventions. Health equity is often discussed as an ethical imperative and a basic human right (Betancourt et al. 2014;

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<sup>3</sup> United States Census Bureau. "About Race." Accessed February 24, 2017. <https://www.census.gov/topics/population/race/about.html>.

Braveman et al. 2017; U.S. Department of Health and Human Services 2011). Health equity may be achieved when marginalized and underserved populations have fair and just opportunities and access to resources for high quality healthcare (Braveman et al. 2017).

Disparities involve comparing groups and social factors rather than individual biological predispositions to health issues. Paula Braveman (2006) differentiated health disparities as not simply differences in health outcomes, but a type of difference that can be avoided or prevented by policies. She defined it as, “a difference in which disadvantaged social groups—such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination—systematically experience worse health or greater health risks than more advantaged social groups” (Braveman 2006: 167). Disparities are often measured in comparison with the most socially advantaged group—that has the most wealth or social power—which, in the United States, is typically constituted by white males (Braveman 2006). The literature largely juxtaposes disadvantaged racial or ethnic groups such as African Americans, Latinos/Hispanics, Native Americans, and Asians/Pacific Islanders “with non-Latino ‘whites’ of primarily European background” (Braveman, 2006: 172). The standard classifications used by the Census Bureau to gather data are aggregated (and therefore extremely limited), often conflate sex with gender, and exclude religion. A large body of literature has demonstrated that ethnic, racial, elderly, sexual, and gender minority groups face disparities in health compared to their white, male, heterosexual, and cisgendered (one whose gender identity matches with the sex/gender identity assigned at birth) counterparts (Baker and Beagan 2014; Lick et al. 2013; Parker 2011; Smedley et al. 2003). In certain cases, however, some minority groups have a better health status (LaVeist et al. 2011). They represent the baseline for health outcome potential that

is possible if given equal opportunities in access to, utilization of, and distribution of health care resources as a group.

Minority groups face racism and discrimination on a daily basis in their personal lives, but it is similarly present at an organizational and institutional level:

Because racism is deeply embedded in the culture and institutions of society, discrimination can persist in institutional structures and policies even in the context of marked declines in individual level racial prejudice and discrimination. Moreover, negative racial stereotypes that are deeply rooted in mainstream culture can serve as an additional source of discriminatory behavior even among persons who may not be prejudiced (Williams and Mohammed 2009: 21).

Health care providers are not immune to implicit cultural racism and culturally embedded stereotypes. A series of experiments has found that patients of different racial and gender identities who present the same set of symptoms receive differential diagnoses and recommended treatments (Smedley et al. 2003). These studies demonstrate that physicians' decisions can be influenced by unconscious biases about gender and race when it comes to patients, which could lead to poorer health outcomes for minority patients. Other studies have shown that minorities are more likely to have preventable hospitalizations or receive both clinical under treatment and more extreme forms of over treatment—such as amputation—than non-minorities (Smedley et al. 2003; Walsh et al. 2016). In its earlier days, the history of Western medicine included numerous ethically questionable methods. Many minority groups do not trust medical institutions for valid historical reasons (such as the Tuskegee syphilis experiment) and may be hesitant to seek care, further contributing to disparities (Oh et al. 2015; Williams et al. 2016). Minority groups represent over 30% of the US population and by 2050, the Census Bureau predicts that the country will become minority-majority (Colby and Ortman 2014). The growing demographic changes could mean that health disparities will increase if the existing disparities and their underlying causes are not addressed (LaVeist et al. 2011). Public health literature has reached a consensus that increasing diversity in the health workforce and teaching cultural and linguistic

competence are vital steps to address health disparities. Those steps can help improve communication between patients and providers, increase trust and satisfaction, and lead to better adherence and follow-up to improve health outcomes and limit miscommunications that could lead to serious medical errors (Oh et al. 2015; Smedley et al. 2003).

## **2.2 Cultural Competence**

### ***2.2.1 Conceptual Origins***

Cross-cultural medicine first appeared in the literature in the 1960s during the Civil Rights movement. The link between culture, illness, and healthcare and the concept of cultural sensitivity gained momentum in the 1970s, but the term ‘cultural competence’ as a skill entered the lexicon in the 1980s and 1990s (Smedley et al. 2003). Cultural competence is most often defined as “a set of congruent behaviors, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations” (Jernigan et al. 2016). In this context, culture refers to “integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups,” a definition of culture developed in anthropology in the first half of the 20<sup>th</sup> century (Stocking 1966). Competence implies “having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities” (Jernigan et al. 2016). In other words, cultural competence refers to the policies, knowledge, and skills required to allow health care systems and providers to effectively work with all patients and to incorporate their beliefs and practices into medical treatment to ensure high quality care, improve the likelihood of beneficial outcomes, and decrease instances of miscommunications that could have life-or-death consequences. It is important to note that the clinical cultural competence implies application in

situations of cultural *difference*, with an emphasis on various elements that make up one's culture. However, *every* successful doctor-patient interaction can be credited to cultural competence because, for example, in cases of doctor-patient concordance (or shared identity), the physician is already competent in the cultural practices of the patient and vice versa.

### ***2.2.2 Related Concepts***

Arthur Kleinman's 1988 book *The Illness Narratives* helped make cultural competence and explanatory models an essential part of best practices in biomedicine and clinical training (Kleinman and Benson 2006a). There are other important related concepts in the literature that can be taught alongside cultural competence in medical schools to expand its range and make it more reflexive. The first is 'cultural humility,' which emerged in the late 1990s, but is not yet formally integrated into contemporary medical school curricula. This idea acknowledges that it is impossible to be fully competent in another's culture, and instead encourages a lifelong commitment to learning from patients and promotes self-awareness and reflection to mitigate bias and power imbalances (Jernigan et al. 2016). Another overlapping concept is 'patient-centeredness,' which focuses on general listening and interpersonal communication skills, trust-building, and empathy to bring the individual patient's needs, values, and preferences into the interaction rather than the more directive biomedical communication style (Epner and Baile 2012; Swenson et al. 2004). It emphasizes the 'golden rule' of treating patients the way the *provider* would like to be treated in their situation. However, cultural competence would dictate treating the patient the way the *patient* wants to be treated, acknowledging that the doctor and patient may have very different ideas of what constitutes quality care. Interestingly, some, like older patients, may prefer the biomedical communication style to the patient-centered style and view it as more direct and informative (Swenson et al. 2004). The responsiveness of patient-



centered care can help physicians uncover and incorporate the expressed preferences of individual patients, but cultural competence expands its focus across cultures (Betancourt et al. 2014). Finally, the concept of ‘structural competency’ highlights institutional biases and examines the “structural determinants of physician-patient interactions, such as the health care delivery systems, location of clinics (e.g., proximity to trusted communities), hours of clinic operation, urban and rural infrastructures, and even the very definitions of illness, health, and culture” (Jernigan et al. 2016). Because cultural competence demands a “critical understanding of the underlying socio-political and economic processes of power, privilege, and institutional racism that create, support and maintain existing health disparities,” structural competency may allow doctors to recognize the role of social determinants of health more than other approaches (Jernigan et al. 2016).

### ***2.2.3 Curricular Approaches***

While cultural competence is promoted in public health and taught in medical schools, there is no standard curriculum across medical schools. Curricula frameworks and models vary considerably in scope, length, content, and mode of delivery, though accrediting bodies have cross-cultural education standards for undergraduate and graduate medical training (Jernigan et al. 2016; Smedley et al. 2003). Before beginning my fieldwork, I hypothesized that the implementation of cultural competence curricula may have occurred after my study participants left medical school, but that they would have been exposed to it in their required annual continuing education. However, physicians choose what they take for their continuing education hours, and two of the participants had never heard of cultural competence (more on this below).

Cultural competence education is intended to serve as the start of a lifelong learning process (Watt et al. 2016). Smedley et al.’s seminal 2003 report *Unequal Treatment: Confronting*

*Racial and Ethnic Disparities in Health Care* outlined three interdependent approaches to teaching cross-cultural education in the health professions that focus on attitudes, knowledge, and skills. Knowledge refers to awareness of the local context of the patient, social determinants of health, and relevant cultural protocols; Attitudes refer to underlying assumptions, biases, and prejudices that need to be addressed and a curiosity or willingness to learn about other cultures; Skills refer to cross-cultural communication and patient-centered skills (Watt et al. 2016).

The first approach is the ‘sensitivity/awareness approach,’ which concentrates on professional attitudes such as “humility, empathy, curiosity, respect, sensitivity, and awareness of all outside influences on the patient” (Smedley, et al. 2003: 203). This approach also promotes “self-reflection, including understanding one’s own culture, biases, tendency to stereotype, and appreciation for diverse health values, beliefs, and behaviors” by encouraging students to consider their own lives and times they felt different, open dialogue about the impact of various types of discrimination, and exercises to uncover their own hidden biases based on stereotypes (Smedley et al. 2003: 204). Such abstractions may seem impractical to clinically minded medical students, so it is important to stress the need for effective communication in clinical encounters and more effective treatment. This approach is generally taught early in medical school and in certain residencies.

Second is the ‘multicultural/categorical approach’ that provides knowledge on the “attitudes, values, beliefs, and behaviors of certain cultural groups” (Smedley et al. 2003: 204). This method provides a checklist of methods to care for patients of set demographics (i.e. Asian or Hispanic) that includes common health beliefs and practices with practice ‘do’s and don’ts.’ Absolute cultural classification is misguided and Smedley et al. make clear that:

With the huge array of cultural, ethnic, national, and religious groups in the United States, and the multiple influences such as acculturation and socioeconomic status that lead to intragroup variability, it is difficult to teach a set of unifying facts or cultural norms (such as ‘fatalism’

among Hispanics, or ‘passivity’ among Asians) about any particular group... These efforts can lead to stereotyping and oversimplification of culture, without a respect for its fluidity... Research has shown that teaching ‘cultural knowledge’ can be more detrimental than helpful if it is not done carefully (Smedley et al. 2003: 205).

The field of anthropology has developed from this old, inflexible, and harmful view of culture to a more holistic one currently in use after acknowledging that cultures and individuals change over time and vary greatly within groups. However, Smedley et al. provide two instances where this categorical approach can be useful in medicine. The first community-oriented instance is for areas with a large number of members from one culture—e.g., near borders, reservations, or communities with a new influx of a specific immigrant group. In this case it would be beneficial for providers to know certain details of the particular surrounding community such as:

...the social and historic context of the population (new immigrants or longstanding residents), the predominant socioeconomic status, the immigration experience (was the immigration chosen or forced), nutritional habits (diet high in protein, fiber, or fat), common occupations (i.e., blue collar or service industry), patterns of housing (i.e., housing development), folk illnesses and healing practices (i.e., empacho, “coining”<sup>4</sup>), and disease incidence and prevalence (Smedley et al. 2003: 205).

It is important to note that these details, while targeted to specific populations, focus more on the concrete conditions of daily life that providers should know about their patients rather than simplifying and stereotyping the beliefs and values of an entire group and calling it cultural knowledge. The second instance where the categorical approach may be useful is for evidence-based factors that can impact healthcare delivery—for example, the authors cite:

ethnopharmacology and drug interactions, disease incidence and prevalence among distinct populations (e.g., Tay-Sachs among Ashkenazi Jews), historical events that lead to mistrust of doctors among groups (e.g., the Tuskegee Syphilis Study), the effects of war and torture on refugee groups and how it may affect their interaction with healthcare, and common religious or spiritual practices that can interfere with therapies (e.g., fasting for Ramadan and how it might

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<sup>4</sup> Treatments like coining and cupping can leave painless and harmless bruise-like marks on the body, but if doctors are unfamiliar with these practices, they may view such marks as a sign of abuse.

affect medications that need to be taken with food). Some populations have a higher prevalence of particular illnesses either from heritable or socio-environmental factors or of reacting differently to certain medications, which doctors should be aware of. For example, “up to 75% of Pacific Islanders are unable to convert the antiplatelet drug *clopidogrel* into its active form and are at higher risk for adverse outcomes following angioplasty” (Oh et al. 2015: 2). In these two instances, Smedley et al. recommend asking the following questions to avoid over-reliance on the lists (205-206): How accurate and generalizable are these group assumptions? How current are they, given the fluidity of culture and diversity among groups? What are the limitations? How can I use this knowledge to deliver better care? All other situations should focus on the context and perspectives of the individual patient and avoid generalizations. This approach is taught in undergraduate, graduate, and continuing medical education.

The third is the ‘cross-cultural approach’ that focuses on skills. It incorporates communication frameworks and ethnographic skills from medical anthropology into clinical medical interviewing. This approach focuses on the patient as the starting point for inductive information gathering, so the doctor can adjust to meet patient needs. It helps providers to remain aware of and incorporate cross-cultural issues, social issues, and health beliefs into their practice by providing methods:

...for eliciting patients’ explanatory models (what patients believe is causing their illness) and agendas, identifying and negotiating different styles of communication, assessing decision-making preferences, the role of family, determining the patient’s perception of biomedicine and complementary and alternative medicine, recognizing sexual and gender issues, and being aware of issues of mistrust, prejudice, and racism, among others (Smedley et al. 2003: 206).

This is a more practical clinical approach that better avoids generalizations and can work for any patient. It is taught in undergraduate, graduate, and continuing education courses. It is challenging to evaluate whether providers learn what was taught, use what they were taught, and if it has an impact on care, patient satisfaction, and health outcomes (Watt et al. 2016). Studies

have shown mixed but promising results in the improvement of provider knowledge, skills, and attitudes following cultural competence education as well as patient satisfaction (Govere and Govere 2016; Watt et al. 2016).

#### ***2.2.4 Beyond the Classroom: Models for Practice***

There are number of clinical cultural competency models for providers to employ in their practice, many of which are simple acronyms (AAMC 2005; HRSA n.d.). For example, the CRASH model signifies: Consider culture, Respect, Assess and affirm, Sensitivity and self-awareness, and Humility. Other models list a series of action steps, such as the BATHE model, which stands for Background (What is going on in your life?), Affect (How do you feel about what is going on?), Trouble (What troubles you most?), Handling (How are you handling that?) and Empathy (This must be very difficult for you.). Another model called BELIEF stands for Beliefs about health (What caused your illness/problem?), Explanation (Why did it happen at this time?), Learn (Help me to understand your belief/opinion.), Impact (How is this illness/problem impacting your life?), Empathy (This must be very difficult for you.), and Feelings (How are you feeling about it?). The LEARN model recommends that doctors Listen with sympathy and understanding to the patient's perception of the problem, Explain their perceptions of the problem, Acknowledge and discuss the differences and similarities, Recommend treatment, and Negotiate treatment. The ESFT model for communication and compliance helps providers uncover their patients' Explanatory model, Social risk for noncompliance, Fears and concerns about the medication, and engage in Therapeutic contracting and playback. The ETHNIC model lays out Explanation (How do you explain your illness?), Treatment (What treatment have you tried?), Healers (Have you sought any advice from folk healers?), Negotiate (mutually acceptable options), Intervention (agreed on), and Collaboration (with patient, family, and healers). These

are just some of the acronyms in the literature. Finally, Arthur Kleinman's (1978) aforementioned influential questions to incite illness narratives consist of: What do you call your problem? What name does it have? What do you think caused your problem? Why do you think it started when it did? What does your sickness do to you? How does it work? How severe is it? Will it have a short or long course? What do you fear most about your disorder? What are the chief problems that your sickness has caused for you? What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment? While I think these are excellent questions, I do not expect doctors to ask each of these with all of their patients, even if they are familiar with them, given time constraints<sup>5</sup>.

