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A Sociological Analysis of the Cultural Competence Construct: Essays on the Conceptualization, Operationalization, and Implementation of Cultural Competence in the U.S. Medical Profession

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A SOCIOLOGICAL ANALYSIS OF THE CULTURAL COMPETENCE CONSTRUCT: ESSAYS ON THE CONCEPTUALIZATION, OPERATIONALIZATION, AND IMPLEMENTATION OF CULTURAL COMPETENCE IN THE U.S. MEDICAL PROFESSION

By

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DISSERTATION

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DEDICATION

I dedicated this dissertation to my mother, Elena Guzman. As an immigrant, Spanish speaking woman, single parent, she is my biggest hero and role model. This is for you.

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As a first-generation, immigrant, English as a Second Language, undocumented, Latina woman, my educational achievements would not have been without the support of my mentors and family. I dedicate my dissertation to my family, whose struggles, tears, and love kept me alive and fighting every day.

Without my family's support, I would not be where I am today. No one in my entire family history had gone to college. My mother, Aurora, barely finished an elementary-level education, while my father, Sebastian, nearly completed a high school-level education in Mexico. My parents worked two to three jobs in order to provide my brother and me opportunities they never had. I have childhood memories of my brother Pablo and me helping them clean office buildings and throw newspapers at five in the morning. I also remember seeing the hard labor that went into working in the fields. Pablo is now at Stanford University finishing his PhD in mechanical engineering, and it is an honor to be completing my PhD in Sociology at the University of New Mexico. I thank my family for always telling me to keep fighting no matter how hard things got. A very special thank you goes out to my mom, Aurora Elena Guzman for her daily phone calls, texts, and messages of encouragement that keep me going.

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A SOCIOLOGICAL ANALYSIS OF THE CULTURAL COMPETENCE CONSTRUCT: ESSAYS ON THE CONCEPTUALIZATION, OPERATIONALIZATION, AND IMPLEMENTATION OF CULTURAL COMPETENCE IN THE U.S. MEDICAL PROFESSION

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ABSTRACT

PURPOSE: At the turn of the 21st century, the concept of cultural competence in medicine became a strategy to address cultural diversity and widening health and healthcare inequities. Cultural competence combines the tenets of patient-centered care, with an emphasis on the social and cultural factors that affect the quality of medical services, treatment decisions, and health outcomes. Substantively, this dissertation answers core questions about the parameters of cultural competence in medicine. Theoretically, it considers the jurisdictional terrain of the medical profession and its changing nature concerning the adoption of cultural competence. The overarching research question is how, why, and with what consequence did the medical profession integrate cultural competence?

METHODS: I analyzed the conceptualization, operationalization, and implementation of cultural competence. I conducted semi-structured interviews with 14 key policy actors from four major organizations concerned with U.S. medical education to examine the

conceptualization of the cultural competence mandate passed in 2000. Using discourse analysis, I analyzed 89 articles published in *the Journal of the American Medical Association* (*JAMA*) to assess the diverse operationalization of cultural competence within the medical profession. Moreover, I conducted a comparative case study analysis on data from a larger NIH-founded research team studying biased decision-making using mixed-methods to assess the implementation of cultural competence. We conducted 125 interviews with 52 administrators, 51 faculty or staff members, and 22 students at 15 diverse public and private medicals schools. We also led focus groups with an additional 196 third and fourth year medical students. These three empirical chapters provide a cross-sectional snapshot of the medical profession's legal, workplace, and professionalization jurisdictional claim to cultural competence.

RESULTS: The first empirical chapter demonstrates that the conceptualization of cultural competence is a moving target. Cultural competence was conceptualized as being integral to the identity of the 21st century provider, but the standards, mission, approach, and policy effect has expanded. In the second study, three themes capture the tensions with implementing cultural competence into the practice of medicine. Culturally competent providers provide appropriate health information and make culturally-appropriate medical decisions, but such practices are constrained by the biomedical structure and culture of medicine. Finally, in the third chapter the implementation of cultural competence varies widely among the fifteen medical schools. Three themes capture the manner in which schools incorporated cultural competence, but the medical school structure limits the ability for integration. This dissertation shows that the medical profession's jurisdictional claim to the legal aspect of cultural competence was poorly constructed, the profession's jurisdictional

claim in the workplace was limited by the culture of medicine, and their jurisdictional claim in professionalization was restricted by the current education structure.

DISCUSSION: The medical profession's adoption of cultural competence potentially changes the work performed by medical providers. However, cultural competence has yet to be integrated enough to modify the actual work performed by providers. The jurisdictional claim to cultural competence is an example of what I call a *surface jurisdictional claim.* The vagueness of the cultural competence mandate allows the profession to adopt cultural competence without specifying or providing a uniform definition or approach. The practice of cultural competence through providers' behaviors is limited given that the biomedical framework not only structures the clinical encounter, but also structures the culture of medicine. Additionally, the training of cultural competence is further restricted within an education system that operates under a didactic knowledge-based framework. The adoption of cultural competence may not be possible unless the underlying assumptions of the biomedical model are further critiqued and analyzed. Additionally, adopting cultural competence at the provider level is insufficient; it requires a modification at the systems level beyond a public claim to addressing health disparities and improving the quality of care that places the onus on medical providers.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION CHAPTER

A Sociological Analysis of the Cultural Competence Movement: Essays on the Conceptualization, Operationalization, and Implementation of Cultural Competence[1] in the U.S. Medical Profession

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[1] Cultural Competence and Cultural Competency are interchangeable in the literature. For consistency purposes, I use the term cultural competence.

THE EMERGENCE OF CULTURAL COMPETENCE

The increasing racial and ethnic diversity of the United States population has become a challenge for education, social work, psychology, and medicine (Suh 2004). The U.S. Census has tracked a significant transformation in the composition of the United States' racial/ethnic population since 1970. As of 2010, one out of every six Americans identifies as Latino/Hispanic, the largest minority population in the United States, and Asians are the fastest growing group (Ennis, Rios-Vargas, and Albert 2011). Much of this growth reflects historic waves of migration to the United States. Immigrants bring distinct cultural ideas, values, and practices; and many do not speak English. The increasing racial and ethnic diversity in the United States has created both challenges and opportunities for U.S. schools and other institutions (DeVita and Pollard 1996). Institutions are transforming to provide effective services to a diverse population.

In addition to the racial and ethnic diversity, the emergence of identity politics increased centuries-old tensions between the universalistic principles ushered in by the American and French Revolutions and the particularities of nationality, ethnicity, religion, gender, race, and language (Benhabib 2002). The United States, as a prototypical liberal democracy tends to underemphasize ways in which citizens are not in fact equal in society. Documented inequalities in life outcomes and differing levels of access to a range of services have captured the attention of the public, the government, and policy makers. In the field of education, for example, research indicates that compared to their white majority counterparts, minority schools and students perform worse, lack equitable access to high quality education, and have poorer outcome trajectories (Entwisle, Alexander, and Linda 1997; Ferguson 1998).

Attention to such unequal outcomes and treatment has provided motivation for fundamental changes in the structure and content of multiple professions.

The concept of "cultural competence" as a strategy to help professions better align to a diverse population emerged from the multiculturalism framework, which emphasized that ideologies and policies should be responsive to cultural diversity and promote equal respect for various cultures in a society and/or institutions (Joppke 2004). Rather than embracing the traditional liberal image of the melting pot into which people of different cultures are assimilated into a unified national culture, multiculturalism generally holds the image of diverse members of society maintaining particular identities while residing in the collective. The concept of multiculturalism captures the complex range of issues associated with cultural and religious diversity in society, and the social management of the challenges and opportunities such diversity offers. From the 1970s to the mid-1990s, a range of multiculturalism policies and minority rights diffused across several western democratic countries in response to growing recognition of diversity (Brubaker 2001).

The historical roots of multiculturalism lie in the civil rights movements of various historically oppressed groups. These movements emphasized the rights of minority groups in an effort not just to increase their overall sense of recognition and belonging, but also to create opportunities to have policies tailored at closing the gaps of disparities to achieve equality of opportunity. African Americans and other people of color challenged discriminatory practices in public institutions during the civil rights struggle of the 1960s (Banks 1989; Davidman & Davidman 1997). In the 1960s and early 1970s, the women's rights movement joined. Feminist scholars and other women activists, including women of color, demanded that curricula become more inclusive of their histories and experiences

(Hearn 1982). Other groups joined in the overall identity politics movement throughout the 1970s; gay and lesbian groups, the elderly, and people with disabilities organized visible and powerful demonstrations (Davidman & Davidman 1997). The actions of these various groups who were challenging the status quo and seeking to address existing inequities were strong influences in the earliest conceptualizations of multiculturalism.

Multicultural education, or what eventually became known as cultural competence training, emerged in a number of fields including business, education, psychology, nursing, social work, and medicine (Suh 2004). The disparities in access and outcomes between minority and majority members of various professions has created a need for culturally competent professionals not only in the education field but also, increasingly, among other sectors of our society. Scholars of multicultural education have amassed a body of research concerned with the client, the student, or the patient's cultural characteristics (Suh 2004). As a result, the professions of education, social work, and psychology in the United States started to establish guidelines and accreditation strategies to better instruct teachers, counselors, and social workers in working effectively within a multicultural society (See Table 1-1). This dissertation is primarily concerned with the emergence of cultural competence within the medical profession field from a sociological perspective.

"Cultural competence" can be understood as a socially constructed idea. Sociology has approached the study of ideas as a reflection of the specific historical and social environments in which they are produced (Berger and Luckmann 1967). Constructs are not true or false expressions of the world *per se*, but as the realized expressions of particular social interests within particular social systems and contexts (Merton 1973). Sociologists have studied the social construction of many different ideas, but of interest to me here are the

ideas that sustain the medical profession's definition and approach to health and illness, and the effects of those ideas on the incorporation of cultural competence in the medical profession. The meaning of cultural competence changes over time. This is important to note because how cultural competence is defined shapes what can be accomplished under its banner.

A CASE STUDY: CULTURAL COMPETENCE IN MEDICINE

The concept of "cultural competence" in medicine was primarily a method of approaching cultural diversity and addressing widening health and healthcare inequities (Betancourt, Green, and Carillo 2003; Betancourt et al. 2005). A large body of literature has documented how the distinct health-related cultural assumptions of various minority groups bring additional challenges to the patient-provider interaction, communication patterns, and decision-making processes because their definitions and approaches to health, as well as their expectations of care, can be in conflict with the priorities and standards of the profession (Kleinman, Bisenberg and Good 1978; Denboba et al. 1998; Carillo, Green, and Betancourt 1999; Coleman-Miller 2000). Additionally, inequalities by race/ethnicity, gender and sexuality in health care access, utilization of services, and unequal treatment are well-documented even after controlling for insurance status, income level, and health status (Cohen and Goode 1990; Bach et al. 1999; Schulman et al. 1999; Chin 2000). The medical profession adopted a version of cultural competence in health care that combines the tenets of patient/family-centered care with an understanding of the social and cultural influences that affect the quality of medical services and treatment, as well as outcomes (Anderson 2003). With an ever-increasing diversity of the population in the U.S. and strong evidence of

disparities in health and healthcare, cultural factors were an important issue that the medical profession needed to address at the turn of the 21st century.

Historians, anthropologists and sociologists have made influential contributions challenging the effectiveness and legitimacy of the medical profession around meeting the needs of racial/ethnic minority and women populations for decades. Researchers have challenged the medical profession's core assumptions that definitions of health and illness can be understood as separate from social context. For example, they have demonstrated that health and illness are culturally variable and historically contingent: what is designated as an illness varies according to time, place, or social context (Durkheim 1979; Mishler 1981; Williams 2000). Scholars have also revealed racial and gender bias in medical texts and practices that have challenged the assumption that medicine is scientifically neutral (Nelson 2011; Hoberman 2012). At the level of social interactions, the medical profession's scientific neutrality and its universalism have been challenged by studies showing the racial disparities in patients presenting the same symptoms, yet receiving different diagnoses and treatment (Lock and Gordon 1988; Esptein 2006) and feminist scholars show that doctor patient interactions are plagued by patriarchal assumptions about women's "nature" (Hearn 1982; Barker 2005). These challenges have resulted in a body of theory and research demonstrating that the very acts of defining and treating illness are consummately social and cultural processes.

