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IS CULTURAL COMPETENCY A BACKDOOR TO RACISM?

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Introduction

In the US, medical and public health professionals recognize that there is a disparity in health care and that the disparity is correlated with ethnicity and "race." In an attempt to deal with this disparity, cultural competency models have been incorporated into the curricula of most health professions and into many healthcare institutions. These models, in general, call for sensitivity to cultural differences between the health care provider and the patient.

What is of interest to us is that these models fail to capture the diverse and fluid nature of culture and self-identity. Instead, these models tend to focus on constructed categories of race that are reaffirmed and reified by the myriad of health studies that neither question nor explain the racial divisions.

From Lists of Differences to Differences in Power

Many common texts (see *Health Issues in the Latino Community* 2001; *Health Issues in the Black Community* 2001, *Cultural Health Assessment* 2003, *Caring for Patients from Different Cultures* 1997, *Transcultural Health Care* 1998) are primarily lists of characteristics for particular races and ethnic groups. We argue that such lists will paradoxically lead to reinforcement of racial stereotypes and deter the effective communication necessary for adequate health care.

Rather cultural competence, race and compliance, in our view, should be understood within the framework of a medical model that requires the production and reproduction of conformity. We also contend that it is really the differences in power that are at the heart of the disparity in health care: while this may be

inherent in discussions of race, we believe that it needs to be central and manifest.

Cultural competence is defined in multiple ways. The most widely accepted definition is that developed by Cross, Bazrom, Dennis and Issacs:

Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations. "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. "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.

Popular models for achieving cultural competence are the AWARE Model based on Noel Day's work and the LEARN Model. Other models include BELIEF, BATHE and ETHNIC. All of these models, in general, encourage health care professionals to be sensitive to differences and to ask questions.

Clearly, these are necessary for effective cross-cultural communication; but they fail to legitimize different beliefs and practices and actively create an environment for real discourse. Their interpretation of cultural competency focuses on the traits of particular cultures as gateways to effective communication. Culture becomes limited to lists of characteristics, effectively denying the changing, multifarious, integrated and interaction-al nature of identity. Also, knowledge of the patient's "culture" is invested in the hands of the medical practitioners, potentially de-legitimizing the patient's own identity in preference for that constructed by public health and other health care professionals.

Analytic Perplexities

These traits-based constructions tend not to differentiate between the national cultures of foreigners and that of hyphenated Americans. For example, in a section, "Filipino-Americans: Cultural Communication Patterns," in *Transcultural Health Care*, the works of social scientists who had studied people in the Philippines, not Filipino-Americans, are cited.

Also, there is a general tendency in the cultural competency literature to use race interchangeably with culture and ethnicity. This is evident in the discussion and research on patient-physician concordance. Although the term ethnicity is used, it is often in concordance with perceived races. Due to an absence of data on ethnicity in health plan and provider databases, such studies resort to guessing at ethnicity or race by methods such as the Generally Useful Ethnicity Search System software (GUESS), which estimates Hispanic "ethnicity" based on family names.

Multiple studies report that patients who have doctors of the same race have higher rates of satisfaction, and it is interesting that degree of satisfaction was defined in the John Hopkins Bloomberg School of Public Health's 2002 study as a patient's greater likelihood to keep follow-up appointments, comply with a prescribed medical regimen and a reduced likelihood of initiating a malpractice suit. More research is needed to understand the reasons for the racial concordance; but research such as Cooper-Patrick and colleagues, which suggests a link between racial concordance and participatory decision-making, point to the importance of communication and respect for what is communicated. There is also research which suggests that perceptions of minorities are involved.

In one study by Van Ryn and Burke in 2000, it was found that physicians, in general, view African Americans as more likely to abuse alcohol or other drugs than whites. African Americans were also viewed as less pleasant, not very rational and likely to be noncompliant with medical advice. Similarly, Rathmore and colleagues presented medical students with an African-American female patient actor and a white male patient actor with identical health states and found that non-minority students assigned lower health values to the health state described by the African American female actor while minority students rated the health states of the African-American female and the white male as similar. In their 2000 article in the *American Journal of Medicine*, they conclude that perceptions of patient symptoms are affected by non-medical factors and that physicians themselves contribute to the variations in care by patient race.

Patient compliance is often used as an indicator of level of health care. This fact speaks volumes about the medical community's perception of the doctor-patient relationship. The doctor is seen as the expert on medicine and on the patients. It is generally assumed that if the patient demonstrates compliance by following the course of treatment outlined by the doctor, the patient is doing what is best for her health. Others, notably medical anthropologists, such as Hunt and Arar, have challenged the notion that patients cannot knowledgeably speak about their symptoms and drug effects or that such discourse is not necessary for better health outcomes.

Studies on another indicator, patient satisfaction, show that communication skills are the major determinant of patient satisfaction and compliance, not race or socio-demographic variables. Communication skills include courtesy, information-giving and listening behavior. While patient satisfaction may be skewed by a patient's expectations, these studies suggest that a sense of being able to make informed decisions on the part of the patient may be a better indicator than compliance.

Compliance, Culture and Communication

Journalist Anne Fadiman's 1997 *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors and the Collision of Two Cultures*, is rife with the contestations of compliance. Lia Lee is an epileptic child whose parents are found to be non-compliant in their administrations of Lia's

medications. Lia is placed in foster homes where she suffers from increased seizures although the medications are given religiously and Lia eventually becomes brain dead.

This book has become, according to anthropologist Janelle Taylor in a 2003 article in *Medical Anthropology Quarterly*, “[a] canonical text for burgeoning efforts to impart ‘cultural competence’ to health care practitioners.” In the text, Fadiman warns doctors that, “[i]f they continue to press their patients to comply with a regimen that, from the Hmong vantage, is potentially harmful, they may find themselves, to their horror, running up against that stubborn strain in the Hmong character which for thousands of years has preferred death to surrender.”

Historian Mai Na M Lee criticizes Fadiman for defining a culture by a history of persecution and a resistance to assimilation. Also, Monica Chiu reads this characterization as an attempt to explain the Lee family’s departure from the Asian-American stereotype. Although the intention behind the inclusion of Fadiman’s text in medical training is to foster cultural awareness, instead, it constructs and reinforces stereotypes of “Hmong-ness” and pathologizes ethnicity.

Our BASIC Model

Different belief systems and world views cannot be addressed without first leveling the field of discourse. In our model, BASIC, we ask participants to avoid well intentioned but alienating *behavior*, view *apologies* as a tool to better and equalize communication, to be highly *self-aware* of one's own institution’s beliefs and self value, to always explain *intent*, and to pay attention to those *cues* that speak discomfort.

We also stress that acting unquestioningly upon what one thinks one “knows” about a particular culture in one’s interactions with an individual is racist behavior. Rather than using trait-based cultural competency models, practitioners need to adopt a more dynamic, interactive view of culture and communication and pay attention to important cues that could help improve the delivery of medical care.

Practitioners need also to take personal responsibility for miscommunication rather than blame cultural differences for unintended outcomes, thereby pathologizing race and ethnicity. We need to emphasize respect and acceptance of patients as collaborators in determining their health outcome. Teaching healthcare providers how to make this collaboration happen is the cornerstone to creating culturally competent care.

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