All of these models have their strengths, but I came across an unpublished framework created by Dr. Carrie Byington<sup>6</sup> that is worth noting. Via email, she informed me that it was developed while working in a public health clinic in Utah to teach medical students and residents how to care for poor patients that were recent immigrants. She intends to use it in future inter-professional education courses. Her acronym, the EQUALSS model, combines elements of the other models, naturally fits within the components of the clinical encounter (Boutin-Foster et al. 2008), and consists of action steps that are easy to recognize as an observer, rather than concepts for the provider to keep in mind (e.g., empathy) while giving care. EQUALSS follows seven clear steps. The E stands for Environment; Qu for Question; A for Alternatives; L for limits; S for Strengths; and the last S stands for Suggestions. In the first step, the doctor should gather basic information about the patient's *environment* such as family structure (e.g., single-parent, extended family, divorced, etc.), insurance (i.e. type, eligibility, limits), country of origin (for

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<sup>5</sup> I have never been asked these questions as a patient at a doctor's office. Kleinman is trained as a psychiatrist, so he may be used to more face time with patients during appointments and in talk therapy.

<sup>6</sup> Byington, Carrie L. 2003. "Clinical Cultural Competence." UPenn Perelman School of Medicine. Accessed February 21, 2017. [https://www.med.upenn.edu/gec/user\\_docs/PDF/Health%20Equity%20and%20Literacy/Kleinman\\_s\\_8\\_Questions.pdf?](https://www.med.upenn.edu/gec/user_docs/PDF/Health%20Equity%20and%20Literacy/Kleinman_s_8_Questions.pdf?)

parents and children if working with children), ethnicity, language (for parents and children), and literacy level. In the *question* phase, the provider inquires about the issue to be addressed and the patient's concerns. The model recommends Kleinman's questions at this stage. In the following step, the provider should discuss treatment options and *alternatives* patients may wish to engage in that might include allopathic medicines in addition to alternative cultural healing modalities such as herbal or natural medicines, traditional treatments and healers, or religious ceremonies. The next stage should include a consideration of the *limits* to implementing a health plan. The model differentiates limits into two categories: (1) concrete issues that stem from the environment, such as logistics and (2) psychological or family issues, which may include children or job commitments. The penultimate step encourages doctors to recognize that all individuals and families have *strengths* that can aid in building a health plan and examine these with the patient. The model lists resilience, adaptation, strong family structure, and extended institutional resources such as a school or religious community. In the final step, the doctor should make *suggestions* to enhance adherence to the agreed upon treatment plan and ask the patient for ways to ensure it happens. These steps are intended to aid the physician in determining a patient's individual context and needs and collaborate with them to create a culturally appropriate treatment plan.

### ***2.2.5 Cultural Competence at the Institutional Level***

Cultural competence education is one element of a series of recommended interventions to improve care for underserved populations. Prominent authors in the literature agree that increasing underrepresented minority providers is a vital step to help alleviate disparities by increasing patients' access to providers who share their culture or language, but it is only one aspect of achieving a culturally competent workforce (Cohen et al. 2002; Sullivan Commission

2004; U.S. Department of Health and Human Services 2013; Walsh et al. 2016). Ongoing cultural competence training is recommended as a requirement for all providers despite background. Some have argued that cultural competence cannot be learned only from books, but must be experienced in person (Williams, et al. 2016). This is another reason that the literature advocates for increased diversity in medical schools to address disparities; it is beneficial not only for minority patients, but for other providers to gain cross-cultural experience as well.

The Office of Minority Health has outlined National Standards for Culturally and Linguistically Appropriate Services (CLAS), which recommend a number of practices for public health and health care institutions (U.S. Department of Health and Human Services n.d.). They are not mandatory, but have been increasingly adopted. The original 2004 National CLAS standards were enhanced to be grounded in a broader definition of culture that recognizes health as being influenced by factors ranging from race and ethnicity to language, spirituality, disability status, sexual orientation, gender identity, and geography (U.S. Department of Health and Human Services 2013). The *Principal Standard* is to “provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs” (U.S. Department of Health and Human Services 2013). For example, the

*Communication and Language Assistance* standards include:

- (5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- (6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- (7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- (8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (U.S. Department of Health and Human Services 2013: 13).

The remaining 15 standards address the ongoing training of providers and the management of



facilities. The blueprint provides detailed guidelines for implementation. The national CLAS standards align with some accreditation standards and have inspired individual state-level laws. Additionally, the Association of American Medical Colleges (AAMC) has created a Tool for Assessment of Cultural Competence Training (TACCT) that medical schools can use to assess their own curricula for knowledge, skills, and attitudes in cultural competency<sup>7</sup>. The original five domains include: 1) the rationale, context, and definition of cultural competence, 2) key aspects of cultural competence, 3) understanding the impact of stereotyping on medical decision-making, 4) health disparities and factors influencing health, and 5) cross-cultural clinical skills (AAMC 2005).

### ***2.2.6 Failure to Comply: Resistance to Cultural Competence***

There are a number of practical impediments to cultural competence training and practice. Faculty and students may be averse to training because of its time and labor intensity, lack of institutional commitment or funding, or lack of culturally competent role models (Jernigan et al. 2016). Medical learners may desire neat categorical information with high clinical relevance, or the cultural checklists (Watt et al. 2016). Further, students may be apathetic because they view it as a ‘soft science’ that is less valuable than basic science and clinical knowledge, and may perceive themselves as more culturally competent than their attending physicians and residents (Jernigan et al. 2016). Students might also feel alienated, defensive, and resistant when asked to critically examine their own biases or ethnocentrism (Boutin-Foster et al. 2008; Watt et al. 2016). In practice, physicians may aspire to be ‘culture blind’ and treat all patients and medical cases uniformly, either because they view culture as irrelevant to the medical problem at hand or because they fear stereotyping if they focus explicitly on race or

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<sup>7</sup> Association of American Medical Colleges. “Revised tool for assessing cultural competence training.” Accessed March 1, 2017. [www.aamc.org/initiatives/tacct/](http://www.aamc.org/initiatives/tacct/).

ethnicity (Baker and Beagan 2014; Beagan and Kumas-Tan 2009). They may view interactions with minority patients as difficult or stressful and lack confidence on how to handle them (Watt et al. 2016). Providers might only accommodate different values or expectations when patients explicitly state them and can lack information on or access to community resources like interpreters; Using family members and children among immigrants to interpret remains common despite increased miscommunication risks and the CLAS standards (Watt et al. 2016). Time limits serve as a another barrier to practice, given that providers only have an average of 13-16 minutes with patients (Brodwin and Radovanovic 2016). Limited time with patients is a financially motivated structural barrier to quality care that will be discussed in depth in the ethnographic analysis.

### **2.3 Anthropological Concepts of Culture**

Sociocultural differences between patient and provider can influence communication and medical decision-making. Research indicates that provider-patient communication is directly linked to patient satisfaction, adherence to treatment, and therefore health outcomes (Rapp 1998; Smedley et al. 2003). Conversely, miscommunication in the medical encounter could lead to patient dissatisfaction, non-adherence, and poorer health outcomes, and it could perpetuate racial and ethnic health disparities (Smedley et al. 2003). Studies have shown that culture matters in health, but the contemporary definition of culture is not singular or static. Contemporary theories from postmodern, feminist, and biological anthropologists can help shift outdated notions of culture to improve the concepts and practices of clinical cultural competence.

The early 1970s were a time of rapid technological growth, reductionism, and bureaucracy in medicine, but there was also a mounting concern that patients were not being treated as individuals living in a social context (Kleinman 2013). Arthur Kleinman popularized

the distinction between illnesses as patients experience them and disease as physicians diagnose, treat, and understand it. He intended for the inclusion of patient experience to enhance medical care, but instead it became co-opted and compartmentalized as a “discrete element of a rote medical science” (Kleinman 2013: 1376). Kleinman created a renowned list of questions to uncover patient explanatory models (Kleinman et al.1978). These widely taught questions were intended to open up conversations for understanding and shift a one-sided doctor-patient dialogue to a more equal one. However, by the 1990s this intention was undermined as they were used as a conversation stopper and “a mechanical task that assumed that dynamic meanings could be fixed as a single, unchanging, material thing in the patient’s record” (Kleinman 2013: 1376). Explanatory models were treated as a concrete parameter (like blood pressure) in clinical rounds and “what was meant to humanize care by providing room for lay voices and practices appeared instead to be reducing complex lives to limiting, biased stereotypes” (Kleinman 2013: 1376). Some fetishized illness narratives as symbols and stories that removed meaning from their “economic, emotional, and relational context of the lived experience of suffering” (Kleinman 2013: 1376). Ethnographic examples can demonstrate a wide variety of illness and healing practices to initiate the process of cultural awareness and curiosity, question universals, and reveal the pitfalls of ignoring its importance. Texts such as Anne Fadiman’s (1997) *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* became canon in teaching cultural competence, but they promote an essentialized static notion of culture that problematically compares it to billiard balls destined to collide rather than examining unequal distributions of power (Taylor 2003). Nuanced anthropological notions of cultural processes became stereotypes and checklists in medicine’s cultural competence movement (Kleinman and Benson 2006b).

The biomedical model has been criticized for being reductionist because it tends to treat humans as bodies rather than beings (Good 1994). For example, nutritional science reduces a food down to the specific nutrient, vitamin, or mineral within a food to be avoided or prescribed for health, and ignores the food itself, including the flavors or cultural relevance. Similarly, one of the pitfalls of biomedicine is the potential to reduce a person down to their disease, focusing on a singular identifiable cause (such as a specific pathogen to be treated), while ignoring the person, their experience, or environmental contributing factors. The scientific and mechanical nature of the beast lends itself towards a tendency to distil the complex and isolate components that can be easily tested in trials. However, like all cultural systems, biomedicine is not one singular or static model. Though it is based on the scientific approach to disease and illness, it has changed over time and is practiced differently among various cultures and individual health care providers. The limitations have been noticed and there have been attempts to incorporate new models through policy, like cultural competence interventions that expand biomedical focus.

### ***2.3.1 Classic vs. Poststructural Cultural Models***

Problems can occur when sociocultural elements are essentialized, naturalized, biologized, and pathologized. Anthropologists in different subfields have addressed the ways these processes happen and why they should be avoided. Postmodern anthropologists have illustrated the ways that the concept of an inherent culture can be used to fix differences between people as ‘innate’ (Abu-Lughod 1991; Trouillot 2003). Feminist anthropologists demonstrate this by identifying gender difference in culture rather than biology (Abu-Lughod 1991; Mascia-Lees, et al. 1989). Biological anthropologists have demonstrated that race is a social, rather than biological concept (Brown and Armelagos 2001; Chakravarti 2014). It is essential to remain cognizant of the fact that these populations are social constructs, making health disparities a

social problem to address accordingly. Human variations exist on a spectrum, and there is significantly more genetic variation within groups than across them (Brown and Armelagos 2001). Humans all share genetic ancestry and have never been separated into isolated breeding populations long enough for significant genetic differences to occur (Brown and Armelagos 2001). Health disparities are thus largely due to socioeconomic stressors, environmental and epigenetic influences, cultural factors, and societal prejudices that can impair development, cause downstream effects on physiology, and lead to chronic or acute health problems. For example, there are higher rates of hypertension among people who classify themselves as African Americans, but this pattern is not true of African-descended populations in the Caribbean or among sub-Saharan Africans, which rules out ancestry or genetic vulnerability and indicates social factors (Adler and Rehkopf 2008; Kawachi et al. 2005). Additionally, the health of recent immigrants is often better than the next generation, which shows that social or environmental conditions (e.g., poor nutrition) rather than heritage cause disparities<sup>8</sup>.

There are a few cases of differences in health among small isolated population groups that therefore have higher frequencies of certain genes (like in a founder population or bottleneck) that can have medical impacts. Overall, differential population health outcomes do not stem from genetic components, with the exception of a few ethnic groups that have either been ostracized or self-isolated in repose to economic, political, or religious contexts—such as Ashkenazi Jews, Basques, Sardinians, and Sorbs (Chakravarti 2014)—and the exception of a few diseases such as Tay-Sachs or sickle cell anemia (Adler and Rehkopf 2008). The social and economic inequalities that intersect with racial and ethnic categories are the underlying cause of

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<sup>8</sup> PBS, 2008. “Arriving Healthy” from *Becoming American*, Episode 3 of *UNNATURAL CAUSES: Is Inequality Making Us Sick?* California Newsreel, uploaded 4 June 2009. Accessed November 6, 2016. <https://www.youtube.com/watch?v=W5KfDL-nlrE>.

health disparities, and they are what must be addressed (Dressler 2010). When unavoidable biological causes are given up, all that remains are unjust social conditions.

The postmodern anthropological view of culture stresses context and history, power structures, structural and institutional violence, multivocality, subjecthood, and reflexivity through awareness of one's own cultural context, the situatedness of their own knowledge, and their positionality in relation to the other being studied (Abu-Lughod 1991; Trouillot 2003). Like anthropology, medicine is a study of humans that was historically dominated by the West (Abu-Lughod 1991). Michel Foucault (1995) argued that the medical discipline, like all Western sciences that came out of the Enlightenment, was born from a system of power and domination that use the body as a means of subjugation (Foucault 1995). In its early days, the history of medicine included ethically questionable and unethical methods that Foucault called a "political anatomy" to explore, break down, and rearrange the body (Foucault 1995: 138). Because these methods were usually practiced on marginalized groups and colonial subject populations, there has been a historical power divide and many minority groups do not trust medical institutions for good reason.

One important example as to why members of certain minority populations maintain mistrust for the medical industry is the famous 40-year long Tuskegee syphilis experiment, in which African American men were studied without informed consent and denied proper treatment for syphilis in order for researchers to document its natural progression<sup>9</sup>. Another example is the federally funded coerced and forced sterilizations of (primarily) Hispanic and Latina women over a 70-year period in California state institutions without their consent (Stern 2005). Similar legal eugenics programs also affected African American and Native American

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<sup>9</sup> U.S. Public Health Service Syphilis Study at Tuskegee. "The Tuskegee Timeline." Accessed October 17, 2017. <https://www.cdc.gov/tuskegee/timeline.htm>.

groups as well as the impoverished and those considered disabled, and occurred in various parts of the country. Cultural humility encourages doctors to be aware of historical contexts, power dynamics between them and their patients, institutional bias in medicine, and their own personal biases to address health disparities (Jernigan et al. 2016). These inequities in social class, gender, and ethnicity were born from a history of unequal political, economic, and social power and resource distribution (Boutin-Foster et al. 2008; Parker 2011).

If cultural competence is taught the wrong way, following the classic culture concept, it has the potential to contribute to the othering of cultural groups or perpetuate essentialized stereotypes, enforce marginalization and inequality, and accomplish the opposite of its intended purpose (Baker and Beagan 2014; Beagan and Kumas-Tan 2009). In clinical settings, making assumptions about the values, morals, or beliefs of specific groups can impact clinical decisions made (Boutin-Foster et al. 2008). If cross-cultural skills are only taught in the context of the ‘other,’ where the doctor and patient belong to discordant racial or ethnic groups, it could further promote the harmful dichotomy of ‘them’ and ‘us’ (Boutin-Foster et al. 2008). For example, despite the proliferation of cultural competence education, sexual and gender minority patients (LGBTQ) often remain invisible and continue to face unique health needs, risks, and disparities (Baker and Beagan 2014). Health care providers do not generally discuss gender identity with patients, which reinforces heterosexuality as the assumed and preferred norm (Baker and Beagan 2014). Equally, framing cultural competence as something to be used on an unchanging racialized ‘other’ depicts whiteness as the norm that exists somehow outside of culture and reinforces its neutral hegemony. Doctors may view patients of a different background than themselves as arduous because of language barriers, sociocultural differences, or fears of stereotyping (Paternotte et al. 2015). This understanding can unintentionally place the blame on

the patient's culture as both a source of problematic behavior and solution to the difficulties of working with minority patients (Parker 2011).