The medical education system has also been criticized for inadequately training medical students, who enter the workforce unable to address the needs of diverse and complex patient populations. Several issues undermine the development of adequately trained doctors. First, the body of biomedical knowledge is larger than any one person can

master, and it continues to grow at an unmanageable pace (Beck 2004). Second, despite advances in knowledge about the multidisciplinary determinants of health, the dominant focus of didactic study remains on the biomedical sciences (Jenks 2011). Third, the current approach does not develop providers' capacity to meet the care needs of diverse populations, they must master a new set of skills (Barzansky and Gevitz 1992). Finally, the current system of medical education does not adequately nurture the skills needed for lifelong learning, nor does it develop in learners the ability to analyze practice performance and make subsequent changes that can improve patient outcomes (Fox 1957; Fox 2005). The central downfall many scholars point to is that the social mission of medicine has long been unacknowledged and must become a priority in order to address health problems in our society (Kaplan, Satterfield, and Kington 2012). Today, knowledge and skills outside of the traditional biomedical model are being emphasized, areas that have historically been the territory of the social sciences (Barbzansky, Harry, and Eszel 2000; Boutin-Foster, Foster, and Konopasek 2008). However, the medical arena is a context in which different pedagogical models are contested; some thrive while others remain on the sidelines.

These criticisms have led to an institutional investment in "cultural competence" by the medical profession. Policies that address the need for cultural competence emerged across the country at nearly every legislative level, as well as among accreditation bodies and professional associations. In 1999, the American Medical Association published the "Cultural Competence Continuum" handbook filled with resources. In February 2000, the Liaison Committee for Medical Education (LCME) (the accreditation body of all U.S. medical schools) passed a mandate requiring medical schools to teach cultural competence. In December 2000, the U.S. DHHS OMH presented the National Standards for Culturally

and Linguistically Appropriate Services (CLAS) in Health Care, which provided a framework for implementing culturally and linguistically competent health services. The federal government furthered this commitment in its published report Healthy People 2000 and Healthy People 2010. Furthermore, at this time 11 states have considered legislation that require their workforce to have cultural competence training: Arizona, California, Colorado, Georgia, Illinois, Maryland, New Jersey, New Mexico, New York, Ohio, and Washington (Graves et al. 2007). In 2005, New Jersey became the first state to pass legislation requiring cultural competence training for physicians and medical students. Cultural competence training in medicine has become part of multiple standards, mandates, and legislation for both practicing and in-training medical providers. This new focus has resulted in no shortage of textbooks, pocket guidebooks, websites, taskforces, and training curricula in cultural competence.

There is almost a near consensus in the medical profession about the importance of cultural competence (Betancourt 2004). Cultural competence is defined as acquiring the knowledge, attitudes, and skills to better interact and serve patients from diverse cultural backgrounds, which has become an important expectation for the modern American physician (Suh 2004). Although some cross-cultural medical education curricula date back to the 1970s (Kimball 1970), the requirement to have some form of cultural competence in medical education has recently become institutionalized. While many have postulated that a strong commitment to cultural competence will lead to a reduction in disparities and improvement in quality of care delivered, only a few studies have found direct links between cultural competence and health care improvement (Brach and Fraser 2000). The medical profession and the medical education system have increasingly incorporated cultural

competence training, but conceptual clarity around cultural competence is still inadequate (Barzansky et al. 2000; Saha, Komaromy, Koepsell and Bindman 1999). Despite the promising promise of cultural competence, there is a high degree of debate among providers and researchers around the definition, approach, and assessment of cultural competence. Some have even proposed alternative names (e.g. cultural humility or cultural sensitivity) (Tervalon and Murrary-Garcia 1998). Within the profession of medicine, the concept of cultural competence moves from a theoretical construct to one that is incorporated into the training and practice of medicine. Next, I elaborate on how this transition has occurred in medicine thus far.

THE CULTURAL COMPETENCE STORY: KEY FRAMEWORKS AND LITERATURE

In a foundational document introducing cultural competence in 1989, *Towards a Culturally Competent System of Care,* Cross and colleagues conceptualized the term as, "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross et al. 1989). The authors argued that health care systems and medical schools could augment their efforts to teach and practice culturally competent care. Cultural competence during its initial formulation in medicine was thus described as the ability for *systems* to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs (Anderson et al. 2003; Betancourt, Green, and Carrillo 2003).

The concern for a more culturally competent health care system grew in magnitude shortly after the release of a timely book on culture and healthcare, Anne Fadiman's *The Spirit Catches You and You Fall Down* (1997), which today is still widely read within the

profession by providers and students alike. The book is an account of misunderstandings and mistakes made by the medical system, by well-meaning physicians, and by the state in the care of a young Hmong girl suffering from epilepsy. Fadiman highlights how the systemic issues that produce disparities in healthcare are issues that are more resistant to analysis. Disparities rest not only in relationships between physicians and patients, but also in organizational practices, cultures, and the financing of the health care system (Fadiman 1997).

In an attempt to achieve a more culturally responsive health care system, Brach and Fraser (2000) proposed a comprehensive framework that covers nine categories through which individual organizations can enhance their overall level of cultural competence. Leaders at health care organizations can provide interpreter services, recruit and retain minority faculty/staff, implement cultural competence training programs, coordinate with traditional healers, involve community health workers, provide culturally appropriate health promotion materials, have providers involve family members in decision making processes, provide employers with opportunities to immerse into other cultures, and diversify their administrative and organizational accommodations (e.g. clinic location and hours of operation, network membership). This conceptual model details how each of these opportunities has a direct impact on the ability of the health care system to address health disparities and meet the needs of diverse patient populations. However, despite these initial conceptualizations of cultural competence at the healthcare systems level, the operationalization of cultural competence within the profession shifted away from addressing the health care system itself, and came to focus more on the clinical encounter.

The focus of cultural competence has primarily been on the patient-provider encounter, with little attention given to whether the systems of care in which they function are culturally competent (Chin 2000). Arthur Kleinman's seminal *Annals of Internal Medicine* article (Kleinman, Eisenberg, and Good 1978) articulated the importance of medical providers making efforts to address culture. Anthropological and cross-cultural studies have yielded key contributions about clinical aspects of cultural differences, such as patient belief systems and ethno-medical practices. Another critical work was *Patients and Healers in the Context of Culture* (Kleinman 1980), which introduced and popularized the concept of "explanatory models" of illness. A larger body of literature shows that a primary source of non-adherence to treatment recommendation, as well as clinician and patient dissatisfaction stems from the frequent divergence between clinicians' and patients' explanatory models, and the clinicians' failure to appreciate and negotiate this divergence (Good and Good 1980, 1981). The key consensus of this literature is that cultural assumptions and expectations shape the doctor-patient relationship and may present a formidable barrier to effective care. Accordingly, the literature on cultural competence in medicine has thrived within a patient-provider clinical encounter framework.

At the provider level, cultural competence training is concerned with equipping providers with knowledge, attitudes, and skills to work effectively in cross-cultural contexts (Betancourt 2003). Both medical students and medical providers receive training in order to increase their knowledge about diverse cultural understandings of health and illness (Juckett 2005; Welch 2000), knowledge about the social determinants of health model (Seeleman, Suurmond, and Stronks 2009), awareness about health and health-care disparities (Gornick 200); awareness of the impact of stereotyping and bias in medical decision-making (Crandall

et al. 2003), and skills centered on cross-cultural communication with diverse populations (Perloff et al. 2006; Teal and Street 2009). The American Association of Medical Colleges captured these elements when they published the Tool for Assessing Cultural Competence Training to assist medical schools (See Table 1-2). Cultural competence is a means by which to broaden providers' recognition and understanding of the social-cultural aspects that affect patient outcomes and delivery of care.

Over the last two decades, the models and theories of cultural competence at the clinical encounter level have become significantly more refined. Early contributors proposed cultural competence continuums ranging from culturally destructive to culturally proficient that allowed providers to self-assess their level of competence (Campinha-Bacote 2002). It soon became apparent that achieving and maintaining cultural competence would require a lifelong process of learning and reflecting, not just about patients and their cultures, but about providers and their own biases and prejudices. Scholars of cultural competence increasingly emphasized that providers' attitudes and dispositions towards patients, such as respecting a patient's background, were essential to examine (Juckett 2005). Furthermore, the initial target populations of immigrants and refugees expanded to include LGBTQ individuals, women, people with a disability, and a range of other social groups. Cultural competence also evolved from a more static knowledge-based approach to a more dynamic "awareness and skill-based" approach focusing on the development of a set of interpersonal skills, as well as a framework that allows the clinician to assess – for an individual patient – what *sociocultural* factors might affect that patient's care (Betancourt and Green 2010).

The preceding has covered how the medical profession has defined and approached cultural competence. Understanding the rise of the medical profession is necessary to

understand the nature of the development of cultural competence in medicine. I now talk about the medical profession from a sociological perspective.

THE RISE AND CONSOLIDATION OF THE MEDICAL PROFESSION: BIOMEDICINE'S CULTURAL HEGEMONY

In the nineteenth century, the medical profession was generally weak, divided, and insecure in its status and its income, unable to control entry into practice or to raise the standards of medical education. By the twentieth century, however, the profession had succeeded in shaping the basic organization and financial structure of American medicine centered on the biomedical scientific model (Starr 1984). The medical profession managed to monopolize medical knowledge and access to training, and it created a unified front against outsiders such as patients, the state, and insurance companies (Berg and Mol 1998). The consolidation of the biomedical model that structured the entire profession resulted in a high degree of cultural authority in defining what and how to approach diseases and illness. The professionalization of medicine would not have been possible without control over the standards for medical education (Ludmerer 1985, 1999; Stevens 1971). Medical education reform within the biomedical framework was a critical foundation upon which the medical profession secured professional prestige and autonomy. Within a relatively short period, the medical profession and medical education became firmly established around the biomedical model (Starr 1984). By the mid-twentieth century, the medical profession in the United States stood at the height of its professional power, prestige, and cultural authority, enjoying great public trust. John McKinlay (2002) refers to this time as the "golden age" of doctoring.

The biomedical system of medical knowledge has five assumptions about the body, disease, and ways of knowing. The first assumption is mind-body dualism. The biomedical

model assumes a clear dichotomy between the mind and the body; physical diseases are located within the body, and are therefore treated in isolation from other aspects of the person inhabiting it (Engel 1977; Lock and Gordon 1988; Kirmayer 1988; Leder 1984; Hahn and Kleinman 1983). The second assumption is physical reductionism. The medical model also assumes that illness can be reduced to disordered bodily (biochemical or neurophysiological) functions, which excludes social, psychological, and behavioral dimensions of illness (Engel 1977). The third assumption, called the "doctrine of specific etiology", is the belief that a specific potential identifiable agent causes each disease (Dubous 1959). The fourth assumption, the machine metaphor, understands the body as a complex machine and encourages an instrumentalist approach to the body. Any malfunctioning, the physician can repair one part in isolation from the rest. Finally, the fifth assumption is that the body is the proper object of regime and control, emphasizing the responsibility of the individual to exercise self-control in order to maintain their health. Although many of these assumptions have a long history, they do not necessarily produce better medical care. Furthermore, they deflect attention from nonmedical measures for promoting health, such as nutrition and public health.

The underpinning of the biomedical model continues to govern the structure and organization of the U.S. medical profession. Subsequently, the biomedical training and socialization of medical providers strongly influences the doctor-patient interaction and has concrete implications for the delivery of health care. The biomedical model produces social distance between the practitioner and the sick person normalizing the expert-layperson relationship. The doctor is positioned as the knowledgeable expert, while the patient is the relatively ignorant recipient of the doctor's professional services. As the medical profession

becomes increasingly specialized, mediated by advanced technology and informed by a growing body of complex knowledge, the distance between laypersons and various experts will presumably grow wider. Modern medicine has maintained a conception of disease as separate from the person experiencing it, but patients cannot just "leave their bodies at the repair shop". Although individual doctors may choose to relate to their patients as persons not just bodies, such an approach has not been essential in the biomedical model. In many ways, the training and socialization of medical providers actively discourages them from understanding their patients as whole persons with social, emotional, aesthetic, spiritual, and other health-related facets to their lives.

A Sociological Critical Analysis: The Sociology of Professions

In this dissertation, I use and expand upon theoretical concepts within the sociology of professions. Medicine, like most professions, is organized to serve its own ideology. The profession seeks to legitimate its own interests and ideas about health and illness in order to justify their desired courses of action (Berger and Luckmann 1967). As described, the medical profession has organized itself to promote its interests around the biomedical model. Medical ideas and practices thus reflect or serve as ideology. In contrast to the universalism assumed in biomedical and naturalist ideology, biomedicine – both in theory and in practice – has been very much a product of particular social and cultural conditions (Lock and Gordon 1988).

The early literature on professions was marked by a functionalist perspective. Carr-Saunders and Wilson's *The Professions* (1933) argued that professions were organized bodies of experts serving the public who applied knowledge to particular cases. Then in the 1960s, scholars shifted to a monopolist view of professions. Eliot Freidson (1970) argued

that dominance and autonomy were the hallmarks of a true profession. Magali Larson's *The Rise of Professionalism* (1977) argued that professions were organizations attempting to control certain areas of social concern. For decades, the literature on professions was concerned with the structure rather than the content of the profession. Thus, I utilize Abbott's framework of professions, which focuses on the nature of work done by professions.

Abbott's (1988) approach assumes that analysis of the tasks of occupations is the key to understanding changes in professionalization. He defines professions as "exclusive occupational groups applying somewhat abstract knowledge to particular cases" (pg. 8). The critical distinguishing characteristics of professional occupations from this perspective is the possession of a body of abstract knowledge on which the occupation bases its claim for the exclusive right to control specific work activities. By focusing on the problem of jurisdictional negotiations among occupations, Abbott's framework provides a much broader, more dynamic framework for answering the traditional questions of how and why some occupations achieve economic and social dominance in society. Under what conditions will members of an occupation mobilize to claim occupational control over some specified set of work activities, in this case cultural competence? What factors affect the strategies that are used in pursuing such claims? And what factors affect the success or failure of this pursuit? Abbott's work helps identify how the negotiation of control over work activities is linked to a profession's ability to maintain legitimacy and authority.

In general, the medical profession has accepted a reductionist approach to addressing culture. Often, culture is reduced to language, nationality, or a checklist of other essentialist components. Cultural competence advocates argue a fundamental problem in medicine is that cultural competence is framed as a technical skill that can simply be acquired, or an issue that

can be handled by a translator. In actuality, what this approach does is equivocate the nuanced concept of culture with a rigid set of "dos" and "don'ts" that can be learned and referred to when a physician encounters a patient who fits a given description. As Santiago-Irizarry (2001) puts it, "medicalizing ethnicity as it happened at these [cultural competence] programs allowed it to be incorporated into medical discourses and practices as an anthologized element to be monitored and controlled." As an elusive and obscured concept, "culture" continues to frustrate the medical profession's attempts to neatly quantify and display accountability with their minority patients. Because so much of "culture" is about experience, solidarity, and history, attempting to compress physicians' understanding of a given culture, or all minority cultures, into a mere few training sessions falls far short of adequate.

Culture cannot be separated from the social process that creates it (both for patients' and providers' culture), and thus it must be regarded as a material process, so that medical providers can understand it both as a product and an ongoing production. If culture were merely a static product, perhaps translators would suffice in bridging the culture gap between physicians and patients. Yet, since culture is a continuously evolving process, a successful patient-physician relationship requires a much deeper consideration of how social, political, and economic factors might account for the prevalence and understanding of disease. Additionally, the cultural hegemony of the biomedical model that governs both the practice and structure of medicine needs to be part of this discourse.

The rise of the biomedical model brought an incredible degree of cultural authority surrounding the profession's license to define how they approach health and illness. Unfortunately, adopting cultural competence seems to be in direct conflict with this model.

Cultural authority as defined by Starr (1984) is the probability that particular definitions of reality and judgments of meaning and value will prevail as valid and true. This form of authority does not necessarily reside in an individual; instead, it may also reside in cultural objects such as books or the law. As Starr says, cultural authority is often the antecedent to action. Cultural authority in medicine is the authority of providers to interpret signs and symptoms to diagnose health or illness; by shaping the patient's understanding of their own experiences, physicians create the conditions under which their advice and approach seems appropriate. An important question is has or will the profession's cultural authority change with the adoption of cultural competence?

CULTURAL COMPETENCE AS A PROFESSION'S PROJECT: DISSERTATION OVERVIEW

Substantively, the dissertation answers core questions about what the concept of cultural competence means within the medical profession. Theoretically, it considers the jurisdictional terrain of the medical profession and its changing nature concerning the adoption of cultural competence in medicine. Modern American medicine has come under severe criticism for failing to recognize or respect the ethnic cultural identities of patients. Stakeholders in all areas of U.S. medicine – professional organizations, public advocacy groups, hospital administrations, medical school leadership, and insurance carriers – have embraced the focus on cultural competence as a solution. Drawing and building on a sociology of professions literature, I assess the jurisdictional claims made by the medical profession and the embedded assumptions of cultural competence in terms of the causes and consequences of the practice of medicine. I add to our understanding of the current state of the medical profession in contemporary US society by examining the rise of cultural

competence discourse and I provide an alternative way to understand professions' responses to challenges. Specifically, "cultural competency" can be seen as a professional tactic designed to maintain jurisdictional authority in the context of demographic, political and social changes, which collectively had the potential to threaten the legitimacy of the medical profession's jurisdiction. Understanding cultural competency in this fashion sheds light on its potential for progressive or radical change but such potential ways to bring significant changes to medicine fell short.

This dissertation contains three empirical chapters that investigate the parameters of cultural competence in medical education and furthermore analyze the assumptions such new requirements reveal about the practice of medicine in the United States in the 21st century. The overarching question guiding this dissertation is as follows: *How, why, and with what consequence(s) did medicine adopt cultural competence?* To answer this, I conducted three empirical research projects, each with a specific objective (See Figure 1-1). The first chapter examines the legal jurisdictional claims of cultural competence by examining the conceptualization of cultural competence as embodied in the initial educational mandate requiring cultural competence training. The second chapter examines the workplace jurisdictional claims by assessing the manner in which the medical profession operationalizes cultural competence. Finally, the third chapter examines the professionalization claims of cultural competence by investigating the implementation of cultural competence training in U.S. medical schools. I argue that the medical profession makes an effective jurisdictional claim publically and legally on cultural competence, but as my dissertation reveals the profession's overall commitment to cultural competence remains low resulting in a *surface jurisdictional claim* (See Figure 1-2). Each of the three empirical chapters demonstrate the

ways through which the profession is asserting its cultural authority to adequately apply and practice cultural competence narrowly.

Manuscript 1: Establishing and Conceptualizing the Cultural Competence Mandate Legally

In the year 2000, the Liaison Committee of Medical Education (LCME, the accreditation body for all U.S. medical schools) passed a mandate requiring medical schools to provide cultural competence training. The purpose of this chapter is to assess the perceptions of the 2000 cultural competence mandate and any subsequent changes to the mandate. I asked founding key policy makers, "What was the originating vision behind the LCME's cultural competence mandate and how has the current mandate expanded?" I used snowball-sampling methods to find 14 key elite policy actors in medical education. I then recorded and transcribed the semi-structured interviews. Analysis of the transcripts used qualitative content analysis (QCA) in Nvivo 10. Three themes captured the ways in which the cultural competence mandate has expanded from its original intentions. First, cultural competency's primary mission expanded from addressing racial and ethnic disparities to addressing all health disparities. Second, cultural competency's primary approach shifted from providers learning about other groups to providers looking at themselves reflexively. Third, the policy effect shifted from stimulating medical education innovation to achieving assessment and long-term learning of such medical education training. These findings provide a framework in medical education around the mission, approach, and policy effect of the cultural competence movement in the last two decades. The cultural competence mandate attempts to change the socialization process of medical students, but the organization of medical education seems to limit the movement's goals.

Manuscript 2: Operationalization of Cultural Competence in the Medical Profession Workplace

Given the institutional support by accreditation and government agencies, the practice of medicine today should reflect the cultural competence framework to some extent. In this chapter using discourse analysis, I examined 89 articles published in the *Journal of the American Medical Association* (*JAMA*) to assess the operationalization of cultural competence as it discussed by the medical profession. Authors frame cultural competence as potentially capable of increasing the profession's ability to mitigate health disparities and improve delivery of care. Yet they also recognized that the ideal realization of cultural competence was severely undermined by dominant aspects of the biomedical framework that structure the medical field. Three themes capture the tensions present in implementing cultural competence into a biomedical framework. First, cultural competence is conceptualized as providing culturally appropriate health information to members of diverse minority populations, but this inadvertently expands the boundaries of cultural competence to capture anything and everything while reinforcing individual responsibility for improving health outcomes. Second, cultural competence is practiced when provider decision-making takes into consideration their patients' cultural background, but such requests ignore limitations imposed by the biomedical model and the realities of the patient-provider encounter. Third, the culture of medicine and the professional socialization of practitioners places severe restrictions on the possibility of implementing practices emphasizing socio-cultural aspects of patient care. Medical education, professionalization processes, and patient-provider encounters are all structured by the biomedical model that resists modification or inclusion of other frameworks. I argue that research on the profession should

move beyond an emphasis on the culture of patients to a systematic analysis of the ways in which the biomedical model determines medical practice, structures the culture of medicine, and influences the professional identity of the provider.

Manuscript 3: Implementation of Cultural Competence Training in U.S. Medical Schools, Professionalization

Sixteen years have passed since the Liaison Committee on Medical Education (LCME) mandated cultural competence training in U.S. medical schools. This chapter explores how medical schools implement cultural competence training using comparative case study analysis. Fifteen regionally diverse public and private medical schools in the United States participated in the parent study funded by the National Institute of Health. We conducted 125 interviews with 52 administrators, 51 faculty or staff members, and 22 students. We led focus groups with an additional 196 third- and fourth-year medical students. Interviews were recorded, transcribed, and imported into NVivo 10 for qualitative data analysis. Queries captured topics related to student preparedness to work with diverse patients, engagement with socio-cultural issues, and participants' general perception of pre-clinical and clinical curriculum. Three categories emerged concerning cultural competence training: formal curriculum, conditions of teaching, and institutional commitment. At the formal curricular level, schools offer a range of courses collectively emphasizing communication skills, patient-centered care, and community-based projects. Conditions of teaching emphasize integration of cultural competence into the preclinical years and reflection on the delivery of content. At the institutional level, commitment to institutional diversity, development of programs, and degree of prioritization of cultural competence varied. Even with the LCME mandate, there is tremendous variation in how medical schools

approach cultural competence topics and a high degree of reductionism. Schools that incorporated longitudinal experiential learning and leadership support were the most effective in integrating cultural competence content into the curriculum, but few schools modeled such approaches.

Cultural Competence as a Surface Jurisdictional Claim

The principles of cultural competence are attempting to change the work of medical providers, but the concept has yet to be integrated enough to modify the actual work performed by the medical profession. The first chapter centers on the legal jurisdictional claim of cultural competence. The medical profession's ability to self-regulate and maintain high level of autonomy over their practice and work led to a mandate that passed with built-in flexibility. The vagueness of the mandate allowed the profession to adopt cultural competence without specifying or providing a uniform approach. The second chapter centers on the workplace jurisdictional claim of cultural competence. The practice of cultural competence within a biomedicine framework is difficult given the hidden curriculum, limited time with patients, and complexity of multiple identities of a patient. Cultural competence is reduced to practices at the communication and medical decision-making level. The third chapter on professionalization claims reveals that medical schools implement cultural competence primarily in the first few years, emphasizing communication or patient-centered skills and often without even using the term "cultural competence." This dissertation shows that the medical profession's jurisdictional claim to the legal aspect of cultural competence was poorly constructed, the profession's jurisdictional claim in the workplace was limited by the culture of medicine, and their jurisdictional claim in professionalization was restricted by

the current education structure. These three empirical chapters reveal the jurisdictional claim to cultural competence is an example of what I call a *surface jurisdictional claim.*

Cultural competence became defined and integrated into medicine by the medical profession in the legal, workplace, and education arenas in ways that did not challenge the status quo. According to Abbott (1988), a full jurisdictional claim is one where there are both a public and legal jurisdictional claim. The example of cultural competence in the medical profession shows that jurisdictional claims operate on a continuum. Sometimes what seems to be a strong and deep jurisdictional claim is weak and shallow. I found that the medical profession's strategy of addressing cultural competence was to fit it into the existing model of care, avoiding radical change and keeping protocols as is. This conceptualization, operationalization, and implementation of cultural competence enhances the biomedical framework in small ways. First, the medical profession is able to show legally they are re-forming the educational process for the next generation of medical providers. Second, the medical profession has made changes to the workplace arena by providing translated materials and having interpreters available. Third, the medical education system have incorporated courses concerning cultural competence and increased their student's exposure to diverse patients.

CONCLUSION

The medical profession defines the problem and solution of cultural competency at the clinical encounter level. The provider was the problem and hence training providers was the solution to address diverse patients and growing health and healthcare disparities. The systems level approach of cultural competence was recognized but marginalized. Through the execution of this dissertation, themes around the culture and structure of medicine as

limiting the full integration of cultural competence continued to emerge. I realized cultural competence was never a compromise nor a new jurisdictional claim. I originally approached this dissertation thinking cultural competence is a new task claimed by the medical profession, but it appears as though the claim to this kind of new work instead strengthens the biomedical jurisdictional claim of the medical profession. Through each of the chapters, we come to understand how cultural competence is a *surface jurisdictional claim*. The integration of cultural competence I would argue was "successful" because the goal of the profession is to maintain legitimacy and control over their work. It may be in the medical profession's interest to have a less definable and measurable cultural competence to protect from outsiders being able to assess the profession's performance or become involved with regulation. The challenge seems to be that cultural competence is a moving target that continues to expand at the legal, workplace, and education arena, flexible and encompassing more and more that in the end the construct may become meaningless.