Consequently, relationship-based models and patient-centeredness have been promoted to replace encounter-based models of cultural competence (Epner and Baile 2012; Parker 2011). This would address the many dimensions of care that are influenced by culture and extend to family members as caregivers (Parker 2011). Postmodern anthropology deconstructs the self, other, and the old essentialized versions of culture, recognizing them as fluid rather than static (Abu-Lughod 1991; Trouillot 2003). Cultural competence is not limited to race, ethnicity, and language. It applies to *all* people because everyone has beliefs and practices regarding health that are influenced by their personal experience and broader culture that can differ from person to person—even those within the same group.

### ***2.3.2 The Culture of Medicine***

Though they may ethnocentrically view it as the “culture of no culture,” medical providers are situated within their own culture that contains a particular dress code, stylized language, and explanatory model (Boutin-Foster et al. 2008: 108). For example, the iconic white coat traditionally symbolized “sterility, science, and healing,” is often ritually bestowed in a ceremony, and confers a sense of authority in the doctor-patient relationship (Boutin-Foster et al. 2008: 108). Additionally, ‘doctor talk’ is not explicitly taught, but “the lexicon of physicians is characterized by statistical facts, presented in terms of probability, gradations of severity, and the use of acronyms and medical terminology that is often unfamiliar to the patient” (Boutin-Foster et al. 2008: 108). This necessitates linguistic competence skills needed for patient understanding (Rapp 1998). Patients require a certain amount of medical literacy to navigate the healthcare system, understand their doctor, make informed choices, and advocate for themselves; while



providers must be able to explain complex concepts clearly in a way that patients can understand (Tsai and Lee 2016). Therein lies potential to place most of the burden on the patient. Finally, the pathophysiological explanatory model that physicians learn in medical school may be incongruous with their patients' models, which should be kept in mind when negotiating treatment plans (Boutin-Foster et al. 2008).

These examples can be pointed out to medical students to demonstrate the values and biases within 'biomedical culture,' in-group variability, and spark self-reflection for cultural humility (Boutin-Foster et al. 2008). This practice echoes the reflexivity encouraged in anthropology and could aid doctors both in questioning their perspectives and recognizing that they have a distinct cultural standpoint with their own explanations of illness that might be different from *all* patients, not just those often stereotyped as 'diverse.' Poststructural anthropology also questions the validity of science and objectivity, illuminates the partiality or bias of the observer, and the partial or incomplete nature of what they observe (Abu-Lughod 1991). Physicians can similarly note the origin of medicine and that their own health model is one of many, recognize that they do not uncover all of their patients' views and context in consultations, and strive to see their patients' models as valid rather than dismiss them (Boutin-Foster et al. 2008; Kleinman 1988).

Different cultural traditions advance different ideas of what wellness is, what causes illnesses, and the appropriate way to cure them. These explanatory models are meaningful and valid to their patients whose practices and beliefs will influence their health outcomes. Additionally, cultures are not isolated; they are interconnected with each other, and doctors should not assume that patients are unfamiliar with biomedicine in such a globalized world (Abu-Lughod 1991; Boutin-Foster et al. 2008). Medical pluralism in a heterogeneous society like

the United States means that patients from any background may practice or seek out available treatment from various healing modalities in replacement of, in conjunction with, or to supplement biomedical treatments (Kaptchuck and Eisenberg 2001). Diagnosis derives from value-laden medical traditions and takes on culturally specific meanings. It is based on a discourse of perceived and interpreted symptoms that does not include socioeconomic variables. Dialogue opens diagnosis to debate (Crandon-Malamud 1991). Patients can hold multiple and conflicting explanatory models for illness and treatment at the same time. Furthermore, explanatory frameworks for the causes and treatments of illness are not set in stone. An individual's explanatory framework draws from their broader group culture, but can also be influenced by personal experiences or interactions with others (like doctors), and it change over time (Mattingly and Garro 2000).

### ***2.3.3 The Medical Interview as Ethnography***

Cultural competence is best viewed as an investigative collaborative skill set or way of thinking and behaving rather than a checklist of cultural traits. It would be impossible for providers to sustain a detailed knowledge of the cultures of all of their patients in addition to everything else they must learn. Additionally, cultures are not static; they are always changing and individuals are influenced by and navigate their culture in different ways (Abu-Lughod 1991). Physicians must understand that individuals within a culture are not homogenous and avoid notions of cultural coherence (Boutin-Foster et al. 2008). Rather than assume difference or similarity without investigation, doctors can work with individual patients the way that postmodern anthropologists use ethnography of the particular to avoid essentializing or stereotyping (Abu-Lughod 1991; Trouillot 2003). Physicians can conduct a 'mini-ethnography,' using Kleinman's questions as a guide, during the medical interview to move away from

checklists and uncover their individual patient's explanatory models of illness (Kleinman et al. 1978; Turner 2005). Kleinman and Benson (2006b) created a revised cultural formulation that lists six steps to conduct such an ethnographic interview in a medical setting. Firstly, the clinician asks about ethnic identity and determines if it matters for the patient, because its importance can vary across individuals. Second, physicians evaluate what is at stake for patients and their families to understand the moral experience of illness and suffering—meaning the experience has value and matters to the patient (Kleinman 2013). The third step is to gather the illness narrative, which can have serious implications for care (Mattingly and Garro 2000). Fourth, the clinician inquires about ongoing psychosocial stress and existing social support to make recommendations. Fifth, the doctor maintains awareness of the influence of culture in clinical relationships including bias, appropriate or inappropriate technology use, and stereotyping. Finally, they remain conscious of the problems with cultural competence, such as patients finding it intrusive, if an intervention works in that particular case, and that 'non-compliance' may not have a solely cultural root, but a socioeconomic one. This system gathers information on the body, psychology, and culture of patients. When employed correctly, cultural competence has been shown to improve patient-provider communication, build trust, allow for better collaborative decision-making, and increase patient satisfaction, which heightens the likelihood of treatment adherence and follow-up visits for healthier outcomes (Govere and Govere 2016; Watt et al. 2016).

#### ***2.3.4 Biocommunicable Models***

One way to understand individual illness narratives is to contextualize them in broader narrative discourses. Biocommunicability is the way that health information and narratives are communicated and circulated across institutions, media, and the public sphere (Briggs and Hallin

2016). Health inequities and are intertwined with communicative inequities through syndemics, the process of where layers of disadvantage (like race, class, and gender) compound and interact with disease to produce exponential rather than simply additive adverse health effects (Briggs and Mantini-Briggs 2016; Singer and Clair 2003). Communicative inequities that stem from power imbalances determine whose voices are heard and given credibility, which can impact doctor-patient interactions and health outcomes and have broader implications for public health and epidemiology (Briggs and Mantini-Briggs 2016; Wilce 2009). Scientific medical knowledge is hierarchized and privileged over the subjectivities of patients and their relatives; it monopolizes the hegemonic institutions that control the flow of health information and biomedical interventions. This linear top-down approach to health creates power imbalances (Briggs and Mantini-Briggs 2016). Patients who are not medically literate may not get heard or properly treated (Briggs and Hallin 2016; Wilce 2009). A biocommunicable model is “a cultural model of the creation, circulation, and reception of health-related knowledge” (Briggs and Mantini-Briggs 2016: 230). Following are three intersecting, recurring cultural models of health reporting that can aid in framing clinical interactions and communication. Each has positive and negative implications.

The ‘biomedical authority model’ (Briggs and Hallin 2016: 25) operates under the assumption that if people are merely educated with information on proper practices (e.g., proper hygiene or condom use) and follow orders, they will not get sick (Briggs and Hallin 2016). The patient is the passive recipient of knowledge and it is their job to do what they are told by the doctor. The burden of cultural barriers is then placed on the ‘other’ (i.e. minorities) rather than the doctor who told them the ‘correct’ information. Failure of biocommunicability is thus caused by unreceptive patients who failed to play their part or abandon ‘superstition’ (Briggs and Hallin

2016). This broader culture creates a linear paternalistic view of medicine that gives unquestioned authority to biomedicine, technology, and health care providers. It legally establishes formal institutions as the only legitimate source of medical knowledge that supersedes other explanatory models, systems, or practitioners (Baer, et al. 1986). While the strict regulation and standardization of this model can help ensure a certain level of safety and consistency, it can also perpetuate victim blaming and ignore systematic institutional inequalities that are the true cause of disparities. Other cultures have their own medical discourses and conceptualizations of illness that differ from the biomedical model. These different discourses must be taken into account in order for biomedical providers to be considerate of their patients and find appropriate treatment plans and improve health outcomes. This model ignores the agency and knowledge of the patient about their own situation.

The backlash against the biomedical authority model of medicine created a push for more patient-centered care and a model that views health as more than the absence of disease. Unlike the paternalistic scheme of the doctor-patient relationship, the ‘patient-consumer model’ views individual patients as rational actors who make their own health choices outside of their physician’s supervision (Briggs and Hallin 2016: 33). They have agency and educate themselves about their options. Rather than viewing patients as passive recipients, this model recognizes that patients can come to the doctor prepared with questions and their own research into alternatives. It acknowledges that patients may have a different or conflicting expectations of the role of the doctor, the role of the patient, how a consultation should be run, how long it should last, how many people are involved, who speaks to the doctor, the causes of illness, or appropriate treatments (Guzmán 2014; Harvey 2008). Patients may weigh risks and refuse the recommendations given by doctors due to their knowledge of their own situation (Rapp 1998).

This neoliberal model places the burden to decide on medical care on the patient. However, with the wide range of conflicting or false information available, their choices may not always be the best for their health. The anti-vaccine movement, which endangers not only the children who are not vaccinated, but those around them as well, is a good example of the pitfalls of such a model. Ideally, doctors and patients work together to find the best course of action, but the model fails to consider those without many options, such as immigrants who do not speak English and people living in rural areas or in poverty.

The ‘public sphere model’ views patients as “citizen-spectators” who make collective social decisions and values that may conflict with the linear biomedical authority model (Briggs and Hallin 2016: 39). Politicians, private businesses such as drug companies, and broader social movements can influence these agendas. The media is not separate from medicine and health communication, but is influenced by health institutions and can influence health outcomes (Briggs and Hallin 2016; Briggs and Mantini-Briggs 2016). Additionally, non-hegemonic media sources, such as conspiracy theories or other popular discourses, can influence patient decisions (Briggs 2004; Rapp 1998; Wilce 2009). The way certain diseases are communicated in the media and broader culture can also serve to promote othering and fear of those with ‘primitive’ lifestyles. This process of bioethnic conscription places “social identities and life conditions onto biological explanations of differences and disease causality” (Briggs and Hallin 2016: 172). In other words, it essentializes illness and blames it on culture or ‘inherent’ features of a population. This was seen during the Ebola outbreak, with the AIDS epidemic, and an indigenous rabies outbreak in Venezuela where media and political narratives paternalistically viewed marginalized groups as innately naive, blamed ‘unhygienic’ cultural practices, or genetics rather

than the true social, economic, environmental, and political disease vectors (Briggs and Mantini-Briggs 2016; Briggs and Hallin 2016).

These performativity models may help to examine doctor-patient interactions, particularly among (but not limited to) cross-cultural encounters where patients may seek out alternative or traditional healing methods in addition to their biomedical treatments. To be culturally competent, doctors can seek to elicit this information from patients and be aware of medical pluralism. To ensure effective care, patients' explanatory models must be included in decision-making and treatment planning. Their input and worldview should not be written off.

All cultures hold medical discourses, practices, and conceptualizations of illness that can differ from the current biomedical model. These different discourses must be taken into account in order for providers to be considerate of their patients and find appropriate treatment plans. When doctors move away from classic culture concepts to focus on the whole person in front of them and utilize ethnographic skills, they can improve care and health outcomes. Medicine should recognize that culture is not a "static trait that can be memorized and applied categorically" (Boutin-Foster et al. 2008). Culture itself cannot be reduced to a technical skill in which to develop expertise or competence (Kleinman and Benson 2006b). Likewise, it is not only the domain of the patient and their family. Cultural competence must be taught and practiced in a nuanced way that does not reinforce stereotypes for it to be successful. Doctors can integrate cultural competence concepts with patient-centered practices and cultural humility to be aware of their personal and institutional biases, be sensitive to patient needs, and determine the complex ways that individual patients experience health and illness to work together for the best possible health outcomes. However, providers have limited time to interact with patients and cultural competence training ought to allow them to better work with them as individuals under

their constraints (Brodwin and Radovanovic 2016). This thesis examines how, if at all, distinct models of culture or cultural competence enter into the medical consultation process, and why doctors make the decisions they do with regards to culture and medical practice.



### 3 RESEARCH METHODS

#### 3.1 Overview

This thesis utilizes ethnographic methods to research the conceptualization of culture and practices of cultural competence among Atlanta doctors as well as the ways that the medical establishment limits or shapes how they engage with the idea of cultural difference. The focal participants include one medical student and three practicing physicians in different offices in the greater Atlanta, Georgia area and surrounding cities: Dr. Primmer, a family medicine provider in Austell; Dr. Hart, a cardiologist in Atlanta; Dr. Rast, an allergist in Marietta; and Dr. Young, a second-year medical student. Due to the small number of participants, the ethnography constitutes a more focused analysis. Participant observation techniques were employed to gather core data by shadowing two of the doctors who agreed: the family medicine provider and cardiologist. Other methods included semi-structured interviews, informal interviews, and patient questionnaires (Bernard 2011; Trotter and Schensul 1998). Although nurses, nurse practitioners, and physician's assistants also receive cultural competence training and interact with patients (often times more than the doctors), their overall educational experience is different than that of physicians. Concentrating on physicians focused the scope of the study. Patients under the age of 18 who would require parental consent were also excluded. The research took place between August-September of 2017.

#### 3.2 Research Design

##### *3.2.1 Field Sites*

The participant observation portion of this research took place in a cardiology office in a suburb of the Atlanta metropolitan area and a family medicine office in the city of Austell. Both are private practices. Written site permission was obtained for the two offices prior to conducting

participant observation. Before commencing the fieldwork, I attempted to determine possible characteristics of the patients I might come across at the two sites to predict the likelihood of cross-cultural or linguistic interactions I might witness. The populations of the two cities that host my research sites are broken down into demographics as follows<sup>10,11</sup>: The racial and ethnic diversity of Atlanta is separated into approximately 38% White, 54% Black or African American, 5% Hispanic or Latino, 2% Other, 1% Multiracial, 3% Asian, below 1% American Indian, and below 1% Native Hawaiian or Pacific Islander. Those who are foreign-born make up 7.6% of the overall population. People who speak a language other than English at home (above 5 years old) encompass 10.8% (between 2010 and 2014). The median household income was \$46,439 (between 2010 and 2014) and the per capita income in 12 months was \$35,719. Those who fall under the poverty line make up 25.2% of the population and 19.7% do not have insurance. The racial and ethnic diversity of the city of Austell is differentiated into approximately 32% White, 55% Black or African American, 11% Hispanic or Latino, 6% Other, 2% Multiracial, and 1% Asian. Those who are foreign-born make up 13% of the population. People who speak a language other than English at home (above 5 years old) comprise 18.8% (between 2010 and 2014). For 2010-2014, the median household income was \$45,931 and the per capita income in 12 months was \$18,709. Those who fall under the poverty line make up 18.7% and 24.2% do not have insurance. I could not find Census data for religion. Problems with limited governmental racial and ethnic categories are discussed in another section.