TABLES

Table 1-1: Cultural Competence Adopted by Multiple U.S. Professions

	Psychology/ Mental Health	Education	Social Work	Medicine
Time Frame	60 years	50 years	30 years	20 years
Key Scholars	Carl Jung Erick Erickson Alan Boland	Ellen Grote Michael Mangan	Lum Doman James Green Karen M. Sowers-Hoag Patricia Sandau-Becker	Joseph R. Betancourt Alexander R. Green Emilio Carillo
Framework	Cultural Competence Psychotherapy	Cross-Cultural Competent Educator	Culturally Competent Social Work	Cultural Competent Health Professional
Accreditation	American Psychological Association (APA) Board of Ethics Minority Affairs established guidelines in 1993	The Department of Education & the National Education Association (NEA)	National Association of Social Work (NASW)	The Department of Health and Human Services & The Liaison Committee on Medical Education (LCME)
Definition	Culturally competent psychologist possesses awareness of diversity, cultural knowledge, cross-cultural communication skills, and proper attitudes necessary to provide effective care for diverse populations	Cultural competent is a dynamic process of growth through ongoing questioning, self-assessment, knowledge and skill building, starting with the student's level of current competence and supporting enhancement of their abilities.	In general, cultural consciousness or awareness, cultural knowledge, proper skill, and attitudes or values are considered as key components of cultural competence in social work practice.	Cultural Competence is considered a process that requires individuals and healthcare systems to develop and expand their ability to effectively know about, be sensitive to, and have respect for cultural diversity.

Table 1-2: Tool for Assessing Cultural Competence Training (TACCT)

TACCT Domains		
Domain I	Rationale, Context, and Definition	**A.** Definition of cultural competence
		B. Definitions of race, ethnicity, and culture
		C. Clinicians' self assessment and reflection
Domain II	Key Aspects of Cultural Competence	**A.** Epidemiology of population health
		B. Patients' healing traditions and systems
		C. Institutional cultural issues
		D. History of the patient
Domain III	Understanding the Impact of Stereotyping on Medical Decision-Making	**A.** History of stereotyping
		B. Bias, discrimination, and racism
		C. Effects of stereotyping
Domain IV	Health Disparities and Factors Influencing Health	**A.** History of health-care discrimination
		B. Epidemiology of health-care disparities
		C. Factors underlying health-care disparities
		D. Demographic patterns of disparities
		E. Collaborating with communities
Domain V	Cross-Cultural Clinical Skills	**A.** Differing values, cultures, and beliefs
		B. Dealing with hostility/discomfort
		C. Eliciting a social and medical history
		D. Communication skills
		E. Working with interpreters
		F. Negotiating and problem-solving skills
		G. Diagnosis and patient-adherence skills

FIGURES

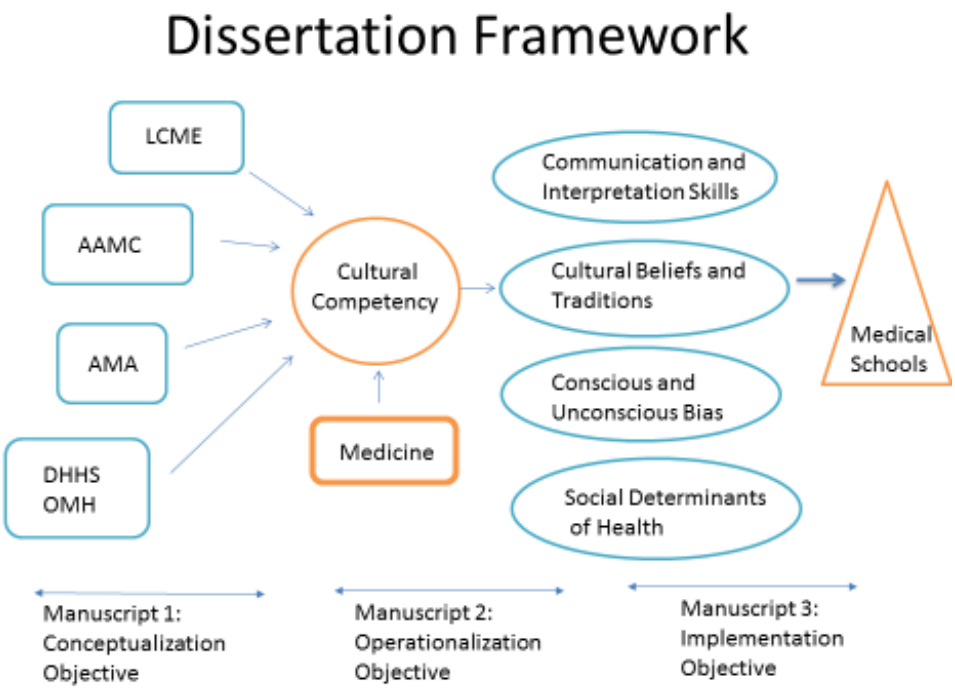

Figure 1-1: Dissertation Objectives Framework

Figure 1-2: The Surface Jurisdictional Claim of Cultural Competence in Medicine

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AN ASSESSMENT OF THE CULTURAL COMPETENCY TRAINING MANDATE IMPLICATION ON MEDICAL EDUCATION REFORM

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ABSTRACT

Purpose: In the year 2000, the Liaison Committee of Medical Education (LCME, the accreditation body for all U.S. medical schools) passed a mandate requiring medical schools to provide cultural competence training. The purpose of this paper is to assess the perceptions of the 2000 cultural competence mandate and any subsequent changes to the mandate. I asked founding key policy makers, "What was the originating vision behind the LCME's cultural competence mandate and how has the current mandate expanded?" **Method:** I used snowball-sampling methods to find 14 key elite policy actors in medical education. I then recorded and transcribed the semi-structured interviews. Analysis of the transcripts used qualitative content analysis (QCA) in Nvivo 10. **Results:** Three themes captured the ways in which the cultural competence mandate has expanded from its original intentions. First, cultural competency's primary mission expanded from addressing racial and ethnic disparities to addressing all health disparities. Second, cultural competency's primary approach shifted from providers learning about other groups to providers looking at themselves reflexively. Third, the policy effect shifted from stimulating medical education innovation to achieving assessment and long-term learning of such medical education training. **Conclusions:** These findings provide a framework in medical education around the mission, approach, and policy effect of the cultural competence movement in the last two decades. The cultural competence mandate attempts to change the socialization process of medical students, but the organization of medical education seems to limit the movement's goals.

Key Words: Cultural Competence Training, Policy/Mandate, Undergraduate Medical Education

INTRODUCTION

Demands for culturally competent health and mental health services grew out of the failure of service delivery systems to be responsive to all segments of the populations (Cohen 1990; Chin 2000). A robust body of literature has highlighted that the failure of health care providers to acknowledge, understand, and manage socio-cultural variations of diverse patient populations, thus impeding effective communication and trust-building, leading to patient dissatisfaction and non-adherence, and ultimately culminating in poorer health outcomes, particularly among racial/ethnic minority populations (Saha et al. 1999; Smedley et al. 2002; Perloff et al. 2006; Teal and Richard 2009). As originally conceived, the intended purpose of cultural competence training was to equip the next generation of providers with the knowledge, skills, and attitudes necessary to deliver high-quality care to patients from diverse sociocultural backgrounds (Betancourt 2006). Medical education has witnessed a steady increase in efforts to train the next generation of providers in cultural competency.

Regulatory efforts through the Liaison Committee of Medical Education (LCME), which is the accreditation body of all U.S. medical schools, have accelerated the institutionalization of cultural competence training (Graves et al. 2007). In 2000, the LCME passed a cultural competence mandate. The LCME standard states that students must understand the manner in which people of diverse cultures and belief systems perceive health and illness, respond to various symptoms, diseases, and treatment. Additionally, they must learn to address gender and cultural biases in healthcare delivery (LCME 2003). All medical schools must demonstrate evidence of cultural competence training as part of their accreditation process. Since the adoption of the cultural competence training mandate in

medical education, however, a range of concerns and confusion about the concept and specifics of implementation have provoked a number of discussions and debates.

Over the past few decades, medical education in the United States has experienced rapid transformation. Time devoted to basic sciences and emphasis on laboratory teaching has declined as new subjects such as ethics, humanism and cultural competence have become integrated in medical curricula (Barzansky and Gevitz 1992, MacLeod and McCullough 1994; Cooke et al. 2006; Duffy 2011). A number of reports from foundations, educational bodies, and professional task forces have criticized medical education for over-emphasizing scientific knowledge over clinical reasoning, practical skills, and, in particular, under-emphasizing the development of character, compassion, and integrity in the medical provider (Fraser 1991; Betancourt, Green, and Carillo 2002; Smedley et al. 2002; South-Paul et al. 2005). Today, becoming a physician means mastering not only the traditional set of "hard sciences" (e.g. biology, chemistry, anatomy, physiology), but also demonstrating an understanding of the social/cultural aspects relevant to clinical care.

The purpose of this article is to analyze the mission, approach, and policy effect of the LCME's cultural competence mandate within the field of medical education. In a similar paper, Betancourt et al. (2005) interviewed experts in cultural competence from managed care, government, and academia to identify their perspectives on the state of affairs regarding cultural competence. He found that motivations for advancing cultural competence depend on each sector's mission, goals, and sphere of influence. However, we have yet to understand the views of cultural competence in the medical education field. Through interviews with key policy actors in medical education, I assess the perceptions of the 2000 cultural competence mandate and any subsequent changes to the mandate. The aim of this article is to understand

the expanding concept of cultural competence in medical education and the implications of the expansion on ongoing efforts around transforming medical education. I argue that while the cultural competence mandate attempts to change the socialization process of medical students, the organization of medical education needs to change as well to support such efforts.

METHODS

Study Design and Setting

This study employed a qualitative in-depth interview design with policy experts who were decision-makers in the cultural competence mandate in 2000. This study took place from 2015 to 2016, shortly after the release of a major cultural competence report entitled, "*Assessing Change: Evaluating Cultural Competence Education and Training*" published in 2015 by the American Association of Medical Colleges, which reviewed over 100 studies published between 1995 and 2013 concerned with assessing the effectiveness of diverse cultural competence training strategies. Experts in this field were, therefore, already involved in a major initiative to review the state of progress in cultural competence training in medical education during the period this study was conducted.

Data Collection

This study used a snowball sampling approach (Berg 2007). Policy makers were defined as individuals who played a key role in establishing the 2000 cultural competency mandate[2]. Potential participants were identified through multiple sources including a

[2] The American Medical Association (AMA), the American Association of Medical Colleges (AAMC) and the Liaison Committee on Medical Education (LCME) are directly involved in the creation and transformation of the medical education system. The AMA, established in 1847, is an influential, multi-sector organization engaged in setting standards for medical education. The AAMC, established in 1876, has the goal of strengthening the medical care system by supporting a spectrum of educational, research, and patient care

literature review, organizational reports, and websites of four major organizations involved in medical education: the American Association of Medical Colleges (AAMC), American Medical Association (AMA), the Liaison Committee of Medical Education (LCME) and the Department of Health and Human Services Office of Minority (DHHS OMH). Individuals from this initial pool who agreed to participate were sent a detailed overview and consent form. At the end of the interview, I asked for referrals to other key decision-makers in the cultural competence medical education arena. Recruitment stopped after no new names emerged.

Two of the interviews were conducted face-to-face, and the remaining twelve took place over the phone. The interviews lasted approximately one hour (ranging in length from 45 minutes to over two hours) and followed a semi-structured format. The semi-structured interview guide consisted of three major sections (See Appendix A). First, to establish respondents' backgrounds and general orientation towards cultural competency, I asked participants about their role with the mandate, experiences, and general perceptions of cultural competency. The second and largest part of the interview attended to the cultural competency mandate itself. The questions in this section focused on the major topics of discussion related to the mandate, the nature of the conversations, and the reasoning behind the proposed mandate. I also asked them to discuss how this mandate has changed and/or expanded from its original conceptualization. For the final portion of the interview, I asked

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activities. In the 1920s, both the AMA and the AAMC provided oversight of the medical education system, but this quickly became overly complicated. Therefore, in 1942 they both sponsored the creation of the LCME in order to streamline accreditation standards and centralize oversight and enforcement protocols. Together these three organizations are all heavily involved in the debates over what kind and to what extent do scientific and non-scientific courses need to be part of medical education.

participants to comment on the state of the field and challenges for the cultural competency mandate. Three follow-up contacts occurred with different participants for clarification.

Sample

I interviewed 14 stakeholders (See Table 2-1). Five individuals came from the AAMC, three individuals from the LCME, two individuals from the AMA, and two individuals from the DHHS OMH. In addition, I interviewed two prominent academic experts on cultural competence involved in medical education who contracted with the listed organizations on various cultural competency initiatives.

Data Analysis

Each interview was audio-recorded, transcribed verbatim, and analyzed using the qualitative software NVIVO 10. My coding strategy followed the principle of Qualitative Content Analysis (QCA) (Shapiro and Markoff 1997). Following Schreier (2012), I coded the interviews by breaking the text down into manageable categories developed to adequately represent the concepts of interest. In QCA, one examines *all* of the material and decides where each part fits in the coding tree. Two rounds of informal coding occurred before a final coding tree was developed (See Appendix B). Themes were identified in iterative dialogue over the course of concurrent coding transcription, notetaking, and memo writing. The Institutional Review Board at University of New Mexico reviewed and approved all research activities (IRB # 682173-3).

RESULTS

The introduction of the cultural competency mandate occurred in 1999 at the American Association of Medical Colleges' 110th Annual Meeting: *Closing the Gaps: A Resolution for the New Millennium.* A majority of the interviewees reported that at the time,

there was very little to no debate about the mandate proposed by the former president of the AAMC. Participants' perceptions about the 2000 cultural competency mandate revealed three themes (See Table 2-2). First, the primary mission of cultural competency expanded from addressing racial/ethnic disparities to addressing health disparities more broadly, redefining a core aspect of what it means to be a twenty-first-century medical provider. Second, the primary approach of cultural competency training expanded from acquiring knowledge about others to reflecting on one's own biases, increasing the need for providers to engage in self-growth. Third, the primary policy effect of the original LCME mandate was to guard against having no curriculum, but this led to emphasizing all kinds of social-cultural medical education training. Today, the policy effect aims to assess such medical education training.

Mission: Redefining a Core Aspect of a Twenty-First-Century Physician

There was consensus among interviewees that the primary mission of the original cultural competence mandate was to teach students the importance of working effectively with racial/ethnic populations to address health disparities. As one interviewee said,

> It derives from the fact that the racial and ethnic representation of patients in this country has changed significantly over the past two or three decades. As medical students learn, they are learning with other than the typical patient that was seen fifty years ago. And they have to respond to the needs of patients in different ways by virtue of language, culture, ethnicity, expectation, understanding of disease, the kinds of somatology and people's perception of symptoms and ideology of disease (Interviewee 6; LCME).

The changing demographic composition of patients served as an impetus to transform the medical education curriculum in order to increase preparedness among medical students entering the workforce. A majority of the respondents described how cultural competence training allows the profession to better address an increasingly diverse patient population.

About half of the respondents felt the original 2000 cultural competence mandate was necessary due to the lack of racial and ethnic diversity in the healthcare workforce. Regardless, the documented racial/ethnic disparities in health and health care were a critical impetus for the mandate. The mission has expanded beyond addressing racial/ethnic populations. For example, one interviewee said,

> The dimensions of cultural competence- most people early on thought it was predominantly focused on race and ethnicity. Over time, it has been broadened to socioeconomic status, broadened to sexual preferences, and broadened to a more diverse spectrum of cultural competence [training]… which, frankly, I think has helped the concept become more important (Interview 11).

The perception of the cultural competence mandate as primarily addressing racial and ethnic health disparities remained a salient theme, but over time, participants reflected on how the mandate "symbolically" came to encompass other social groups. The actual language of the mandate did not change, but the perceived mission of cultural competence expanded to address *all* health disparities.

Because of the ever-expanding boundaries of cultural competence, the majority of the interviewees started to equate the concept with a core aspect of a physician's identity. Multiple interviewees reported it was impossible for students to be culturally attuned to all variations of a patient. Therefore, as described by one participant, "[Cultural competence]

makes it more of a core function of what it means to be a good physician or a clinician of any sort" (Interviewee 1). In about two-thirds of the interviews, the cultural competence mandate was perceived as having become synonymous with being a "good" doctor. For example, one person said:

> It does not allow you to think about culturally competent as something separate from being professional. If you are not empathetic and humanistic, you cannot be culturally competent. And, so to me, the big shift that has occurred is we moved from thinking culturally competent education as something in addition or nice to have. It is actually now core to being a quality humanistic empathetic physician in the twenty-first century, and that is why the LCME added it to the sort of standards to medical schools in terms of the graduation. It is no longer just a nice thing to have; it is a must (Interviewee 1).

Most interviewees perceived the concept of cultural competence to be necessary for all providers, regardless of their racial/ethnic background, in order to increase their effectiveness in working with *all* types of patients. Many reported that teaching students about health disparities broadly emphasizes their role in eliminating them. The mission of the mandate is thus not just to provide a specific training about different patient populations. Being a medical professional means being culturally competent, caring, and respectful for all in order to deliver the best care.

Approach: Increasing Attention to the Physicians' Role through Self-Reflection

Initially, the primary approach of the cultural competence mandate was knowledge acquisition about diverse cultures. Participants described the mandated training as learning through a "checklist" of practices and behaviors associated with a particular ethno-racial

group. For example, one interviewee said, “Oh, let me learn how Puerto Ricans act, or how African Americans act; the training was very stereotypical” (Interviewee 2). A majority of the participants explained how such a shallow approach to fulfilling the cultural competence mandate led to unintended consequences around stereotyping. As one interviewee said,

> You can’t teach cultural competence by coming up with a continuum necessarily, it will have to be more. It will have to be an awareness, it has to be ingrained in the educational process and that was what was missing. So, you can’t think of it as a book and learn about it, because as I said, you run into the risk of stereotyping (Interviewee 5).

These concerns with how the mandate was being fulfilled were not only internal. Participants reported that community members and those teaching cultural competence also shared such concerns.

In response to these concerns, the LCME revised the mandate to emphasize reflective practices about providers’ biases. The shift from a checklist approach to self-reflection about bias was evident through the 2002/2003 revisions of the LCME standards. One interviewee said,

> With regards to the standards set forth by the LCME, bias was always in the original mandate, but later revisions of the standards expanded and clarified this aspect. Clearly, in the original formulation, there were two separate standards: one that dealt with cultural competency on its own terms, and the other that dealt with students’ ability to recognize personal biases in themselves and in others’ health care delivery. They remained separate standards for up until the most recent revision of the LCME standard (Interviewee 4).

The original approach of teaching about different patient population cultures was not necessarily replaced, but expanded to emphasize the importance of self-reflection. Roughly half of the participants talked about the need for students to engage in self-growth about their biases and prejudices.

Participants discussed how the revised cultural competence mandate is now more concerned with teaching students to reflect and learn about themselves. A participant stated, "I think it's a reflection of where we are today with cultural competence… it has evolved to where we are looking more at biases [of providers]" (Interviewee 2). Another interviewee described this as two sides of the same coin. "On one side, you have cultural competence for the patients' sake, but on the other side, you have cultural competence for the providers and they both have to be present in order to be culturally competent" (Interviewee 14). Not everyone, however, viewed the expansion as a good thing. For example, one of the interviewees reported a concern:

> I think some people in the community who are committed to cultural competence feel like they don't - they almost feel like the re-organization may dilute the importance of these things (concern about the patient and their culture), but we don't know that for sure, it's just a feeling (Interviewee 2).

Although a minority of interviewees expressed doubt about the shifting of cultural competence from the checklist approach to self-reflection, most interviewees felt that cultural competence was better off with a broader approach addressing both the patients' and providers' cultural backgrounds.

Policy Effect: Promoting Long-Term Learning and Assessment

Over two-thirds of the interviewees discussed how the original mandate was designed to stimulate innovation in cultural competence training. During those initial years, many interviewees described the cultural competency mandate as spearheading the transformation of medical education. An interviewee said,

> I recall there were not that many major publications dealing with cultural competency issues at that time and no major organization you could point to [that was advocating for cultural competency]. It [the cultural competency mandate] was really a champion for those issues at that time…The goal was to improve medical education with the goal of improving patient care (Interviewee 4).

While the goal was to improve medical education, the original policy effect of the LCME mandate was specifically to guard against a total absence of curriculum concerned with cultural competency training. One interviewee said,

> We say based on your curriculum, and your mission, there are certain things that need to be there and we need to look at what you got. Your mission and your outcomes. And, [we] see if it is appropriate. Again, standards are mandates, they are requirements but they are not quantitative requirements... [The LCME] allows flexibility, but it puts boundaries around that flexibility. You do not have to teach well; you do have to teach cultural competency, but how you do, it needs to fit with who you are as a school and what you do as a school (Interviewee 3).

All of the participants discussed how the original mandate stimulated diverse practices and implementation around cultural competence training. The LCME laid out the standards, but did not specify how to meet them. The mandate's language encouraged a considerable degree

of curricular innovation and provided a relatively high degree of autonomy and flexibility. Participants highlighted how the mandate did not assess *how well* schools taught cultural competency, and instead only evaluated *whether* schools engaged in cultural competence training.

Many interviewees also emphasized how medical schools still have a high degree of autonomy over their curriculum design. While such a high level of autonomy for teaching hard science topics such as anatomy and chemistry has worked well, some interviewees did not see the direct translation to topics within the social sciences, such as cultural competency. These interviewees saw mandating the teaching of sensitive topics surrounding cultural competence as difficult. One said,

> Do you teach bio-ethics in your curriculum, do you teach anatomy and physiology in your curriculum, I mean the answer to that question is sure. It is very easy to measure a knowledge base in biochemistry or anatomy; you can do that with, you know, comprehensive examination. Assessing cultural competency and being able to deal with a culturally diverse population of patients is not easy to assess (Interviewee 11).

The lack of testing around and insufficiently "objective" measures of cultural competence consistently emerged in interviewee accounts. Adding cultural competence to the medical education curriculum has not necessarily led to clarity regarding assessment.

Furthermore, a majority of the interviewees said that continuous and sustained cultural competence training is difficult to implement because the systems of socialization in undergraduate and graduate medical education are not always aligned. The cultural competency mandate is an educational standard, but the LCME has jurisdiction only over the undergraduate medical education system. One said,

> The LCME has struggled over the years with not having a close relationship with the graduate medical education [system]. They have gotten closer over time, but since the beginning of the ACGME, the two organizations have functioned almost completely independently of each other (Interviewee 4).

Over half of the interviewees discussed the broken system of socialization medical providers go though and the absence of an infrastructure that tests and actively assesses topics including cultural competence. The idea of "sustaining knowledge" among medical students is largely unknown and has not been a concern of the LCME.

DISCUSSION AND CONCLUSION

In this article, I have presented key policy makers' perceptions on the cultural competence mandate passed in 2000 by the Liaison Committee on Medical Education (LCME). The mission of the cultural competence mandate emphasizes the providers' role in not only learning about but addressing health disparities. The approach of the cultural competence mandate is not just to acquire an external body of knowledge, but also for providers to reflect about their prejudices. Moreover, the policy effect of the cultural competence mandate shifted from stimulating medical education innovation to fostering assessment and long-term learning. The mission, approach, and policy effect of the cultural competency mandate has expanded from merely being add in medical education to a central aspect of a medical provider's identity and practice in the twenty-first century.

This study revealed cultural competence is conceived to be more than knowledge, attitudes, or skills today – it is a *perspective* that providers must work to acquire and maintain. Participants no longer view the cultural competence mandate as something "nice" to add to the curriculum, but as essential if providers intend to be successful in practice. It

should be a part of the mindset of a twenty-first-century medical provider to not only understand, but address all health disparities (Kumagai and Lypson 2009) However, cultural competence is still largely conceived of as "a professional ability that can be taught and implemented in clinical training, rather than primarily as virtues associated with moral character" (Fox 2005: 1316). Cultural issues in medicine reflect a larger set of issues around health disparities. How the medical education system can or will train providers to be concerned with meeting the needs of vulnerable patient populations is an ongoing challenge.