It should be noted that while these are the demographics for the cities hosting the participating offices, they do not necessarily reflect the characteristics of the actual patient populations. While these statistics represent the cities' overall populations, cities and their

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<sup>10</sup> United States Census Bureau. Accessed February 24, 2017. <https://www.census.gov/quickfacts/table/>.

<sup>11</sup> Suburban Stats: Population Information and Statistics From Every City, State and County in the US. 2017. Accessed February 24, 2017. <https://suburbanstats.org/population/georgia/list-of-counties-and-cities-in-georgia>.

surrounding areas are often segregated. There are a number of factors that may influence patient diversity in terms of socioeconomic status. Patients might have to travel from other nearby cities to visit these offices, especially in the case of specialists that may not be available close to their homes. This may serve as a barrier to low-income patients who only have access to public transportation or cannot afford to take time off of work. Private offices can choose to take different types of insurance plans than public ones, which could affect patient demographics. Because of this, private offices may have patients of a higher socioeconomic status than their public counterparts.

### ***3.2.2 Research Participants***

Dr. Primmer is a 53-year-old family medicine provider practicing in Austell. He is an African American man who is very involved in his community and gives presentations on cultural competence. He first heard about cultural competence in 2002 at a Georgia Medical Care Foundation training that included a couple of hours of lectures and a post-test on cultural awareness and competency. Dr. Primmer joked that he wanted to become a doctor because his father wouldn't let him be a teacher, he did not want to be a preacher, his brother was already going to be a lawyer, and he was good at math and science. Morehouse School of Medicine's emphasis on primary care lead him to specialize in family medicine. He has had experiences with many different nationalities and cultures from living in various places and through contact with his students, classmates, coworkers, and patients. He speaks Spanish, has done medical mission work in Jamaica, and served in the Air Force. He sees many patients with Medicare and Medicaid of all backgrounds.

Dr. Hart is a 57-year-old cardiologist practicing in a surrounding suburb of greater Atlanta. His Jewish heritage is very important to him and influences much of what he does,

including the way he practices and talks to people. He wanted to become a doctor from a very young age because he found the mechanics of the body intriguing. When he was in high school, his grandfather suffered a heart attack and he witnessed him go through care with a doctor he described as “obnoxious.” Dr. Hart felt that people deserve better care going through something like that, which guided his decision to specialize in cardiology. He claimed that most of his patients are older and middle upper class due to the location of his office, but that he has treated people from all backgrounds and parts of the world, especially during his training in New York. He has not had any formal cultural competence training.

Dr. Rast is a 54-year-old allergist who practices in Marietta. He wanted to be a doctor from his youth to help people and because he enjoys math and science. He decided on his specialty due to a mentor he had during his residency who was at the top of her field. He said that diversity training wasn’t emphasized when he was in school, but that they were aware they would treat a wide patient population and were taught to serve everyone. Nonetheless, he is not surprised that cultural competence is incorporated into medical school now and approves of the idea. Dr. Rast takes all insurance, but claimed that most allergy patients are of a higher socioeconomic status because most people don’t manage their allergies unless they have the means to do so, and that many lower socioeconomic status asthma patients tend to go to the larger academic centers rather than suburban offices. Though his culture was important in the way he was raised, Dr. Rast does not believe it influences his profession.

Dr. Young is a 22-year-old second year medical student who is interested in becoming a neurosurgeon. She has worked in pediatric neurosurgery and plastic surgery offices. After her best friend was diagnosed with brain cancer, she saw how “terrible” the medical field was, witnessing lapses in judgment—both medial and personal—that she thought could be improved.

She wanted to do her part to help evolve the surgical field. She has also studied psychology and aims to treat the whole patient—not just functionally, but also mentally—because treatments can have a highly emotional cost. Dr. Young learned about cultural competence in medical school and has taken three sensitivity courses. While she does not view her own culture as important to her, she believes that culture is important and plays a bigger role in medicine than people think. She sees patients of all kinds.

### ***3.2.3 Data Collection Methods***

#### *3.2.3.1 Interviews*

This research centers on interviews and focal follows, or shadowing, with four physicians. All four doctors were interviewed at their convenience; three of the interviews were carried out at coffee shops either after work or while they were on call, and one was held at a doctor's office during lunchtime. The family medicine provider and cardiologist were interviewed before the focal follows began. These preliminary interviews served as a guide for the subsequent observations. The interviews focused on what the providers were taught about culture in medicine, their views on its importance or relevance, to what extent they include it in their work, and what types of patients they commonly see. Overview questions (e.g., Walk me through a typical day), which are good for breaking the ice and encouraging long answers, were employed at this stage (Bernard 2011: 163). The interview process for all four participants followed the same format: recorded semi-structured interviews with set open-ended questions (see Appendix A for interview questions). This method is ideal for limited opportunities to conduct interviews and for elite community members or professionals who expect efficient use of their time, but still facilitates conversation and encourages respondents to guide the content within a focused topic (Bernard 2011: 157, 199). The interviews were logged and coded, and

relevant sections were transcribed. Participants were given pseudonyms to protect confidentiality.

### *3.2.3.2 Participant Observation*

Participant observation is a common quantitative research method employed in ethnography that is characterized by gaining as much contact and full immersion into peoples' lives and culture as possible (Bernard 2011: 256). Because medical culture has an existing space for medical students to observe doctors and their interactions with patients, I was able to easily fit into that role for the focal follows. I shadowed two of the doctors as they went about their normal workday, which included examinations and consultations. These focal follows were conducted at the offices of Dr. Primmer and Dr. Hart. At both of these locations, I witnessed the doctors' workday from start to finish. I arrived at their respective offices before business hours and stayed until the patients had gone and the offices closed. I observed and participated in interactions with patients, other staff members, pharmaceutical representatives, and other visitors. Both doctors saw a wide range of patients. Patient informed consent was gathered in an IRB-approved written consent document during the check-in process before the visit so as not to interrupt the clinical encounter. In both offices, I provided the front desk staff with a script and instructions to give patients that agreed two copies; one to sign and return for me, and one to keep for themselves with my IRB contact information if they had any questions or concerns. Patients were offered questionnaires upon checkout in a stamped and pre-addressed envelope marked with a code for the doctor they saw.

As with medical students, the doctor verbally introduced me to patients upon entering the rooms and asked if I could observe. Their introductions differed from patient-to-patient and between the doctors, but all patients had previously read and signed a consent form clearly

stating that participation is not mandatory and that their identity will remain confidential. Due to the sensitive nature of clinical interactions, audio recording devices were not employed. Taking notes in front of patients can make them uncomfortable and is not recommend practice for medical students<sup>12</sup>. Accordingly, I relied on detailed field notes written between and after examinations and consultations.

Before entering the patient rooms, I observed the nurses present the important information of the next patient's case to the doctor. In the clinical encounters, I paid special attention to the steps or phases of the interactions and the types of questions the doctors asked. I also noted if it was a new or returning patient, the types of questions the patients asked, and their demographic characteristics. After the visits, I listened to the doctors enter what they considered to be the pertinent information into their electronic medical records and discussed the encounter with them. I spent two days at each office, with four days of observation in total.

### 3.2.3.3 *Patient Questionnaires*

To include patient perspectives and determine if the physicians' cultural competence efforts transfer to their experience, I created a 30-question satisfaction-style self-administered questionnaire for participating patients to take home and mail back (Bernard 2011: 192). The questionnaire (included in the appendix) gathered demographic information including age bracket, gender, English fluency, self-identified race or ethnicity, education level, and LGBTQ status in addition to patient complementary and alternative medicine (CAM) use, doctor-patient concordance, and their thoughts about their doctor. Collecting such data may be germane to analyzing elements of cultural competence.

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<sup>12</sup> Association of American Medical Colleges. "Shadowing a Doctor." Accessed February 24, 2017. <https://students-residents.aamc.org/applying-medical-school/article/shadowing-doctor/>.

The 15 questions in the first half of the questionnaire captured demographic data and the patients' overall impressions of their doctor. Eleven patients returned questionnaires in the mail. Two were patients of Dr. Primmer, and the rest were patients of Dr. Hart. The raw data were entered into SPSS with scaled numeric values. Each question was analyzed for mean, median, mode, and standard distribution. A sample of eleven is not statistically significant. Some responses were left blank, resulting in missing values. The demographics of the respondents, gleaned from the first half of the questionnaire, are as follows:

All but two of the respondents fell into the "60+" age bracket, which reflects the majority of Dr. Hart's cardiology patient population. There was a fairly even split between male and female respondents. All but two of the respondents identified as "White." Each of them denoted that they speak English fluently. The majority marked "graduate or professional degree" as their highest education level. None of the respondents identified as LGBTQ. Only one indicated that they use alternative medicine and that their doctor is aware. Two of the respondents were new patients, but the rest had seen that doctor before. When asked if their doctor is of their same background, there were mixed results for perceived doctor-patient concordance—which has been linked to increased patient satisfaction, communication, and trust (Cooper et al. 2003; Street et al. 2008). This indicates that there may have been confusion about the meaning of the question and the wording may be ambiguous. The patients generally had a good opinion of their doctor, their quality of care, and would recommend their doctor to others in general and to others who share their same background.

The second half examined specifics of the clinical interactions for patient-centeredness and cultural competence practices identified in the literature. The 15 questions in this section fell into three categories: the significance of culture, doctor-patient communication, and patient



involvement or control over their own health. These questions, phrased as statements, utilized a scaled response ranging from ‘strongly disagree’ to ‘strongly agree.’ Some of the statements were phrased in positive terms that indicated positive opinions (i.e. My doctor does...) to agree or disagree with, and some were phrased as a negative statement indicating negative opinions (i.e. My doctor does NOT...) to agree or disagree with. Including both phrasing styles can help control for internal consistency of an overall positive or negative attitude towards the doctors (Dressler 2015: 27). This means that if a respondent holds their doctor in very high or low regard, their answers will be opposite among the positive and negative value questions. Questions 3, 5, 6, and 11 of section two were negative statements with negative values, which were reversed for analysis. Doing so helped determine the respondent’s average positive numerical score value, which corresponded to an overall high or low opinion of the doctor (Dressler 2015). The questionnaire was translated into a Spanish option for patients for whom English is not their first language, and back translated to ensure proper conversion (Bernard 2011: 207). The questions and answer choices remained in the same order so that the analysis could be uniform despite the language of the questionnaire (Bernard 2011). The Spanish version was not needed during my fieldwork, but both versions can be viewed in Appendix B.

The enclosed consent form stated clearly in eighth grade level English that the questionnaire is not affiliated with the doctor or office and that their responses will not be shared, that participation is not mandatory, their identity will remain anonymous, they may skip questions they do not wish to answer, and the reason I desired their input. In order to prevent patient identification through handwriting, the entire questionnaire was in multiple-choice format. To further protect identity, consent was granted by checking a yes or no box instead of a signature. Two copies of the consent form were included: one to check and be returned with the

questionnaire, and one to keep for themselves with my IRB contact information if they had any questions or concerns. The questionnaires were offered in stamped pre-addressed envelopes during checkout after the visits when payment and scheduling follow-up appointments occur. These were marked with a code indicating which doctor they saw. Patients did not need to write their return address, and none did. If they had, to ensure anonymity the envelopes would have been shredded immediately upon retrieval of the documents inside.

### ***3.2.4 Analysis***

The nature of this research demanded a coding system to standardize analysis across observations and differentiate between culturally competent or incompetent care. In the preliminary research, I found existing in-depth standard coding systems to analyze empathy and patient-centeredness in recorded clinical encounters, but I would not be recording or transcribing medical encounters for this thesis. Those existing coding categories were still useful. The field notes from my participant observation provided context for the data gathered and were used to gain a holistic sense of the cultural patterns at the two field sites. They enabled analysis of provider-patient interactions, the types of questions asked in diagnosis and treatment planning, and considerations given to the individual patient and their needs. The preliminary interviews allowed me to understand the broader context of the medical encounters and the frameworks or intentions of the providers to be compared to their practice. The notes from the interviews and focal follows were logged and coded. Four key themes were identified. In the first theme, I discuss the forces outside of the doctors' control that constrict their ability to practice the way they would like to. The second theme covers the amount of time that the doctors spend with their patients as a result of the previously discussed external forces and how they exert their agency within those constraints. The third theme examines the doctors' inconsistent views on culture's

place in medicine. It is broken down into two subsections—acknowledging and disregarding culture. The final theme reviews the doctors' recommendations for the best method to learn about culture—through experience. Lastly, I analyzed the returned patient questionnaires, which helped me to evaluate the efficacy of the cultural competence techniques practiced. The questionnaires were analyzed using SPSS software. My interpretations and critiques are grounded in anthropological theoretical frameworks that incorporate cultural models, poststructural thought, and biocommunicative models (Bernard 2011).

### ***3.2.5 Ethical Considerations***

#### ***3.2.5.1 Patient Protection***

Responsible practices are vital in praxis-driven research, and patient privacy protection was my top priority in designing this research plan. All research was conducted with approval from, and in accordance with, the Georgia State University Institutional Review Board (IRB) requirements. Due to the sensitive nature of observing patients, my Institutional Review Board (IRB) approval took longer than expected, which limited the amount of time I was able to conduct my fieldwork. For patient privacy protection, one doctor's office required me to sign Health Insurance Portability and Accountability Act (HIPAA) documents. To avoid feelings of coercion, the patient informed consent documents stated that participation was strictly voluntary, that refusal would not affect their care or relationship with their doctor, and that they could end participation at any time. It cannot be guaranteed that the provided introductory script was followed, that the forms were read in full before they were signed, or that they were read at all in the case of illiterate patients. Due to this consideration, and because a signature is the only thing that can connect a patient to this research, I attempted to waive the IRB's written consent requirement in favor of verbal consent to ensure clarity and protect patient identities, but I was

unsuccessful. If patients did not grant written informed consent after reading about my role and the purpose of my research, I would not enter the room. If at any point they felt uncomfortable, I would leave the room. In certain cases of miscommunication, I went into rooms of patients who did not sign a consent document, but gave verbal consent when the doctor introduced me. I did not take notes or use any of the information from those observations.

In navigating the role of observer in the slot of the medical student, doctors might wish to demonstrate or instruct me on minor procedures. Due to ethical reasons and because I did not have the legal protections that cover medical students, I could not touch patients. I told the doctors that I could only observe. As previously stated, I excluded patients under the age of 18 who would require parental consent from my study. I did not record or take notes in front of patients for their comfort, but there was not always much time in between patients for writing detailed notes. Jottings were used to aid in writing full field notes when time permitted.

#### *3.2.5.2 Observer Effects*

Due to the third-party-present effect and social desirability effect, doctors may have behaved differently than they ordinarily would (Bernard 2011: 180). Because the physicians were aware that I was studying culture, they may have incorporated it more than usual or in instances where they typically would not. Patients generally understand the importance of letting medical students shadow doctors and observe interactions. However, the presence of additional medical personnel such as a medical student or visiting doctor in a room with patients can alter the focus of the doctor-patient interaction, make the patient feel excluded or objectified, and may leave the patient with more unanswered questions than a one-on-one visit (Bristowe and Patrick 2012). The physician may spend more time focused on talking to the third party (explaining and teaching) than to the patient. However, this effect is stronger with professionals than students and

because of my non-medical role, the doctors may have viewed me as an observer and not felt as much need to include me in the interaction. This may have limited negative effects.