The additions to the medical education curriculum around non hard-science topics have been extensive in the last two decades, ranging from ethics, humanism, and professionalism to cultural competency. Concurrent with these additions has been a movement towards critical thinking and having students take a more active role in their learning (Boutin-Foster, Foster, Konopasek 2008; Jenks 2011). The teaching of cultural competence seems to be encouraging such practices through self-reflection of bias, with the onus on students to engage in self-growth. The structure of medical education has historically been conducive to didactic teaching (Reissman et al 1960; Pickering 1978), but in the new millennium, self-reflection is becoming ever more important. Hospitals used to serve as the traditional foundation for context and content in regards to teaching medical students (Fraser 1991). Today, there is an increasing emphasis on community and local clinics to teach medical students the various social-humanistic aspects of medicine and to get them outside their comfort zone. Overall, medical education seems to be shifting to help students focus on personal growth.

The infrastructure of medical education is built to look for evidence of teaching and learning around cultural competence, rather than to look for impacts of such training on

outcomes and practices (Suh 2004). It is clear that the goal of the LCME was to create a floor, not a ceiling, but only a few schools go above and beyond to meet the spirit of the cultural competence mandate. Much investment and attention have occurred around programming and evaluation, but we still do not know what effective training looks like or which approaches are more effective than others (Anderson et al. 2003; Beach et al. 2005). Some scholars' haven even proposed alternative frameworks such as cultural humility (Lum and Standley 1994; Trevalon 1998; Wear 2009). Regardless of the name, existing research shows that cultural competence interventions can have a temporally limited positive impact on the knowledge, attitudes, and skills of providers as well as on patient satisfaction (Crandall et al. 2003; Beach et al. 2004), but the concern is sustaining such training and assessing its impact on health disparities. Better coordination between the medical education sector and the healthcare system is a growing priority concerning cultural competence training. Rigorous research on cultural competency would both enable the testing of cultural competency's theoretical premises and provide health systems with constructive information about which techniques are the most successful and under what circumstances (Brach and Fraser 2000). In attempting to accurately assess the impact of cultural competence, however, a tension exists between a flexible and localized cultural competency training that is aware of place and context, and a standardized, decontextualized cultural competency training that is more conducive to outcome assessment.

Limitations: A limitation of this study is the low response rate. A total of 24 potential interviewees were identified, but I only interviewed 14 individuals. Six declined to participate and two did not respond despite the three attempts. Some of the reasons for the low response rate include the lack of trust, concerned about their anonymity, and possibly

due to the demanding workload of the participants. Additionally, I faced difficulties contacting two retired individuals whom contact information was confidential. Despite, these limitations, I captured a diverse sample of key policy makers and their perspective on the cultural competence mandate.

I encourage further researchers to explore any significance of policy makers' racial/ethnic backgrounds. It is possible that my small sample size limited my ability to explore these important differences. What I did observe seemed to indicate a pattern. Four respondents were from racial/ethnic minority backgrounds (two African Americans and two Hispanics) and when they reported on the topic of cultural competence, they directly talked about issues of race and racism. However, the majority of the respondents, particularly those from non-racial/ethnic backgrounds reported culture competence does not address racial/ethnic issues. On multiple occasions, these respondents informed me that issues of race and ethnicity are addressed via different committees and through different standards. The relationship between cultural competence and racial/ethnic issues was largely absent beyond these four racial/ethnic minority individuals. The absence of dialogue around race during my interviewees' calls points to the need for future research. It would have been fruitful to obtain participants' racial/ethnic identity, but I relied on assigned racial/ethnic identity of participants that I determined based on last name and physical characteristics (See Table 2-1). The focus of this paper on the standard did not allow further analysis on race.

The various developments of cultural competence in its mission, approach, and policy effects have led to a crossroads. For decades, undergraduate teaching has been uneven in quality, variable in commitment, and lacking in coordinated objectives (Fraser 1991). The field of medical education has made an enormous leap forward by requiring cultural

competency training, which continues to be a priority. Despite decades of research on cultural competence, it seems we are still far from establishing a comprehensive framework, a unifying curriculum, and/or using valid measures to assess the impact of practitioners' training on health outcomes and delivery of care. As we reflect backward to move forward, it is clear that challenges remain. Medical education reform has primarily been concerned with the re-structuring of the medical education curriculum to better equip the next generation of providers. Future studies of medical education should interrogate how the structure of undergraduate medical schools could be altered to train and assess a provider's cultural competency beyond the training period.

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TABLES

Table 2-1: List of Interviewees

INTERVIEW NUMBER	ORGANIZATION AFFILIATION	TITLE / ROLE	Prescribed Racial Background of Participants
1	AAMC	Chief Diversity Officer	African American
2	AAMC	Senior Director Human Capital Portfolio	Non-Racial/Ethnic Background
3	LCME	Co-Secretary (AMA side)	Non-Racial/Ethnic Background
4	LCME	Co-Secretary (AAMC side)	Non-Racial/Ethnic Background
5	AMA	Deputy Provost for Research and Minority Issues	Non-Racial/Ethnic Background
6	LCME	Former-Secretary (AAMC side)	Non-Racial/Ethnic Background
7	Academic Expert Scholar	Beyond Flexner: Social Mission in Medical Education (Organizer)	Non-Racial/Ethnic Background
8	DHHS, OMH	Senior Health Advisor to the Deputy Assistant Secretary for Minority Health	Hispanic/Latino
9	AAMC	President (1994 – 2006)	Non-Racial/Ethnic Background
10	DHHS, OMH	Advisory Committee on Minority Health: Group on Diversity and Inclusion	African American
11	AMA	Medical Education Council Chair: Undergraduate Medical Education and Pre-Med Chair	Non-Racial/Ethnic Background
12	Academic Expert Scholar	National Expert in Cultural Competence	Hispanic/Latino
13	AAMC	Council Staff Undergraduate Medical Education	Non-Racial/Ethnic Background
14	AAMC	Council Staff Undergraduate Medical Education	Non-Racial/Ethnic Background

Table 2-2: Cultural Competence Training's Mission, Approach, and Policy Effect

	Mission	**Approach**	**Policy Effect**	**Challenges**
Pre-Cultural Competence Mandate	Provide sufficient foundational knowledge	Knowledge Based Acquisition	Standardized Learning for Step 1 & Step 2	Overlooks the social-cultural factors of health and health care delivery
2000 Cultural Competence	Increase effectiveness of providers to work cross-culturally	Ethno-ethic Check List Learning	Increase Innovation and Guard against No cultural curriculum	Reductionist and Too Narrowly Focused on the Patient's Role in Disparities
Post-Cultural Competence Mandate	Emphasize Medical Providers Role in Addressing Disparities	Self-Reflection and Self-Growth	Localized Cultural Competence Training	Life Long Learning and Assessment of Impact

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APPENDIX A: SEMI-STRUCTURED INTERVIEW GUIDE

University of New Mexico

"Cultural Competency Training" Interview Guide with Key Policy Actors

I. Introduction and Informed Consent

Good morning/afternoon, thank you so much for speaking with me today. The purpose of this interview is to understand the historical development of cultural competency education in U.S. medical schools. Obviously, there are no right or wrong answers; I am interested in your experiences and opinions. I have provided you with a copy of the consent form ahead of time, but do you have any questions or concerns? If not, I will begin the audio recording now.

II. Interview Discussion (Use Prompts/Probes as Necessary)

Definition: The meaning of the term Cultural Competency

I am interested in understanding why and how cultural competency came to be a topic of discussion as it relates to medical education.

1) How was cultural competency as a concept first introduced and discussed?
    a. Why do you think cultural competency became an area of focus within medical education?
    b. Help me understand what the connection was between cultural competency and medical education?
2) How do you think cultural competency was understood or defined in those beginning years?
    a. There are many ways that people conceptualize cultural competency in medicine. Can you tell me how you define it?
    b. Some people see a focus on race and racism as key aspects of cultural competency, while others do not. What are your thoughts on this?
3) Do you think the way medical educators define and understand cultural competency has changed over time since then?
    a. If so, in what ways?
    b. How has the concept of cultural competency evolved over the last few decades?

Context: The development of the Cultural Competency training mandate

I am interested in understanding the diverse stakeholders involved with the cultural competency agenda and their goals behind the training mandate in medical education.

1) From your perspective, who were the key actors and what were their motivations behind the mandate?
    a. Was incorporating cultural competency into medical education a contested or controversial issue?

    b. If so, in what ways? How did this play out?
2) Who were the initial people and/or organizations that advocated for bringing cultural competency education into medical training?
    a. Individuals, organizations, agencies etc.
    b. What were the intentions or goals of these people/organizations?
3) In contrast, what people or organizations opposed it?
    a. What were the intentions or goals of these people/organizations?
    b. How was consensus ultimately reached?

Approach: Development of the Cultural Competency training mandate

I understand that in 2000, the LCME created a cultural competency standard for undergraduate medical education. I am interested in understanding how and why the LCME took this approach.

1) Why make a curriculum change through a modification of the standards all medical schools are required to abide by?
    a. What considerations guided your decision to create such a mandate?
    b. What were the alternative options, if any?
    c. Why weren't any of these alternatives pursued?
2) What do you think are the advantages and disadvantages of the mandate approach?

Trajectory: Changes over Time: Goals, Implementation, and Effects

Now, I wish to explore how cultural competency has evolved over the last decade.

1) How do you think this mandate has been implemented in U.S. medical schools? What do you see as the major successes and limitations?
    a. How do you ensure that U.S. medical schools are in compliance with the cultural competency mandate?
    b. Is it being implemented in ways anticipated during the debates about mandating this curriculum addition?
2) What is the LCME's agenda as it related to Cultural Competency in the long term?
    a. In your opinion, what do you think are the major changes in how the mandate has been applied and interpreted over the past 14 years?
3) In hindsight, would the agency do anything differently or how has the LCME changed its approach since 2000?
    a. 14 years later, do you think the mandate was the best approach? Why or why not? What would you do differently, if you could?

Other Topics of Discussion: Left to the Interviewee

Is there anything else I should know about Cultural Competency in medical education?

III. Concluding Remarks

Thank you so much for taking the time to talk with me today. This has been a very fruitful and useful discussion. I appreciate your time and value the perspective you have shared with me. Before ending, are there other individuals I should speak with who were centrally involved in the discussion and debates of this mandate? If I have any other follow up questions or clarifications about what you shared with me today, would it be okay for me to contact you again in the future? Great, thanks again for your time.

APPENDIX B: CODING TREE FROM KEY INFORMANTS

LCME STANDARD CODING TREE

(Key Informants)

1. Key Informant
   1A. Interviewee's Background
   1B. Engagement with Culture Competency
2. Definition of Cultural Competency
   2A. Personal CC Definition
   2B. Organizational CC Definition
   2C. Conflict with CC Definition
   2D. Changes in CC Definition
3. LCME and 2000 Culture Competency Mandate
   3A. Rational Behind Standard
   3B. Adoption Story of LCME Standard
   3C. Alternatives to the Standard
   3D. Success of LCME Standard
   3E. Challenges of LCME Standard
   3F. Debate/Discussion of Standard
   3G. Pressures
   3H. Goals and Aims of Cultural Competence
   3I. Process of LCME
4. Key Actors
5. Key Organizations
6. Medical Education
   6A. Culture Competence and Medical Education
   6B. Overview of Medical Education
   6C. Other Topics in Medical Education
7. Trajectory of Culture Competency
   7A. Agenda around CC
   7B. Changes in Approach with CC since 2000
   7C. Assessment of Standard 14 years later
   7D. Recommendations for Tomorrow
8. Race and Ethnic Population and Culture Competency
   8A. Racism and Discrimination Topics
   8B. Health Disparities
   8C. Definition of Race and Ethnicity
   8D. Definition of Culture
   8E. Difference and Diversity Discourse
   8F. Expanding Definition of CC (e.g. gender, LGBTQ, class etc.)
9. Referrals to others
10. QUOTES

CULTURAL COMPETENCE DISCOURSE AS PRESENTED IN THE JOURNAL OF AMERICAN MEDICAL ASSOCIATION (JAMA): CHALLENGING THE BIOMEDICAL MODEL AND RETHINKING THE CULTURE OF MEDICINE

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ABSTRACT

The cultural competence framework emphasizes non-biological, socio-cultural factors that affect the delivery of care and contribute to health disparities. Proponents of cultural competence argue that a one-size-fits-all healthcare cannot model cannot meet the needs of an increasingly diverse American population. Using discourse analysis, I examined 89 articles published in *the Journal of the American Medical Association* (*JAMA*) to assess the discourse around cultural competence as it is presented and discussed by the medical profession. Authors frame cultural competence as potentially capable of increasing medicine's ability to mitigate health disparities. Yet, they also recognized that the ideal realization of cultural competency was severely undermined by dominant aspects of the biomedical framework that structures the medical field. Three themes capture the tensions with implementing cultural competence into a biomedical framework. First, cultural competence is conceptualized as providing culturally appropriate health information to members of diverse minority populations, but this inadvertently expands the boundaries of cultural competence to capture anything and everything while reinforcing individual responsibility for improving health outcomes. Second, cultural competence is practiced when provider decision-making takes into consideration their patients' cultural background, but such requests ignore limitations imposed by the biomedical model and the realities of the patient-provider encounter. Third, the culture of medicine and the professional socialization of practitioners places severe restrictions on the possibility of implementing practices emphasizing socio-cultural aspects of patient care. Medical education, professionalization processes, and patient-provider encounters are all structured by the biomedical model that resists modification or inclusion of other frameworks. I argue it is time to move beyond an

emphasis on the culture of patients to a systematic analysis of the ways in which the biomedical model determines medical practice, structures the culture of medicine, and influences the professional identity of the provider.

Key Words: *Cultural Competence, Health Disparities, Medical Profession, Health Information, Decision Making, Culture of Medicine, and Discourse* (*Up to 8 Key Words*)

RESEARCH HIGHLIGHTS Research highlights are a short collection of 3 to 5 bullet points that convey an article's unique contribution to knowledge and are placed online with the final article. We allow 85 characters per bullet point including spaces.

1. Cultural competence gets translated in medicine under the biomedical model.
2. Medical culture shapes medical education and practice to be culturally “blind.”
3. Delivering culturally competent care requires change beyond the patient and physician.
4. Medicine is resistant to the more transformative features of cultural competence.

INTRODUCTION

Since the late 1990s, the concept of cultural competence has become ever more salient in the field of medicine (Chin 2000; Betancourt 2005; Boutin-Foster 2008). Most definitions are variants of one developed over thirty years ago by mental health researchers, who defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross et al. 1989). Culture refers to values, beliefs, and behaviors that are developed, learned, and shared by people across multiple aspects of identity, including race, ethnicity, gender, and socioeconomic status among others. The goal of cultural competence in medicine is therefore to enable providers and the system to deliver high quality care to every patient regardless of these cultural factors (Campinha-Bacte 2002; Cohen and Goode 1990).

The initial impetus for adopting cultural competence in medicine was twofold. First, increasing racial and ethnic diversity in the United States brought to the forefront substantial cultural and linguistic challenges to medicine (Betancourt et al. 2003; Betancourt et al. 2005). The U.S. Census has tracked a significant transformation in the composition of the United States' population since 1970. One out of every six Americans identifies themselves as Latino/a, making up the largest minority population in the United States, while Asians are currently the fastest growing group (Ennis, Rios-Vargas, and Albert 2011). Much of this growth reflects historic waves of migration over the last hundred years, but especially since the mid-1960s. The result is that people in the United States are from many different cultures, speak languages other than English, and hold different expectations of the medical care system and medical care providers in particular. Therefore, acknowledging this diversity and

acquiring skills to better interact with patients from diverse cultural backgrounds have become important expectations for the modern medical provider (Suh 2004).

In addition, health and healthcare inequities have captured the attention of providers and policy makers (Chin 2000; Cohen and Goode 1990). The Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* by Smedley and colleagues (2002) documented over 100 studies, concluding that ethnic and racial gaps in care were attributable to a range of patient-level factors (patient preference, treatment refusal, clinical appropriateness of care), provider-level factors (bias, stereotyping, uncertainty), and system-level factors (lack of interpreters, geography, challenges with health insurance) (Todd, Samaroo, and Hoffman 1993; Harris, Andres, and Elixhauser 1997; Schulman et al. 1999; and Gornick 2000). Attention to such unequal treatment has contributed to an emphasis on the importance of cultural competence to improve the quality of care for all. The idea of cultural competence is that one-size-fits-all healthcare cannot meet the needs of an increasingly diverse American population.

Given these important reasons, cultural competence has become institutionalized. In 2000, the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) issued the National Standards for Culturally and Linguistically Appropriate Services (CLAS). The aim of CLAS was to ensure that all individuals accessing the healthcare system receive effective treatment in a culturally and linguistically appropriate manner. During the same year, the Liaison Committee on Medical Education (LCME) issued a requirement that medical schools introduce cultural competence into undergraduate medical curriculum (ED-21). The requirement focused on medical students understanding diverse cultures and belief systems, learning about different perceptions of health and illness, and appropriately

addressing cultural biases. Both the CLAS and the LCME standards have since been revised, but cultural competence remains a centerpiece of both. Additionally, eleven states have passed legislation requiring their practicing providers and medical students to receive training in cultural and linguistic competence (Graves et al. 2007). As a result, nearly two decades later, a wealth of tools, measures and assessments have emerged, but successful integration of cultural competence in medicine remains a challenge.

This paper investigates the discourse around cultural competence by the medical profession with particular attention on its conceptualization and integration into medical practice. I argue that critically examining the prevailing biomedical model may help explain why medicine's adaption of cultural competence has yet to lead to a more responsive healthcare system.

The Medical Profession and the Biomedical Model

It was not until the early 19th century that Western medicine began a process of professionalization. Due to widespread reform, medical educators and practitioners began to rely heavily on clinical observation and an anatomical understanding of health and illness. The adoption of the biomedical model was critical to physicians gaining control over the content of their own work and putting competitors and those they identified as "quacks" out of business (Quadagno 2004; Starr 1982; Freidson 1970). By the mid-20th century, the biomedical paradigm of formal medical knowledge was shared among members of the medical profession, mainly due to having undergone similar educations and professional initiations to share a common language, rules of evidence, conceptual schemas, and reliance on the same professional literature and communication (Kuhn 1970: 176). As a result, the

end of the 1960s saw the medical profession entering into the “golden age of doctoring” (McKinlay and Maceau 2002).

This system of biomedical knowledge is based on specific understandings about the universal body, disease, and ways of knowing that can be divided into four underlying assumptions. First, this model assumes a clear dichotomy between the mind and the body, meaning physical disease is presumed to be located within the body and can therefore be treated in isolation from other aspects of the person experiencing distress (Gordon 1988; Kirmayer 1988). Second, the model assumes that illness can be reduced to bodily disorders, which limit the clinician from being concerned with how aspects of an individual’s social or emotional life might impinge on physical health (Engel 1977). The third assumption is what Dubos (1959: 130-135) called the “doctorate of specific etiology” or the belief that each disease is caused by a specific, potentially identifiable agent which results in a quest for a “magic bullet”. A final assumption is conceptualizing the body as the proper object of regimen and control. This emphasizes the responsibility of the individual to exercise this control to maintain or restore health including diets, exercise programs, hygiene, and even sexual activity (Foucault 1979; Turner 1995).

Relying on these assumptions has concrete implications for the organization, practice, and delivery of medical care. Physicians use the medical encounter for relatively narrow goals; for example, the efficient eliciting and honing of facts relevant to the medical diagnosis, and the precise application of a set of decision rules leading to a therapeutic intervention. The training and socialization of physicians under the biomedical model therefore discourages providers from understanding their patients as whole people with social, emotional, cultural, and spiritual health-related facets to their lives.

Cultural Competence and the Medical Profession

While some cross-cultural medical education curricula date back to the 1970s, during the late 1990s the cultural competence training movement crystalized as a response to evidence of racial/ethnic disparities in health and healthcare. Patient's culture began to become a matter of importance for improving delivery of care, given that cultural norms and values impact health and illness experience (Subedi and Gallaher 1996), health behavior and practices (Kleinman 1978; Conrad and Leiter 2012), and healthcare communication (Armstrong, Carpenter, and Hojnacki 2006; Saguy and Gruys 2010). Failure to address social-cultural factors during the medical encounter became associated with inferior quality of care, adverse outcomes, increased healthcare costs, and patient dissatisfaction (Flores 2000). Healthcare systems and medical education thus adopted principles of cultural competence so that services better aligned to meet the needs of patients (Saha, Beach, and Cooper 2008).

After a comprehensive review of cultural competence frameworks, Kumas-Tan and colleagues (2007) identified core assumptions. First, culture is often conceptualized as a matter of ethnicity and race, even though other aspects of identity are included (e.g. gender, social class, sexual orientation and disability). Second, culture is possessed by the "Other". The dominant culture is not seen as having a culture; instead, the message within cultural competence is that some people are "ethnically diverse" and others are not. Third, cultural incompetence lies in the practitioners' lack of familiarity with the Other. This implies that cultural competence is achievable through cultural awareness and knowledge of the Other. Fourth, cultural incompetence also lies in the practitioners' discriminatory attitudes towards Others. This implies that ethnocentrism and racism are by nature individual failings, largely

through individual ignorance and individual prejudice. The institutional response has been that practitioners must educate themselves. These assumptions imagine providers as competent health professionals comfortably serving diverse ethnic and racialized patients armed with specialized knowledge and skills.

Given the institutional support by accreditation and government agencies, the practice of medicine today should reflect the cultural competence framework to some extent. Yet in my analysis, I argue that the potential for cultural competence to transform medicine has been impeded due to the tensions between the assumptions of the biomedical model and the values of cultural competence (see Table 3-1). This article investigates these tensions by examining the discourse around cultural competence as it is presented in the medical literature.

DATA

To gain an understanding of the current framing of cultural competence among those in the medical field, I completed a discourse analysis of claims made around the term cultural competence[4] in the *Journal of the American Medical Association (JAMA)*. *JAMA* is the official journal of the American Medical Association (AMA) with print and electronic circulation to more than 320,000 and 1.2 million subscribers, respectively. *JAMA* is a nationally recognized medical journal by and for the medical profession with an impact factor of 35.5. I follow Barker (2009) in utilizing *JAMA* to gauge the position of the AMA and the voice of mainstream American medical professionals.

[4] The term cultural competency is commonly used interchangeably with cultural competence. I use the term cultural competency for consistency purposes.

Using *JAMA*'s catalogue of their journal's database, I search for any and all articles about "cultural competence." I used the phrase "cultural competence" which captured every article published in *JAMA* about "cultural competence" and "cultural competency." This search function captured articles utilizing the term either in the title, abstract, or in the body of the text. The term "cultural competence" first appeared in 1998. Between 1998 and 2015, a total of 109 publications in *JAMA* focused on cultural competence. A total of 20 were excluded because 17 were book reviews and 3 were journal content summaries. My final sample included 89 publications: 28 research and review pieces, 39 opinion pieces, 13 agency updates, and 9 letters.[5] The purpose of this analysis is to document cultural competence as it is framed and discussed by members of the medical profession and to understand the resulting implications.

Discourse is defined as "a group of statements which provides a language of talking about – a way of representing the knowledge about – a particular topic at a particular historical moment" (Hall 1992: 291). Discourse analysis seeks to understand the foundations on which knowledge is built as well as the consequences of knowledge for individuals and society (Wetherell, Taylor, and Yates 2001). Using Nvivo10, I began the analysis using a thematic approach and then developed into a more detailed analysis of the words and phrases used to describe, discuss, and frame the concept cultural competence. I approached these *JAMA* sources as illustrative of discourse, that is, as evidence of larger systems of knowledge and thought that occur within a particular social-historical location (Foucault 1970).

[5] Research and review comprise original contributions, brief reports, special communications, clinical reviews, and grand rounds pieces. Opinion pieces comprise commentary, editorial publications, and pieces published under the section titled "A Piece of My Mind." Agency updates include the following JAMA article sections titled "Medical News and Perspectives" and "Health Agency Updates" by the Centers for Disease Control and Prevention (CDC), National Institute of Health, or from the Surgeon General.

Several limitations of this study are worth noting. First, I included only publications from *JAMA*. The omission of other major outlets makes it difficult to provide a comprehensive assessment of the medical profession's perspective on cultural competency. *JAMA*, however, is a major medical journal capturing the voice of mainstream American medical professionals. Second, my search strategy relied on *JAMA*'s database search protocol, and it is possible there are other articles that were not captured due to the *JAMA* classification and categorization of articles. However, this analysis has provided insight into the unfolding debate surrounding cultural competency and medicine in the United States.

RESULTS

Collectively, the articles published in the *JAMA* articulate that a better healthcare delivery system is desirable and that cultural competence is a critical element for that transformation. Four themes of discussion were identified. First, cultural competence is conceptualized as providing culturally appropriate health information; second, cultural competence requires engaging in culturally appropriate medical decision making; and third, discussions of cultural competence highlight the need to acknowledge and critique the culture of medicine. Finally, a critique of cultural competence as a strategy for eliminating health inequalities is offered.

Culturally Appropriate Health Information

Approximately half of the articles discussed cultural competence as communicating culturally appropriate health information to patients. Addressing health disparities in a culturally competent manner requires providing information about treatments in a language that is understandable, in a manner that is respectful, and at an appropriate literacy level, while also offering access to those treatments (Cooper-Patrick et al. 1999; Wong, LaVeist,

and Sharfstein 2005). These articles interpret cultural competence as addressing "equity" largely through a focus on providers making health information accessible, especially for immigrant patients with limited English proficiency.