### **3.2.1 Limitations**

#### *3.2.1.1 Gaining Access*

‘Studying up’ (studying individuals or institutions in positions of wealth, power, authority, or prestige) sometimes involves difficulty in gaining access to participants (Priyadharshini 2003). I am not a medical student and these were the physicians I was able to gain access to. Doctors are typically willing to be shadowed, but they prefer to know the person or at minimum have some sense of who they are first. The third doctor initially agreed to let me shadow him, but later had to withdraw to train a new physician’s assistant. I also reached out to a fourth physician, an internal medicine practitioner, through a mutual contact at the beginning of the process, but she never responded. Working around doctors’ busy schedules can limit the amount of time available to conduct research.

#### *3.2.1.2 Sampling*

I contacted one medical student and three physicians that I had met personally or through purposive network sampling via mutual connections to participate in this study (Bernard 2011: 145). The targeted sample of doctors is small and necessitates a more in-depth ethnographic focus with thick description (Geertz 1973; Trotter and Schensul 1998). The analysis will not be generalizable. Findings will be site specific, but may provide insight into the larger context of cultural competence. The three practicing doctors in my study are all male, work in private practice, and graduated medical school before the implementation of cultural competence requirements. The medical student is female, works in both a private practice and a large public teaching hospital, and learned about cultural competence in school. Each could be considered a

minority in terms of gender, race, or religion, which may have an impact on their attitude towards cultural competence (Snipes et al. 2011). Despite increasing diversity in medical school enrollment, medicine in general and certain specialties continue to have issues with underrepresentation for women and minorities (AAMC 2016). A study that includes a wider variety of physician perspectives would likely reveal distinct orientations to culture, diversity, and cultural competence.

### *3.2.1.3 Survey Response*

The type of questionnaires utilized for patient feedback pose some limitations: they would not be useful for illiterate patients, people may be confused about the meaning of a question, point-scales (1-5) or semantic-differential scales (i.e., agree or strongly agree) have potential to be ambiguous, and respondents may be limited by the response options to answer in a way that is not culturally appropriate (Bernard 2011: 193, 204). Due to the deference effect, it is possible that respondents chose the answers they thought I was looking for that would reflect positively on their doctors, who hold a position of authority (Bernard 2011: 178).

## 4 FIELDWORK: MAKING THE ROUNDS

### 4.1 Case Notes: Common Themes

#### 4.1.1 External Control: Structure and Agency

*“Unfortunately it’s not about dollars and cents, but it is. This is America.” –Dr. Primmer*

When asked about their favorite and least favorite aspect of being a doctor, the physicians shared comparable sentiments. Dr. Primmer stated that his favorite part of medicine is being able to make a difference in people’s lives, but his least favorite part is government intervention. Dr. Rast similarly echoed that he enjoys working with patients and controlling his own hours, but dislikes how medicine has changed and the ways that government has been involved in changing the field. He touched on some of the major issues from the way that the medical system has recently transformed:

My favorite is really having sort of my own hours, ability to work one-on-one with patients, kind of not really be told what I need to do during the day, versus being at a big corporation and I’m told I have to clock in at certain times. So that’s probably my favorite part of it. You are very independent in your practice. My least favorite is how medicine has changed specifically over the last 5 years, and government has become much more involved with medicine, and it’s changing my field dramatically... Electronic health records has become a huge part of my everyday process, which is very labor intensive and slows me down tremendously in practice. Reimbursement has changed tremendously and we see all these capitated insurance plans, which reduce the amount of money that comes in the pocket for the doc. So that part of medicine I don’t like. I don’t think anybody likes it.

This quote shows that Dr. Rast values his patients, his independence, and ability to control his own practice while highlighting some of the major recent changes to medical regulations that he sees as negatively affecting the ways doctors are able to practice—specifically insurance reimbursement and electronic health records. Dr. Hart, too, said that his favorite part of being a doctor is his patients and his least favorite part is the paperwork that takes up most of his day and often follows him home at the end of the day or continues into the next day. Mandatory electronic health records have drastically changed the way that doctors practice. They are tedious

and time consuming, which means that the time a doctor could have seen patients during the day is cut in half. Dr. Primmer informed me that many older doctors who did not want to make the change to electronic health records were either forced into early retirement or severely limited in what they are allowed to do, resulting in a significant decrease in income.

External forces, like government and insurance companies, have a significant impact on clinical practice from the types of tests doctors can order to the treatments they can prescribe. Dr. Primmer described how:

Being a physician in the 21<sup>st</sup> century doesn't mean a heck of a whole lot in terms of prosperity and prestige. You get told by the insurance companies what you can and cannot prescribe... You get told by the physician-owned practice groups how many people you need to see, how many days a week you need to work, what your holidays are going to be, when you can and cannot be off, and then you get told by the government through their Medicare program what you will be reimbursed. Nobody else in America, or on the planet I would wager, will anybody else tell you what you can be paid for what it is that you do.

This displays Dr. Primmer's strong disinclination towards the structural forces that limit his choices and payment in practice. In order to supplement income, he will take on other jobs like supervising nurse practitioners, speaking engagements, and providing feedback for pharmaceutical companies. These are just some of the ways Dr. Primmer utilizes his agency to work around structural barriers.

The doctors in this study accept all or most types of insurance, but private practices are not required to do so. In order to address or mitigate the new ways that they get paid, some doctors limit their accepted insurance plans, which can have consequences for patients' access to quality care, particularly if they do not live in a place with many options and cannot afford premium insurance. Dr. Young noted:

I've run into cross-cultural differences as far as money goes. You run into a lot of cross-cultural differences because doctors can actually pick and choose the types of health insurances that they accept. So my doctor can go, and my doctor does...take all the insurances, but there are doctors in our practice... who only accept paying insurances. So Medicare/Medicaid, PeachCare, Peach State, all that—not applicable because they don't make any money off that. Which you do, but not enough for them obviously. Some doctors don't accept health insurance at all for that, and I



believe that's a cultural thing, because in that way they're only accepting patients who can pay for their services. Which I understand, it's a business. But also, like, you're a doctor.

This critique reveals that she views such doctors, who she sees as choosing money over the needs of the population, in a negative or perhaps even selfish light and believes that doctors should treat everyone as a matter of equity. Additionally, insurance might influence doctors' implicit biases about patients. Minority patients often correlate to lower socioeconomic status, which means that they are more likely to have low-paying plans, if they are able to afford insurance coverage. Dr. Young explained that her cultural competence education included this aspect and specifically addressed the issue; warning against making judgments about patients (i.e., health conditions or practices they may have) before you meet or talk to them based on race, ethnicity, class, or ability to pay. She postulated:

More than culture, with cultural competency and with issues in culture and making assumptions about your patients, I would say the bigger issue in medicine today is money. And I think that patients who are of a certain culture, people assume they're on Medicaid or they're not going to pay me, and it's not as much about the medical care, unfortunately... and I think that cultural competency plays a huge role in that.

She described assumptions about a patient's ability to pay as a form of discrimination and believes that such profiling "occurs a lot in medicine and that definitely takes away from patient care." This concern over payment because of way that insurance companies handle reimbursements also has an impact on physician practice in how they schedule their patients. Dr. Primmer explained:

People don't show up. When that person doesn't show up, the other person you told you can't see because you were booked up doesn't get seen either. That's two people that don't get seen, that are two potential payments that you have lost. So that's why doctors now have to double-book, because somebody's not going to show up and you can't afford to lose that revenue because your overhead doesn't change. Unfortunately it's not about dollars and cents, but it is. This is America.

Because of the doctors' reliance on insurance reimbursements from patient visits, they might employ the scheduling practice of double-booking in case on "no-shows" to cover potential missed billing hours. This is one of the ways physicians might enact agency to navigate their

financial structural constraints. However, if everyone on the schedule does show up, it can create delays and increase patient wait times. In addition to electronic health records, this type of scheduling practice impacts how much time doctors are able to spend with each patient.

#### ***4.1.2 Time with Patients: Cause or Symptom?***

*“Can you really give good healthcare in 12 minutes? Soup to nuts.” –Dr. Primmer*

The changing structure of the medical field and government influence have implications for scheduling and the amount of time doctors are able to spend with patients. While doctors can be taught about the importance of cultural competence and the literature debates optimal methods, it does not seem likely that it can be appropriately implemented in the short amount of time that most doctors spend with patients. To address this, doctors find various pathways to exercise their agency within their constraints.

Dr. Primmer expressed annoyance at scheduling. In his office, they try to maintain a buffer period that functions like bookends at the beginning and end of the day either to squeeze in any last-minute “work-ins,” or patients who called him outside of his normal office hours that the rest of the staff may be not aware of, or to catch up on the never-ending pile of paperwork. Problems arise surrounding promptness of the 8:30 am starting time slot. To him it means that the patient is in the room, set up, and “ready to rock n’ roll.” If the patient is checking in or the room is not prepared at that time, it means that he is already running behind by that amount of time for the rest of the day—not to mention any other delays that might occur to set him further off track as the day progresses. This affects his time spent with other patients waiting to be seen.

Dr. Primmer described:

Once you get started, you never know who all is coming, who is being worked in, who is cancelling, who is being rescheduled, so you just keep moving as if you have something else to do. So you get through that patient as fast as you appropriately can. You don’t rush people, but you don’t lollygag.

Because of the uncertainty on the amount of patients to be seen in any given day, he must keep the next patient in the back of his mind while remaining focused on the current one. Dr. Primmer mentioned the way that surgeons schedule their day in incremental time blocks as an alternative. His days are busy, fast-paced, and do not necessarily end when his door closes. He said about his day:

It's one after another. You're talking to the patients, you're diagnosing them, you're prescribing the medications and any specialty care they may need, you're talking to the pharmaceutical representatives who may come in during that same time frame, you need to have your left hand and right hand working simultaneously. People are sometimes amazed that I can listen to you, I can't look at you unfortunately, give you eye contact, but I hear everything you say and document in my chart. I can talk on the phone to somebody else while I'm documenting in the chart, because otherwise you'll never get everything done.

The point Dr. Primmer made about not always being able to make eye contact as a result of multitasking reflects the biomedical communication style rather than the patient-centered communication style—direct and to the point. During the encounter as the patients are talking, he may be looking through their chart and rapidly processing an immense amount of pharmacological categories, modifying factors, and drug interactions for their specific needs. “All that's going through my brain when I'm talking to you...I've got all that flipping through my head,” he explained. Multitasking is thus a necessary skill to manage time and his day. In order to address one chief complaint at a time, he will tell his patients to schedule multiple appointments if they have more than one issue.

Dr. Primmer gets frustrated when his patients complain because they do not understand that there are other patients with needs just like them waiting to be seen, and because they tend to have Medicaid and see him either for free or extremely little out of pocket. Low-income patients may have difficulty taking time off of work to see him or getting to the office if they rely on public transit. Dr. Primmer jokes about how this isn't Burger King so they can't “have it their

way” and that it might be different if they had a “black card<sup>13</sup>, ” but prides himself on giving the same high quality care to all and believes that everyone deserves the same level of care. While he makes time to banter with patients, congratulate their progress or lightly cajole them if they did not comply with recommendations, ask new patients a few questions about their lives, and follow-up on some personal aspects of returning patients, the appointments themselves are brief—12 minutes on average, he claimed. Despite his hectic days, Dr. Primmer is willing to take extra time to help patients with a language barrier or who need to be educated. He will even conduct the appointment or write out instructions in Spanish if necessary.

Dr. Primmer is not alone in his willingness to take the time to communicate with patients to “get to people where they are and pull them up to where they need to be.” Dr. Rast also recognizes that sometimes exerting an additional amount of effort makes a big difference. He expounded:

I’ve had a lot of success stories with patients that [are] lower socioeconomic class, poorly educated, that would be a little more labor intensive on my end to educate the patients to get them to the point that they understand their disease, understand management of their disease, and understand that there are avenues to get, for instance, medication that they need for it. So it’s very easy as a physician to just say you have asthma, you need to take this medication, but you have to make them understand why they have the disease, what the disease really means for them, what are the risk factors, and how to afford those medications.

He will take extra time to help those patients who sometimes need visits written off or other creative workarounds. Dr. Rast usually spends 10-30 minutes with routine follow-ups, and his new patients might be in the office for a couple of hours for different types of testing. Dr. Hart usually spends about 20-30 minutes with new patients, but says that he spends “as long as it takes” with all of his patients and doesn’t rush anybody, claiming that, “it’s all about the patient, that’s what we exist for.” He further went on to explain how when it comes to spending time with patients:

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<sup>13</sup> A credit card with no limit.

There's different types of doctors. There are patient doctors that are going to take their time and try to figure it out and the short-tempered doctors that are like: alright, you're here for chest pain, I'm just going to get a couple tests... I don't know what you're talking about, so we'll just do this test. And I'll sit there and try to figure out which test I need to order by the type of chest pain they're having.

This demonstrates that Dr. Hart is willing to spend more time and effort on the front end to prevent problems further down the line. A moderate amount of his time is spent fixing other doctors' mistakes, who did not take the time to properly care for their patients, before they arrived in his office with unnecessary issues. For example, I observed him with a new patient, a young Nigerian woman who came in complaining about dizzy spells. After a conversation with her he learned that these symptoms had been present for a long time where other doctors dismissed them as a one-time occurrence. He stated that he wanted to run a specific test, which she had researched herself and was pleased to hear him suggest. Dr. Hart later told me that it was like a test for him and she can now be confident that he knows what he is doing, as her previous doctors ordered the wrong tests. This also mirrors the patient-consumer biocommunicable model where patients do their own research and come to the doctor prepared with knowledge about their options.

Georgia houses 141 medically underserved areas<sup>14</sup>, which may mean that doctors see more patients, and therefore have less time with them. Some doctors' offices schedule patients in various ways in order to spend more time with them. About once a month, Dr. Hart's office will have what his staff sardonically referred to as "slave days," where they are open from 8 am-8 pm in order to fit in all the patients who need to be seen. They do not leave the office all day. I was able to be present for half of one such overbooked day. Dr. Hart was too busy for me to come in the morning, and when I came in it at noon he had already seen 18 patients. Tensions were high

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<sup>14</sup> State of Georgia Medically Underserved Areas/Populations (MUA/P). Accessed November 29, 2017. <https://dch.georgia.gov/sites/dch.georgia.gov/files/SORH%20MUA%20Map%202015%20March.pdf>.

between the doctor and staff because the schedule had gone off track and each seemed to blame the other. Dr. Hart joked that they had tried to kill him that morning. A pharmaceutical representative had been waiting and had to reschedule her meeting with him for another day. The staff ordered lunch and dinner to be delivered to the office (which lightened everyone's mood) so that they could keep working with brief breaks to eat. I was able to witness Dr. Hart interact with many new patients and a number of international patients that day. True to his word, he did not appear to rush anyone and every patient got to be seen.

The nature of Dr. Young's work in pediatric surgery means that she is able to spend a lot of time with her patients. They are scheduled for one-hour appointment blocks. Her attending doctor only spends about 8 minutes with the patients, so she is the one who spends time with them, presents their case to the doctor, and explains the next steps and treatment to their parents. "I spend a lot of time with my patients, more than most, because I think communication is very important," she explained. She likes to go "above and beyond" the allotted appointment time, checking in on patients through the day during her breaks. She brings them toys or snacks and asks them to call her by her first name so that they can feel comfortable opening up to her. Even if doctors cannot afford to spend a lot of time with their patients, Dr. Young thinks that the quality over quantity of the encounter is what really matters for effective communication. She explained:

I think time is difficult. People have a difficult time spending time with their patients, but I think having a more genuine conversation is more important than that, because I understand that there's not a whole lot of medical professionals that can donate an hour of their time to everybody who needs to talk to them, but even if you can't donate an hour of your time, if I have five minutes with you as a real person and be genuine and ask you the questions that I need to ask and get the answers that I need to get, we're set.

She values "realness" in communication with patients and does not want to put on a "doctor façade" or let professional ego get in the way. While some improvements can be made at the

individual level to increase time spent with patients through scheduling or to optimize existing time though expanding the medical interview process, such options may not always be fiscally feasible or in the physician's control. These are issues that each doctor, practice, or clinic can only determine and address themselves with their own motivation, resources, and creativity. Yet, without structural changes and policy interventions that incentivize and reimburse physicians in a way that facilitates quality time with patients to uncover culturally relevant information such as explanatory frameworks, cultural competence may continue to fall flat in practice.

#### ***4.1.3 Treating People Like People: What is the Best Prescription?***

Just as patients can hold multiple and conflicting explanatory frameworks at the same time, so too may doctors simultaneously hold contradictory ideas about culture and its role or importance in medicine. In both the interviews and in observed behavior with patients, the participating doctors tended to contradict their own statements; they believe that culture is both part of who people are and what they do, and that it is not relevant to particular cases at hand. This is not uncommon in ethnography. People often have a divide between what they think they do and what they actually do—real and ideal culture (Bernard 2011: 184). Physicians are trained to treat everyone the same, primarily to ensure the same standard of care across the board, but also partly to avoid accusations of bias or malpractice. This may lead clinicians to ignore cultural differences even if they are pronounced (Wachtler et al. 2006). Despite this, doctors do recognize difference and adjust their care accordingly to suit individual patients. Therefore, physicians are pulled between two opposing desires and must try to find a balance between being intentionally 'culture blind' and incorporating cultural competence into care.

##### *4.1.3.1 Acknowledging Culture*

*"Everyone is culture, anything that you do has culture." –Dr. Young*

One day during my observation, Dr. Hart had a middle-aged African American patient come in with his wife. When he introduced me with a joke about being there to make sure he was culturally competent, the man responded, "I wouldn't be here if you weren't." Dr. Hart told me that he thinks the patient's last doctor was culturally incompetent because when he first arrived he was on eight different medications, and the first thing Dr. Hart did was get him down to two. The man now feels better and has better results. This case reflects the tendency for minority patients to be treated in extremes, either over or under treated, as one cause of health disparities due to provider bias. This patient's previous physician had overmedicated him to his detriment. Dr. Hart thinks that regrettably some doctors have an unintentional "subliminal bias" when it comes to African American patients, and viewed this example as proof. Although he had never heard of cultural competence before our interview, Dr. Hart has worked with patients from all backgrounds and joked, "I guess I was doing cultural competence before it was en vogue." In fact, he seems to follow a patient-centered approach.

Even if the doctors find cultural differences to be frustrating at times or more time consuming to incorporate, they will recognize and address it when they find it necessary. Dr. Young said that she thinks culture is important when she has patients of different ethnicities and makes a point to be overly sensitive to it and touch base on it. Dr. Primmer comparably stated, "I try to acknowledge that the person has a different culture, whatever that may be." He operates by following the patient's lead and being responsive to them; for example, if he attempts to shake their hand and they bow instead, he will bow back. To him, culturally competent communication "means expressing yourself to the level of understanding of the patient. You have to make sure the patient understands what it is that you're saying." Both he and Dr. Hart stated that they can communicate across all levels, depending on the patient's comprehension.



Dr. Young, too, expressed the need to modify communication to fit the patient. “I think speaking to everybody like they have a college degree doesn’t make sense. Speaking to everyone like they *don't* have a college degree doesn't work either. I think there needs to be a sense of realness, and a sense of openness, and a sense of trust in your fellow human,” she said. Knowing when to employ medical jargon and when to use layman’s terms is thus dictated by their assessment of the patient’s understanding.

Dr. Primmer believes that the basis of cultural competence is “acknowledging that everybody is not the same and not transposing your thoughts and beliefs onto someone else.” Dr. Primmer, who gives presentations on cultural competence, thinks that one way to improve cultural training is through changing the curriculum in ethics courses and:

...realizing what culture actually encompasses now. For years we sort of dealt with countries and possibly even languages or religion, but it’s more than that. So starting off with the question of define culture, or have a list of how many cultural diversities can you think of? In going to the clinical practice, how would you interact with a person of this, that, or the other belief?

He expands on this idea that beyond obvious differences, “culture now doesn’t just include race and sex, but also LGBT communities, geriatrics/elderly—that’s a different culture. So there’s a lot to look into.” Dr. Primmer identified a wide range of elements that can make up an individual’s culture. Dr. Young echoed this acknowledgement that culture goes beyond factors like social class and religion to include many aspects, like sexuality, and noted that there is even a culture of autism, for example.

When discussing where religion might come into play, all four of the doctors mentioned Jehovah’s Witnesses because they cannot receive any blood products for religious reasons, and therefore cannot undergo certain procedures or surgeries. Dr. Hart explained that doctors just have to make sure that these patients understand the risks of bleeding from a procedure and see if they can find an alternative or fix the underlying cause so that there is no need for an alternative.

Dr. Primmer and Dr. Rast both mentioned having Muslim patients who celebrate Ramadan, and discussed how fasting may affect patients with diabetes or who are on medications that need to be taken with food. Dr. Primmer also revealed that he once had a very religious Christian patient who would not “receive” his diagnosis of high blood pressure and refused to take treatment. He said that eventually they just had to agree to disagree, which sometimes happens, and he wound up having to discharge her so she could work with someone else because people blame the doctor over the patient for problems that occur. In this case, the patient did not recognize or cooperate with biomedical authority and was therefore dismissed from it. Dr. Young explained that some surgeries use parts that might be from a cow or pig, or products might contain cow or pig blood, and because of religious beliefs, certain patients (citing Jewish or Muslim patients), can’t receive those products. She finds it frustrating because they cannot provide the best level of care to those patients since they simply lack alternatives, but recognizes that it is not the patient being difficult, it is their belief and right and should be respected. She is optimistic that new technological advances like 3D printing are helping with some of those issues, and that technology will continue to be a big help despite its limits—like functional synthetic blood.

In a similar vein, when it comes to biomedically incongruent beliefs and practices, all of the doctors stated that they had experienced some issues with alternative medicine, but they are willing to work around it. Dr. Hart confided that:

We deal a lot with people just believing in alternative medicine, and then some cultures believe in it more than others. It’s frustrating, but the mind is a big part of disease, so if they feel like it’s making them better, I’m not gonna stop them. I’m gonna check what they have and cross-check and make sure there’s nothing in there that will hurt them, and if I don’t see anything bad in there, I’m like fine, waste your money, go ahead.

From this statement it can be inferred that he does not place much value on alternative medicine’s efficacy and may view it more in connection to placebos, which is in line with the biomedical authority model that denounces other frameworks as less valid. Dr. Hart asks his

patients up front “if they take supplements or alternative medicines or anything holistic” to uncover this patient behavior. Dr. Rast, too, has worked with patients from all walks of life and explained that “you sort of work with anybody, so people that have certain cultural biases or certain things they do, I think open-ended discussion with them [helps] to see what their thoughts are with that.” Open-ended discussion is a large part of cultural competence, and is necessary to conduct an ethnographic interview. Conversely, Dr. Young shared the most poignant patient story from my interviews about a case where a lack of awareness of medical pluralism led to a tragic outcome. Towards the end of our discussion, after I mentioned Kleinman’s questions, she seemed surprised and told me:

Your health beliefs don’t *ever* come up. I mean I have never asked a patient like: Is this something that you want to do? Is this a way that you’d want to go about it? Because I’ve *never* asked that, and that’s really interesting because I would *love* for my doctor to ask me that. You’re sitting here and I’m giving you all this information to absorb, I’m saying alright your kid’s diagnosed with this, these are our three options, this is what’s gonna happen here, this is what’s gonna happen here, and I don’t stop talking. And then you look at me like a deer caught in the headlights and at some point if I could stop that and be like: So how do you practice your health? Are you going to the pediatrician? Are you, not just your kid, but are *you* going to see your family doctor? When was the last time you got a physical? Because if you’re not taking care of your health, why do I think you’re taking care of your child’s health? And in that respect, if you are from India and you believe in holistic medicine, I have to respect that and I have to realize that you’re gonna go home and you’re gonna [practice that treatment]... and you should be comfortable enough to tell me this is what I’m gonna do at home so that I can [prevent a negative reaction]... which has happened.

She followed with this incident from her previous job with a neurosurgeon about a 40-year-old man with a spinal injury from an Indian family:

His wife took him home, he had a wound vac, which is... like a suction cup and it just sucks out all the gross stuff... He had it on his back because he had this huge wound that just wouldn’t close up. So his wife, very Indian, no one is having this conversation with him. Wife goes home, takes the wound vac off, starts treating it holistically—the guy’s paralyzed now. She comes to us, suing us... at no point did she disclose that this is what she was going to do at home. And nobody *asked*. And we didn’t get in trouble for it, her lawsuit was dropped... but I hate to think that had at any point we had said like—what are you gonna do when you get home, what are *your* beliefs—we could have prevented this man from no longer having use of his legs.

This vignette demonstrates the serious consequences that can occur for patients when cultural competence and conversation are absent. Dr. Young and I then discussed *The Spirit Catches You*

*and You Fall Down* as another example that shows the need for cultural brokers in addition to linguistic translators.

Dr. Hart explained that the best thing to do is to lay out a plan for the patient and ask, “how does that work for you?” If they don't agree, then the doctor simply has to take more time to find out why and work with them. He said, “it’s always easy when they say yeah, sure, sounds good to me, see you in six months.” Dr. Hart added, “Compliance with medications is 65% at best if you’re lucky... That’s a whole other story in healthcare and that has nothing with your culture. The culture of medicine is hard enough.” The notion of compliance is fundamental to the to-down biomedical authority model, wherein patients are passive recipients who do as they are told and failure to comply is viewed paternalistically. There may be any number of reasons a patient does not adhere to a medication regimen, from not being able to afford or have access to it, to experiencing negative side effects, to not understanding the proper dosage, or not believing in its efficacy. For example, people (from any background) may stop taking an antibiotic once they begin to feel better, which is why many doctors stress the need to finish the entire prescription. Another example was offered by Dr. Primmer from a television show where a Hispanic patient died because the instructions to take a medication “once” daily sounded similar to “onze,” which is eleven in Spanish. He referred to this as an example of art imitating life. Utilizing tools like Kleinman’s questions may help uncover the reasons behind noncompliance if there is time to do so.

Dr. Primmer, Dr. Hart, and Dr. Rast emphasized that specific cultural diets can be relevant to their respective specialties. Dr. Primmer notes that some groups, like Hispanic or Latino and African American patients, have similar diets, and therefore experience many of the same syndromes. Dr. Rast mentioned that cultural diets can be very important when it comes to

food allergies and can limit what a patient is allowed to eat, which is something he has to work around or work with them on. Dr. Hart cited diet as one of the biggest differences in culture and explained that he sometimes has to have a talk with patients whose diet is high in salt (he mentioned Indian and orthodox Jewish patients as examples) because it can lead to hypertension. He tells them that if their diet is unhealthy they could have “a heart attack at 45” and that they need to adjust somehow. He will recommend that they work with a nutritionist because he doesn’t have time to get too into the details of what they eat, stating that it would take too long.

The biggest cultural issue the doctors recognized, however, was language barriers. Dr. Young works “hand-in-hand” with an interpreter that specifically works for her at the hospital. She explained that public hospitals have a phone line that can get an interpreter for any language they need “in 30 seconds” who can have a conversation with the patient in their native language and can translate for them, which she thinks is a great tool. Interestingly, she said they also have a phone line that can get any religious leader, unlike private hospitals that may at minimum have a priest, where patients must “bring your own Rabbi, BYOR” for example. Private institutions are not required to provide translators. Dr. Hart said they ask their patients ahead of time to come with someone who speaks English and they know that they won’t “get past the front desk” without one, but on very rare occasions his staff will have to go find someone “down the hall.” He said a lot of people bring their kids to translate. Dr. Primmer said he seldom has an issue because most of his non-English speaking patients speak Spanish. He believes that he speaks it well enough to communicate in most cases, or will ask if anyone speaks English at home and write down instructions if necessary, and tells them that they can call with any questions. He divulged that he actually learned a lot of the words for medical terms by working with

translators. Dr. Rast said that his patients usually bring their own professional translator, or occasionally a family member, who speaks English.

The doctors did not seem to mind working with translators, but acknowledged that it can considerably slow down the process or that something can be lost along the way. For example, Dr. Hart explained, “I feed off my patients, and if I don’t understand what they’re saying, even if there’s a translator in the room, I can’t get that sense of the patient.” He lamented that a critical component of care gets impaired through a translator, stating “I’m able to care for their disease, but I feel like I’m not really caring for them as much. There’s disease and then there’s people... You’re not supposed to treat just diseases, you’re supposed to treat the person. Unfortunately, that’s not what most people do, but that’s what I do.” He believes that this can have a negative impact because a lot of what he does is based on intuition and what he senses his patients are trying to get at or say. Dr. Hart also worried that patients with language barriers miss things from encounters, even if there is a translator, and doesn’t think that those types of communication issues can truly be fixed, unless perhaps there is a doctor who speaks that language. He elaborated, “from the treatment perspective, the reverse, them trying to understand me is just as bad, because some of them don’t believe in what I want to do, or do what I ask them to do, or don’t understand what I’m asking them to do, even with the kids around, because they just don’t feel comfortable either.” This suggests the presence of cultural miscommunication or misunderstanding beyond literal translation. He joked that sometimes it feels like veterinary medicine working with language barriers. However, he tries to remedy this through patience, which he believes is the most important factor. Dr. Hart looks at the patients as they are talking and pays close attention to where they point and if they look stressed when discussing one thing or are smiling when talking about another. He said, “You don’t need to understand what they’re

saying to see all that stuff. So body language is important, facial expressions are important, so that's the same in all... a smile is a smile. It doesn't matter what your background is. A tear is a tear, it doesn't matter, so you've just got to look for those things." Some body language is universal, like smiles, but not all facial expressions or gestures mean the same thing across cultures. However, watching to the patient, not the translator, as they talk is in line with patient-centered practices.

Dr. Hart also revealed that it can be a similar experience when he sees patients with dementia who come in with caretakers that speak on their behalf, because he cannot get information directly from the patient and views it as less reliable. He further explained that the field of geriatric medicine has suffered a major decline, almost to the point of nonexistence, due to a lack of monetary incentive to go into the specialty, but thinks that it is incredibly important because elderly peoples' bodies function differently and they require specialized care and altered dosages of medications. Dr. Young also informed me that, in her experience, elderly patients tend to get less innovative care. She said that doctors are unwilling to spend time or resources to fix a problem with someone who is "85." She knows it is "the ideal," but she believes that everyone should receive the same care despite "age or culture or ability to pay," stating that she doesn't know why that's so hard to do and "it doesn't really seem that far-fetched to just treat people like they're people." This indicates that she believes all patients should be treated the same to be treated fairly, which is discussed more in the next section.

Some of the doctors recognized that patients who identify as LGBTQ fall under the umbrella of cultural competence. Dr. Young believes that there is not a lot of cultural competence when it comes to the LGBTQ community in medicine and thinks that it is one of the "biggest issues" in that regard. In her experience, she found that many doctors of an older

generation seem uncomfortable or less open to it. She observed that there is a lot of care taken to avoid racial discrimination, but that it is sometimes the only cultural issue taken into consideration because it is “visible and easy to see.” She stated that her school’s cultural competence seminar, which they take twice (at the beginning and end of medical school), was “stupid” and stereotypical and had not changed or evolved to consider culture beyond issues that were “skin deep,” like LGBTQ rights education. She criticized the way that the school did not view that class as important, in fact viewing it as “a joke,” as well as the medical world’s tendency to be “very much at face value.” Viewing cultural issues as soft or unimportant is in line with what the biomedical authority model prioritizes. Dr. Primmer, too, pointed out that sexuality is a part of cultural competence and is not irrelevant to health. He acknowledged that many doctors are accepting of their LGBTQ patients, but do not necessarily view sexuality as medically relevant to the complaint, such as a “broken arm,” but that it could be—for example, asking how it broke and who will be there to help care for it. He has patients of the LGBTQ community and makes a point to address their significant other, not to express negativity towards their lifestyle, and accept them as a patient in his office, and whatever they do outside of it is their prerogative. He may ask about sexuality depending on the setting or “vibe” he gets and if it is medically relevant to the complaint of the day. During my participant observation, Dr. Primmer had a new patient come in, and after she left he confided that he was unsure of her sexuality and not quite sure how to broach the subject. The staff had noticed that she came with another woman and a baby and that both women wore wedding bands. They seemed confused and did not know if they were married and parents of the child, or who had the child, which might be medically relevant. We discussed potential ways to ask, and he said that he would wait



until they got to know each other better and each felt comfortable with one another before bringing it up.

Dr. Young believes that cultural competence means “understanding and being able to have your culture, understand other peoples’ culture, and have that be in one big melting pot so that you can grow from that, so that you can have different perspectives, so that you can have different mindsets when it comes to certain situations.” She claimed that her university emphasizes to its medical students that “...to be competent and to be culturally competent, understand cultures, and don’t take away from someone’s culture, and add on to it, and even if you don’t understand it, it doesn’t matter. It’s not for you to understand. Embrace it, understand it, don’t let it change your path of care, don’t let it change your way of communication.” This sentiment reflects both the desire to embrace and incorporate culture into medicine and the desire to treat everyone the same.

#### 4.1.3.2 *Disregarding Culture*

*“Diseases are diseases. It doesn’t matter what your background is, the basis for disease is the same. How you believe in the treatment may vary and what you want to know about the treatment may vary, but ammonia is the same in everybody.” –Dr. Hart*

As much as the doctors want to include culture and be responsive to individual patient needs, they also aspire to provide the same standard of treatment to everyone and may not see cultural aspects as relevant to the case at hand to provide a high-quality level of care across the board. This is due to two major factors: (1) physicians fear being accused of discrimination or malpractice and (2) they are trained to treat everyone the same. In regard to the former, Dr. Primmer elucidated, “You tell everybody the same thing—that way you can never be accused of making mistakes.” Furthermore, he keeps detailed records and proceeds the same way every time

to help with liability in the event of court cases. Dr. Primmer claimed that it is negligence more than ignorance that leads to malpractice. This staunchness about record keeping and uniformity in practice reiterates his previous point that when things go wrong, the doctor, not the patient, receives the brunt of the blame and legal repercussions. In addition to documentation, both he and Dr. Hart emphasized reputation as one of the most important things a physician must foster. A sterling reputation can serve the dual function of helping to attract new patients and as protection against damaging ramifications.

As for the latter factor, Dr. Rast expounded, “I think as physicians we learn to be very nonjudgmental across the board, and non-confrontational if somebody’s beliefs aren’t similar to my beliefs... you learn that that’s just not the place of a physician.” Dr. Young stated, “I try to treat everyone the same, I go into every interaction the same.” To her, culturally competent communication means “rounded out communication” and that “everybody gets the same level of care, which should be a very high level of care.” She further explained, “To me, culturally competent communication means that I can communicate with anybody without judgment through no borders, be able to give my absolute medical opinion without bias... and preconceived notions of how they may handle a treatment, how they be able to afford treatment, or how their life is.” This notion equates uniform treatment to issues of equality and justice in medical practice by removing discrimination and prejudice.

Because physicians are trained to treat all patients the same, they may not view culture (however they define it) as particularly relevant to treating peoples’ illnesses and only address it in obvious cases or when medically necessary. Dr. Primmer claimed, “Unfortunately, from what I have seen, if you’re going to get cultural competence, it’s usually at the level of family medicine, internal medicine, pediatrics, maybe obstetrics. But when you get to the other

specialties, I don't think they even care. There's this assembly line. Get 'em in, cut it out, move it on." Aside from the previously discussed barriers associated with low socioeconomic status, which Dr. Primmer emphasized affects all races and ethnicities, Dr. Rast views language as the primary cultural hurdle to effective communication:

The main thing with cross-cultural communication if there's a language barrier, that has to be managed each time the patient comes in with a translator or a family member. I would tell you that ultimately your communication will be very poor or limited if that language barrier exists with each office visit, and so you've got to sort of work around that. To me that's really the only barrier that I see. The only barrier to me that exists.

Dr. Hart stated, "I don't treat patients based on their culture, really. I treat them based on patients, and if they have problems because of their culture, I'll work with them." However, he claimed that he does not think culture affects most patients as much one might think. After noting how the body functions the same way in everyone (in the quote at the beginning of this section), Dr. Hart asserted, "They know that, too. A heart attack is a heart attack. It doesn't matter what their background is, or their sexual orientation, or their race... They may respond to different drugs differently based on studies, but for the most part the treatment is the same." This quote focuses on the somatic elements of illness and alludes to population genetics as the modifying factor. Because of medical pluralism, patients may understand the biomedical explanation for a heart attack, but believe it has different causes or appropriate treatments. They may utilize them in conjunction with his prescribed treatment.

The doctors primarily stressed race as it relates to differential disease susceptibilities or medication considerations. Consequently, physicians may only address or ask about it when directly somatically relevant. Dr. Rast disclosed that he does not ask any questions about his patients' beliefs. The lifestyle questions he asks are mostly about profession, which could impact asthma because of environmental exposures. He said that he doesn't have conversations from a religious or cultural standpoint with patients unless they bring it up to him. Interestingly, his

patients fill out their race on intake forms because of a specific lung function that is based on ethnicity. He explained:

One of the formats, it's an interesting concept, for our lung function's called spirometry. It's based on ethnicity, and so you have to know that in order to plug that into the computer to get the most accurate readings... Sometimes it becomes a little uncomfortable for my nurses because they may have a patient and they're not 100% sure of their ethnicity, and they don't really a lot of times want to confront them. For instance, are you African American or would you consider yourself Caucasian, and sometimes they don't know. So sometimes it becomes a little difficult for them. That's probably the only time, a lot of times, we engage to try to find that out because we need that to figure out the lung functions.

This common approach to spirometry is based in the same history as anthropometry and scientific racism and has been criticized for biologizing race, which falsely suggests group homogeneity and ignores genetic variability and socially mediated mechanisms (Braun 2015; Quanjer 2013). Likewise, Dr. Primmer described how bone marrow transplants are also based on ethnicity and that it can be extremely difficult to find a match in cases of mixed ancestry or when people do not know their ancestry. It can be inferred that while they may not always be taught about the social elements of race and ethnicity, doctors learn about race and ethnicity in terms of population genetics and disease prevalence, which can be problematic and lead to biologizing.

Doctors must walk a fine line between overcoming implicit biases to treat all patients identically, and recognizing and integrating differences into care. Both of these efforts are undertaken towards the singular aim of achieving the best health outcomes for their patients and, more broadly, eliminating health disparities. The doctors may disregard culture because they aim to treat everyone the same out of a desire to protect themselves, to be fair to their patients, or because they are focused on the somatic issue at hand. Simultaneously, they take note of their patients' cultural specificities that may impact care when they come up and adjust their approach accordingly. Each practitioner finds their own way to navigate these conflicting goals by being both rigid and flexible as needed. It appears that they go into each interaction following a

uniform structured approach, but are willing to be reactive and deviate from that mold when deemed necessary. Despite their distinctive educations and experiences, all four of the doctors concurred that the best way to learn about patient care and culture is through hands-on experience.

#### ***4.1.4 Vital: No Substitute for Experience***

*“Learn to appreciate other people’s cultures and learn from them.” –Dr. Primmer*

In addition to expanding cultural competence curricula in the classroom, hands-on experience with diversity is recommended as a crucial part of physician learning. All four participating physicians touched on this an optimal way to learn or improve cultural competence. Dr. Rast did not have cultural training in medical school, and while he does think it would have “enlightened” him on what to expect in his career, he does not think it would have changed how he manages culture. He stated that as a student he understood there would be different cultures he would deal with as a doctor, and he defines cultural competence as the ability to successfully do so. He elucidated:

A lot of medicine, too, is you learn things, but really ultimately most of your learning curve is out in a real-world setting. So you have two years of medical school where you’re learning all your basic sciences, but where you really learn everything is through your next two years of clinical with patient exposure. So really we all as physicians learn about all this cultural diversity when you’re out and you’re practicing. You could never really read that in a book, to me, or be taught that.

This stresses clinical training in the second half of medical school and experience on-the-job, rather than a book or lecture, as the place where the majority of true learning occurs. Dr. Rast went on to discuss that exposure to diversity not only comes from contact with patients, but can include colleagues as well. He explicated:

You mentioned some diversity training in medical school, but I think what’s changed more in medical school also is the actual demographics of each medical school class is incredibly diverse. So as a medical student not only will you deal with a diverse patient population, but your associates, your medical school classmates, are very diverse, and so you’re kind of immersed in that environment. So it’s almost as if your medical school class will mirror what your patient

population ultimately will be. So I think from day one that's just kind of ingrained, that's just normal.

His assertion underscores the benefit of being surrounded by a diverse group of people—such as fellow students, teachers, or work colleagues—with different life experiences and beliefs that can be learned from and brought into patient care. It also hints at the way that exposure aids in normalizing differences and removing stigma or bias. Dr. Young explained that key point in more detail:

It's important you get put into situations. It's human nature to be biased and to have judgment, but as far as medicine goes, you really have to be able to separate it, and I feel like immersing yourself in a volunteer situation or in a situation where you literally have to sit there and give and absorb is really important.

Her statement acknowledges that everyone has implicit biases and the importance of actively confronting them to provide the best care as a doctor. She recommended immersion and service as the path to get there. Cultural humility promotes such self-reflection to recognize biases and power dynamics present in clinical encounters. It also encourages an iterative lifelong learning process that does not terminate in school.

In addition to real-world experience, some of the doctors were optimistic about technology as a way to improve issues with culture in medicine. Dr. Young mentioned 3D printing parts for surgery so that animal parts will not be an issue for certain religious groups. Dr. Hart mentioned the future of precision health, which will be able to treat patients based on individual genetics. He believes that it will take away “culture as we know it on the surface because it goes beyond the culture, it just takes you to your DNA. You know, and obviously some of your culture and everything is there in your DNA. And so we're getting to that level, and so that's kind of the future of cultural competence, because your health and treatment is gonna be based on your DNA.” This statement conflates race and culture and biology. Personalized medicine may indeed eliminate reliance on “surface” cultural elements like race or

ethnicity in terms of population genetics, which doctors use for some measures as previously discussed, and would help to better realize and address the genetic variation within and across such groups by treating individuals. However, it would not eliminate the need for cultural competence to address the many sociocultural factors, beliefs and frameworks, or daily practices in terms of patient habitus—regular embodied practice (Bourdieu 1990)—that have been touched on in this thesis.

Learning about culture through personal contact means that the doctors are learning from their patients just as anthropologists learn from their research participants. This does not reflect the linear top-down biomedical authority model, but recognizes that the patients have something to teach and contribute. Patients are thus a source of knowledge and the doctor is not always the expert. Dr. Hart recognized that this may be the case when it comes to culture; “We don’t practice in a bubble, it’s just experience. I’m still learning,” he admitted. Equally, patients do not exist in a vacuum and medicine goes far beyond the exam room.

#### **4.2 Questionnaire Results: Taking the Pulse on Patient Opinion**

Lastly, after discussing the various ways the providers’ interact with culture in care, this section gauges the patients’ response to their care. In the second half of the questionnaire, patients responded to a series of statements on a scale ranging from “strongly disagree” to “strongly agree” that corresponded to a value from 1-5 with neutral (3) in the middle. The first four statements centered on culture. The initial question asked about whether the patient’s doctor makes an effort to understand their culture. Most respondents either agreed or felt neutral on the matter, but two respondents strongly disagreed. The average response was neutral, at an exact value of 3. The second question inquired if the patient’s heritage or culture is important to them. Responses by all but one respondent ranged from neutral to strongly agreeing. The average

response was between neutral and agree, at 3.5. When asked if their doctor knows about their culture, only one patient thought that their doctor did not know, and the rest were either neutral or believed their doctor was aware. The average adjusted response was between neutral and agree, at 3.6. The subsequent statement questioned if their doctor is well trained to treat patients of their background. Most respondents strongly agreed, but one strongly disagreed. The average respondent agreed, at a value of 4.4. The mean of all four questions came to a value of 3.6 between neutral and agree, signifying that the average patient remained somewhat neutral about the role of culture. Because the respondents primarily fell within the hegemonic culture of the United States, and therefore are more likely to be biomedically literate and experience doctor-patient concordance, they may not consider culture pertinent to their care. The respondents may have viewed such questions as relevant only to patients of ‘other’ cultures.

The next six questions covered communication. When asked if their doctor communicates poorly with them, all of the patients disagreed, with all but one answering firmly. The average adjusted value for good communication was 4.9. The next question inquired if patients feel ignored by their doctor. Every respondent felt strongly that their doctor does not ignore them during visits. The adjusted average was thus a value of 5. The following prompt asked if patients understand their doctor well. All respondents claimed that they understand their doctor well, with most answering firmly—averaging at 4.8. Most patients were neutral about their doctor providing an interpreter as needed, but this is unsurprising as they all claim English fluency. After adjusting for missing values, likely because this question did not apply to them, the response average was 3.1. The subsequent statement questioned if the patient’s doctor asked them enough questions. All respondents indicated that their doctor asks enough questions during an appointment. The average response value for this question was 4.6. Then, each respondent



asserted that their doctor gets all of the information needed to treat them. Most answered firmly, averaging at 4.7. The mean of all six questions resulted in a value of 4.5 between agree and strongly agree, which indicates that the average patient felt positively about their doctor's communication.

The remaining five questions considered patient involvement. All of the respondents believed that they have control over the decisions that are made about their health, with most answering strongly. The adjusted mean value for this question came to 4.8. The next question asked if their doctor hears all of their concerns before making any decisions about their health. Again, each respondent answered in the affirmative, with the mean value at 4.6. Every patient responded positively that they actively participate in the decisions their doctor makes about their health. The mean response value for patient participation was also 4.6. When asked if they have the final say in the choices their doctor makes about their health, all of the respondents answered positively. The mean value for this question was 4.6 as well. Finally, when asked if they follow their doctor's recommendations, every respondent strongly agreed that they do, resulting in a mean value of 5. The mean for the final five questions equaled a value of 4.7 close to strongly agree, indicating that the average patient feels they are included in healthcare decisions and are in control of their own health. Overall, the patients had a positive opinion of their doctors and care with a total mean of 4.3 out of 5. It is possible that those with a high opinion of their doctor were more inclined to offer feedback.

Out of the 11 patients who returned questionnaires, all but two came from Dr. Hart's office. Due to his specialty and the location of his practice, most of Dr. Hart's patients are older, white, and upper-middle class. The questionnaire respondents reflected this. Questionnaires and surveys themselves are a culturally specific activity. White, middle class, educated people

generally prefer such a tool, and the respondents in this study indicate this cultural preference (Porter and Whitcomb 2005). Patients with a favorable opinion of their doctor may also have been more willing to respond, and a correlation between patient satisfaction and concordance has been identified in the literature. Dr. Primmer's patient population reflected more diversity and lower socioeconomic status. He confided that some of his patients are not literate, which could serve as another potential explanation for the uneven distribution of respondents. Patients who do not speak English well or are illiterate would likely have been less prone to participate in a written survey. Finally, leverage-saliency theory suggests that people are more likely to respond to a survey request based in part on perceived importance (Groves, et al. 2000). Because most of the respondents had graduate or professional degrees, perhaps their similar experience in academia caused perceived importance in this graduate thesis research and increased their likelihood to participate.

In a future larger funded study, interviews would undoubtedly function as a better way to capture a broader and more inclusive range of patient feedback. This could decrease the demographic response bias and act as a more ethical medium to include patients with varying levels of literacy and English fluency. Open-ended questions in this format would allow for richer insight into how patients view their own culture as it relates to their healthcare, effective communication with their physician, and the ways in which their doctor includes them in decision-making processes. Patient confidentiality could also be better protected if written informed consent can be waived in favor of verbal informed consent, which would not require a signature—the only item linking patients to the research.

## 5 CONCLUSION

This thesis has reviewed the literature on clinical cultural competence education in theory and examined some of the ways that doctors interact with culture in practice through semi-structured interviews and participant observation. Dr. Primmer and Dr. Young have both had formal training in cultural competence, but Dr. Hart and Dr. Rast have not. Nevertheless, lack of formal training does not mean that doctors do not employ principles of cultural competence in practice. Four key themes were identified in the fieldwork. The first theme was that of external structural constraints that limit the doctors' ability to employ agency. Barriers like government regulations and insurance reimbursements mean that physicians must find creative solutions to navigate their changing field. These changes may have an impact on patients' access to care and foster discrimination based on their ability to pay.

Another change in practice that has resulted from new insurance practices was the second theme—less time spent with patients. In order to deal with structural changes, some physicians double-book their patients to remedy the potential financial loss. Yet that practice can have an adverse effect on patient care. The doctors have come up with their own ways of scheduling in order to fit in all of their patients. Time with patients has implications for the doctors' ability to incorporate cultural competence practices into patient care.

The third theme discussed the various ways that physicians acknowledge or disregard culture in practice and the dialectic between the two approaches. The participants touched on different elements that may be considered “culture.” Several features identified included religion, sexuality, and age in addition to race, ethnicity, and nationality. However, some of the ways the doctors discussed culture were focused in reference to biology (such as population genetics) or framed alternative explanatory frameworks as inferior, in line with the biomedical authority

model. The doctors primarily discussed culture and cultural issues aligned with classic cultural models rather than poststructurally. Culture was referred to largely in terms of minorities, though some did touch on individual variation particularly in the case of alternative medicine use, which is gaining popularity due in part to the public sphere model and broader media discourses (e.g., popular television shows like Dr. Oz that promote natural remedies). The notion of ‘alternative medicine’ in itself is problematic because it is not homogenous and frames it as substandard to biomedicine. The focus on culture as something that belongs only to minorities can promote othering, treat culture as problematic, and make the hegemonic culture appear normal or even invisible. When cultural particularities that may impact care are identified, usually brought up by the patient, the physicians are prepared to take more time and consider alternatives that can better work for their patients. Their responsiveness to patient preference seems more in line with patient-centered care and the patient-consumer model, which recognizes and values patient knowledge about their own situations. However, the doctors also aim to treat everyone the same. This may be to avoid court cases, out of a sense of fairness, or because they do not find culture particularly relevant to providing good care. Treating everyone equally and without bias is a critical part of mitigating health disparities, but ignoring differences can be harmful, such as in the case of LGBTQ patients.

One detail that the doctors all agreed upon was the fourth theme—gaining firsthand experience with diversity in order to learn about culture. The physicians valued the knowledge obtained from interpersonal interactions more than cultural education from a book or lecture. This rebels against the top-down biomedical authority model by acknowledging that patients have something to teach doctors. It is in line with the concept of cultural humility, recognizing that learning is an ongoing process and that “people are not checklists,” as Dr. Young suggested.

## 5.1 Recommendations

Because I have chosen to approach this research with an applied perspective that aims to identify spaces in which agency can be employed to improve or expand cultural competence in practice, both at the institutional and interpersonal level, I conclude by offering several recommendations from my observations. The literature on cultural competence has not changed drastically since its inception, but health disparities remain. My recommendations for educators and policy makers are as follows:

- In future curricula, the concepts of patient-centeredness, cultural humility, and structural competency ought to be combined with cultural competence to continue expanding its definition to fit poststructural cultural models, promote self-reflexivity, and raise awareness of structural and institutional violence. Providing a level of standardization in existing mandatory cultural competence curricula could also be beneficial.
- To improve cultural competence implementation in practice, structural changes are needed to foster an environment that better incentivizes and allows doctors to spend more time with patients. Only then can ongoing and improved education function as a cure.

Doctors may feel that uncovering explanatory models or asking about lifestyle in detail is outside the scope of the chief complaint, or even outside the role of the physician, given their time constraints and purpose of the visit. From my fieldwork, I have identified two potential existing spaces with room for expansion for practitioners to incorporate cultural competence:

- Doctors can implement creative scheduling solutions to increase time spent with patients. The participants in this study highlighted buffer periods, multiple visits, incremental time blocking, and monthly 12-hour days as potential mechanisms, but there are undoubtedly

more possibilities on this front. Individual offices may be able to find new solutions that work for them.

- Doctors can expand existing stages of the patient encounter to maximize appointment time and gather further information that may be important. Primarily, the medical interview at the beginning of the patient encounter—when doctors uncover the chief complaint and ask about symptoms—and the tail end of the patient encounter—when doctors discuss treatment plans and ask if their patients have any questions—could serve as areas to expand for additional questions and dialogue.

Finally, I have identified three possible areas for future research from my fieldwork:

- Continuing education is a gap that could have considerable room for expansion. While continuing education in cultural competence is doubtless offered, physicians choose what they take. If there is no interest or if it is not widely available and promoted, physicians who did not learn about cultural competence in medical school may never come across the concept. Additionally, learning about cultural competence in medical school alone may not be sufficient. Information is always developing and ongoing cultural competence education is recommended. While it may not be possible to make mandatory requirements at this stage, solutions for growth in this area need to be identified.
- There seemed to be communication and information-sharing difficulties between specialists and primary care physicians on both ends. At both offices, I overheard numerous complaints about not receiving records or having to re-send them back and forth, which may result in delays or redundancies in tests that have already been done. This could be a potential topic for future research to improve care.

- Nurses, physician's assistants, and other clinicians who typically spend more time with patients than doctors also receive cultural competence training. However, it is unclear if they share what they learned with physicians. I did not see that happen when the next patients' cases were presented to the doctors. The information was limited to symptoms, numbers, medications, and maybe one or two personal facts. This, too, would be an interesting topic for future research to investigate.

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## APPENDIX A: INTERVIEW QUESTIONS

### Warm-up:

What made you want to be a doctor and what made you want to practice in this specialty?

What is your favorite and least favorite thing about being a doctor?

### Background:

How long have you been practicing?

What is a day at the office usually like? Can you walk me through the day's events?

Can you tell me a bit about your cultural/ethnic/socioeconomic background of your family or origin?

How important is your culture to you?

### Competence:

What kind of training have you had in cultural diversity?

Are you familiar with the concept of cultural competence?

Where were you first introduced to it?

What were you taught about it?

What does the phrase 'culturally competent communication' mean to you as a physician?

How culturally competent would you rate yourself?

How do you put it into practice?

### Patients:

What kind of patients do you normally see? What are your patients like? [Demographics]

What kind of special population groups have you treated?

How do you determine a patient's background?

How comfortable do you feel treating patients from different backgrounds?

Does culture affect how you treat patients? How?

What do you do when you treat patients from different backgrounds?

Do you treat LGBT patients? Does that affect how you treat them?

Does a patient's age affect how you treat them? In what way?



**Practice:**

What kinds of cross-cultural difficulties have you experienced with patients? What made them difficult?

What are some of the obstacles that you run into in trying to communicate effectively with patients of different cultural and/or socioeconomic backgrounds? *Prompts: language barriers, differing expectations for patient and physician, differing health beliefs*

What would help you fix these problems?

What are some of the things you do in your interactions with patients of different cultural and/or socioeconomic backgrounds to improve the quality of the communication?

What is a cross-cultural success story that you have had with a patient? Why was it successful?

What would you say is the most important factor in successful cross-cultural communication and how can it be achieved?

What would you say is the proper balance between teaching about specific cultures vs. emphasizing patient-centered teaching?

What kind of training do you think would actually improve the way you interact with culturally and socioeconomically diverse patients?

## APPENDIX B: PATIENT QUESTIONNAIRES

### PATIENT SATISFACTION QUESTIONNAIRE

This is a questionnaire for a study on doctor-patient interactions for a Master's thesis at Georgia State University. Participation is voluntary and anonymous. Your information will not be shared with your doctor or doctor's office. It will not affect your experience here. You may skip questions you do not want to answer. Your participation will help to better understand and possibly improve cross-cultural doctor-patient interactions. Please check to show that you have read and understand, and consent to take part in the study: Yes  No

#### SECTION 1

1. What is your age?  
18-29  30-59  60+
2. What is your gender?  
Female  Male  Other
3. Do you speak English fluently?  
Yes  No
4. What is your race/ethnicity? Check all that apply:  
White  Black or African American  Hispanic or Latino  Asian   
American Indian or Alaska Native  Native Hawaiian or Other Pacific Islander   
Mediterranean or Middle Eastern  Other  Multiracial
5. What is your highest education level?  
High school or below  College  Graduate or professional degree
6. Do you identify as LGBTQ?  
Yes  No
7. If you answered yes to #6, does your doctor know?  
Yes  No
8. Do you ever use alternative medicine (i.e. take herbal remedies or visit folk healers)?  
Yes  No
9. If you answered yes to #8, does your doctor know?  
Yes  No
10. How often have you seen this doctor before?  
Very often  Sometimes  A few times  Not at all
11. Would you say that this doctor is of the same background as you?  
Yes  No  Unsure
12. Overall, how would you rate the quality of care of this doctor?  
Very good  Good  Acceptable  Poor  Very poor
13. If you had a choice, would willingly return to this doctor again for medical treatment?  
Yes  No
14. Would you recommend your doctor to another person?  
Yes  No
15. Would you recommend your doctor to someone with your same ethnic or cultural background?  
Yes  No

## SECTION 2

In this section, please check the box that best matches whether you agree or disagree with the following statements:

1. My doctor makes an effort to understand my culture.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
2. My heritage or culture is important to me.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
3. My doctor does NOT know about my culture.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
4. My doctor is well trained to treat patients of my ethnic or cultural background.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
5. My doctor communicates poorly with me.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
6. I feel ignored by my doctor during appointments.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
7. I understand my doctor well.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
8. My doctor provides a translator or interpreter when I need one.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
9. My doctor asks enough questions during an appointment.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
10. My doctor gets all of the information needed to treat me.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
11. I have NO control over the decisions that are made about my health.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
12. My doctor hears my concerns before any decisions are made about my health care.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
13. I actively participate in decisions my doctor makes about my health.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
14. I have the final say in the choices my doctor makes about my health.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree
15. I follow my doctor's recommendations.  
Strongly disagree  Disagree  Neutral  Agree  Strongly agree

### CUESTIONARIO DE SATISFACCION DE PACIENTES

Este es un cuestionario para un estudio sobre interacciones médico-paciente para una tesis de maestría en la Universidad Estatal de Georgia. Su participación es voluntaria y anónima, su información no será compartida con su médico ni la oficina de su médico, y no afectará su experiencia aquí. Usted puede saltarse preguntas que no quiera contestar. Su participación ayudará a entender y posiblemente mejorar relaciones médico-paciente de tipo intercultural. Por favor marque la casilla para demostrar que ha leído y entendido, y que acepta participar en el estudio: Si  No

#### SECCION 1

1. ¿Qué edad tiene?  
18-29  30-59  60+
2. ¿Cuál es su género?  
Femenino  Masculino  Otro
3. ¿Habla inglés fluido?  
Si  No
4. ¿Cuál es su raza o etnicidad? Marque todas las que apliquen:  
Blanco  Negro o Africano Americano  Hispánico o Latino  Asiático   
Indio Americano o Nativo de Alaska  Nativo de Hawaii o Islas del Pacifico   
Mediterráneo o Medio Oriente  Otro  Multirracial
5. ¿Cuál es su nivel educativo más alto?  
Secundaria o menos  Universidad  Maestría o título profesional
6. ¿Se identifica usted como LGBTQ?  
Si  No
7. Si contestó si a la #6, ¿su médico sabe?  
Si  No
8. ¿Usa o ha usado medicinas alternativas (por ejemplo, remedios con hierbas o consultas con curanderos)?  
Si  No
9. Si contestó si a la #8, ¿su médico sabe?  
Si  No
10. ¿Cuántas veces ha visto a este médico antes?  
Con mucha frecuencia  A veces  Pocas veces  Nunca
11. ¿Diría usted que el médico tiene los mismos antecedentes que usted?  
Si  No  No estoy segura/seguro
12. En general, ¿Cómo valoraría la calidad del trato de este médico?  
Muy buena  Buena  Aceptable  Pobre  Muy pobre
13. Si usted pudiera decidir, ¿regresaría a este médico para tratamiento médico?  
Si  No
14. ¿Recomendaría a este médico a otra persona?  
Si  No
15. ¿Recomendaría a este médico a alguien con sus mismos antecedentes étnicos o culturales?  
Si  No

## SECCION 2

En esta sección por favor marque la casilla que más asemeje si usted está de acuerdo o desacuerdo con las siguientes declaraciones:

1. **Mi médico hace un esfuerzo por entender mi cultura.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
2. **Mi cultura o herencia es importante para mí.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
3. **Mi médico NO sabe sobre mi cultura.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
4. **Mi médico esta bien entrenado para tratar pacientes con mis antecedentes étnicos o culturales.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
5. **Mi doctor se comunica pobremente conmigo.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
6. **Me siento ignorada/ignorado por mi médico durante mis citas.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
7. **Entiendo a mi médico bien.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
8. **Mi doctor aporta un traductor o intérprete cuando necesito uno.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
9. **Mi doctor hace suficientes preguntas durante la cita.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
10. **Mi doctor obtiene toda la información necesaria para tratarme.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
11. **Yo NO tengo control sobre las decisiones que se hacen sobre mi salud.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
12. **Mi doctor oye mis inquietudes antes de que se tome ninguna decisión sobre mi atención de salud.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
13. **Yo participo activamente en decisiones mi doctor hace sobre mi salud.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
14. **Yo tengo la palabra final en las decisiones que mi doctor hace sobre mi salud.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo
15. **Yo sigo las recomendaciones de mi médico.**  
Totalmente en desacuerdo  Desacuerdo  Neutro  De acuerdo  Totalmente de acuerdo