In theory, culturally appropriate health information should be relayed by the provider when appropriate. A number of articles discuss providing such culturally appropriate information for a range of health problems that disproportionately affect racial and ethnic minority groups, including drug use, HIV/AIDS, under-immunization, tuberculosis and other infectious diseases, as well as a variety of mental health issues (Bacaner et al. 2004; CDC 2004; Pletcher et al. 2008; and Hampton 2014). For example, the Centers for Disease Control and Prevention published a summary of a report in *JAMA* about the prevalence of cigarette use among racial and ethnic minorities who have less access than non-Hispanic whites to culturally and linguistically appropriate anti-smoking educational materials, media messages, and cessation services:

> Racial/ethnic minority populations have been targets of tobacco industry marketing efforts including sponsorships of cultural events and funding of organizations…culturally appropriate interventions can help reduce tobacco use among racial/ethnic populations (CDC 2004: 814).

The issue of tobacco use has an extensive history of educational campaigns, yet this article still urges the medical profession to engage with culturally appropriate information for racial/ethnic minority patients in order to reduce inequalities. Another publication by the CDC (2008) about the prevention of work-related injuries among Hispanic workers called on the medical profession to provide culturally appropriate and effective educational materials for workers, who oftentimes speak different languages and have varying levels of literacy.

Educational interventions, initiated by providers who recognized the opportunity to inform minority patients, were construed as one way that cultural competence could address disparities in health outcomes.

In practice, however, several obstacles impede the ideal flow of information from provider to patient. First, providers might not always be comfortable discussing certain topics with their patients. One publication discussed firearms as a significantly overlooked issue that medical providers need to address to reduce firearm injury and death that disproportionately impacts racial/ethnic minority populations. The authors urge providers to engage in respectful counseling and nonjudgmental communication about guns with their patients, regardless of how they themselves feel about the issue:

> At times, clinicians may feel uncomfortable or uninformed when discussing certain subjects, and may disagree with a patient's choices or beliefs. However, this discomfort or disagreement cannot justify either offensive condescension or silent inaction (Betz and Wintermute 2015: 449).

Secondly, providers might not always know what information to prioritize, or when certain information should be given. Much of this problem is linked to the heuristics that providers use to manage the time demands associated with their clinical workload. If time demands prevent providers from gaining a clearer picture of their patient's lifestyle, how should providers know to refer patients to certain resources? Ten articles directly acknowledged the need to establish rapport with patients so they would share such information in the first place, implying that in order to provide culturally appropriate health information, providers need to have strong listening skills, communication skills, cultural sensitivity, and respect for cultural differences without judgment. Yet if doctors only have

limited face-time with a patient, we can hardly expect them to become fully informed about the range of social determinants affecting the health of their patients.

The discourse in these *JAMA* articles around disseminating culturally appropriate health information highlights one way in which providers have been socialized to meet the requirements of cultural competency in practice: by attempting to connect the patient to as much relevant information as possible so that they can make better choices for their own health. This illustrates how the medical institution has translated the challenging principles of cultural competency into a digestible form that fits the biomedical model's assumptions about individual control and regimen. We see in this example how cultural competence, construed as simply relaying appropriate information to the right populations, can easily be co-opted by the medical institution to reinforce individual responsibility.

Culturally Appropriate Medical Decision Making

While cultural competence is about health information, it is also, about how providers make assessments. Another set of articles portrays cultural competence as being skillful at eliciting and incorporating the culture of "the other" in making decisions about an individual's treatment. In other words, cultural competence is about knowledge, awareness, inclusion, and *integration* of culture in a patient-centered manner. Under this view of cultural competence, the medical provider must "*know*" their patients (knowing their lifestyle and life circumstances). For example, an author who published a piece about refugee mental health claims that it is no longer appropriate to understand patients in general stereotypical ways:

> It is no longer appropriate to conceptualize a world in which the movement of refugees is one way and permanent, or where healthcare professionals can consider themselves naïve outsiders… Healthcare services are not universal receptors that any

> incoming refugee group can plug into, nor are they a plug that can fit in the socket of every postwar nation (Weine 2001).

As demonstrated in this passage, providers need to deconstruct their perception of a "patient," in this case a refugee patient. Everyone is different, and taking that uniqueness into account is at the core of engaging in culturally appropriate medical decision making. Other articles in *JAMA* also emphasize recognizing and understanding a range of identities such as men who have sex with men (MSM), patients with war-related posttraumatic stress disorder, and North American immigrants (Makadon, Mayer, and Gorofalo 2006; Bacaner et al. 2004; Bacanner et al. 2004). This illustrates how the definition of cultural competence can be expanded to the point of becoming so complex and multifaceted as to be impossible to implement. As implied, it is necessary for providers to take the time to understand each patient's unique multiple social positions so they can deliver culturally tailored care to each patient.

The concept of cultural competence in medical decision-making relates to not only providers understanding their patients' "cultural uniqueness" but *then* taking that uniqueness into consideration when designing a medical care plan (Stephenson 1999). The articles claim that merely having awareness or knowledge about a patient's culture is insufficient (Kagawa-Singer and Blackhall 2001).

> The clinical encounter often requires a *negotiation* between the world views of cultures of the clinician and the patient and families to reach mutually acceptable goals. In the end, *addressing* and respecting cultural differences will likely increase trust, leading to better clinical outcomes and more satisfactory care for patients and their families (Kagawa-Singer and Blackhall 2001: 2994).

Two key words here are “negotiation” and “address”, both of which emphasize that cultural competence is not just about awareness of cultural differences, but allowing such differences to positively influence care-giving. Knowledge of patients matters insofar as it enables providers to make decisions.

Unfortunately, several issues often arise that diminish the ability of providers to provide tailored care to their patients, which were discussed in this body of *JAMA* articles. The primary issue lies in how empowering the patient runs counter to the mission of the provider to reduce risk and uncertainty in the diagnosis and treatment process. Principles of patient-centered care bring to the forefront ethical dilemmas and a moral debate over the extent to which medical providers respond to the profession versus to their patient. Conflicting pressures on doctors from their profession and their patients often lead them to merely “consider” and not approve alternative medical considerations or approaches. The problem is compounded by a lack of institutional incentive to incorporate or acknowledge patients’ role in their own treatment, making it too easy to merely pay lip service to them. As discussed by Applbaum and colleagues, a provider’s decision may not always be able to accommodate a family or patient’s request:

> …patients are not entitled to treatment that the treating physician judges to be bad medicine...there are limits on how much accommodation clinicians may or must make to families or patients whose cultural traditions disagree with the publically rendered criteria of death… Because, as citizens, we respect the freedom and autonomy of others, we need a good reason to impose the view of the majority on minorities (Applbaum et al. 2008)

In this case, a Vietnamese family wanted to place a traditional Chinese medicinal substance on their daughter, but their request was denied because the patient could not give consent after being diagnosed as clinically brain dead. Such decisions legitimize biomedical knowledge over the patients' and their families' traditional knowledge, reinforcing the power of professional authority.

Ideally, culturally competent providers can engage with their patients to come up with medical treatment sequences that respect the culture of the patient, while still retaining scientific and biomedical validity. In the field, however, there are real limits on the extent of professional authority a provider can give up as they attempt to negotiate a culturally appropriate medical decision with their patient. The further providers stray from orthodox medical treatment, the more they potentially open themselves up to liability and risk of malpractice litigation. The *JAMA* articles in this section detailed the barriers to fully realizing culturally appropriate decision-making within an institution constructed around norms of authority and hierarchy. The assumptions of cultural competence, while attempting to expand the role of medicine, are still restricted by the boundaries of the biomedical model.

Reflections on the Culture of Medicine

A third set of articles in *JAMA* reflected more broadly on how and why the mission of cultural competence was being systematically undermined. In these publications, authors critically describe the cultural forces that shape our healthcare and medical education system. Some of these articles discussed the disrespect and lack of empathy towards patients that permeates the medical institution (Teno and Connor 2009; Lesser et al. 2010). Others discuss a "hidden curriculum" reinforcing physician superiority and a shortage of mentors who

model cultural competence as equality between provider and patient (Heider et al. 2011; Ng 2011). The hidden curriculum emerged in a few places as described by Brooks:

> I learned that white women are allowed to refuse my involvement at the birth of their child, while poor immigrants are given less space to turn me down. I learned I am more likely to be asked by a resident or attending to try a new procedure when there is a language barrier or a power dynamic that will prevent a family from understanding, refusing, or complaining…I doubt that these experiences are unique to the hospitals or the medical school at which I have thus far trained. I expect that they pervade health care systems throughout the country…But regardless of intent, the message I got was clear. I've learned to minimize the pain, forgo the consent, blame the behaviors, and dismiss the concerns of my patients of color. I've witnessed missed opportunities for healing and the loss of patient trust (Brooks 2015: 1909).

These everyday subtle practices that occur during the medical encounter and delivery of care have implications (often negative) for patients who can be dismissed, overlooked, and/or ignored.

Furthermore, the needs of patients whose personal realities fall outside of the conventional expectations of providers are often reported as disregarded. For example, Rosenthal, a pediatric physician and widowed single parent, describes her realization of the assumptions behind pediatric practice and care delivery:

> I was struck by the number of times I felt people were making recommendations that just seemed impossible for a single parent… My experience raised my awareness of how culturally determined the discourse in medicine is. The judgements work only in a very narrow range in which very few of us fit the assumptions that everyone has

> two parents, ample financial, educational, and emotional resources, and no concern other than raising their children (Rosenthal 2006: 23)

Even after a decade of practice, it is only after her own experience that she urges the profession to learn to be aware of their assumptions when working with patients, in this case parents. Cultural competence thus also means acknowledging the biases that are part of medical culture. These authors, despite the teaching or training they received in cultural competence, articulated the culture of medicine as limiting the ability of physicians to deliver culturally competent care. These authors argued for the need to re-define the culture of medicine to promote structures, practices, and norms that support the practice of culturally competent providers. The culture of medicine is described as hierarchical and as often working in direct opposition to creating a more horizontal, democratic, and hence culturally competent medical workforce and system of care delivery.

Despite the entrenched nature of the culture of medicine, many authors in *JAMA* articulated the belief that change is possible. The culture of medicine as narrow or rigid is reframed as flexible and adaptable and as having the potential to meet the needs of diverse populations. In some cases, it is directly stated that there needs to be more respect for patients and for providers to go beyond listening to actively engaging with patients (Weine 2001; Hoge 2011). Others went as far as to claim that cultural competence meant wanting to work with diverse patients and having an appreciation of diversity, as well as the willingness to reach compromises with patients (Makadon, Mayer, and Garofalo 2006; Saha et al. 2008). The goal of a culturally competent healthcare system is to deliver culturally appropriate care by increasing a provider's level of consciousness regarding his or her own biases, tendency toward discrimination, and potential for lack of empathy (Kagawa-Singer and Blackhall

2001; Cohen 2003; Champaneria and Axtell 2004). Cultural competence is defined in terms of the patient's culture *and* the medical profession's culture.

Some of the *JAMA* articles argue that for the culture of medicine to change, the workforce must also be diversified. There are, however, two different perspectives on increasing workforce racial/ethnic diversity. On the one hand, the benefits of racial concordance have been well documented: "It has been repeatedly shown that cultural competence of physicians improves the quality and effectiveness of care when the patient and physician are of concordant race/ethnicity" (Liu et al. 2006: pg.1979). There is also an assumption that having students from diverse backgrounds will increase the number of practicing physicians in underserved communities, which will theoretically increase access to healthcare for underserved populations (Cohen 2003). Others claim that merely diversifying the workforce would do little to ensure the delivery of culturally competent care and shift the mooring of medicine.

Regardless of how the articles position themselves vis-à-vis the debate, the importance of cultural competence for *everyone* in order to address health disparities is frequently evoked. The medical profession, faced with the difficult task of increasing student diversity, considers cultural competence as a way to train the existing student population to become better providers. A consistent theme is that there are a range of opportunities for medical students to experience cultural immersion to raise their awareness, improve their ability to address cultural differences, become aware of their own biases, develop respect and appreciation for cultural differences and understand the core cultural issues that impact the health of all types of patients (Champaneria and Axtell 2004; Fortin and Barnett 2004; Haider 2011). Some medical schools are even providing opportunities for students to leave

the insular world of medical school and become immersed in different cultural experiences abroad, while others are requiring their students to participate in community-based projects among marginalized communities (Kundhal and Kundhal 2003). In these ways, cultural competence is operationalized into activities to shape their professional identity of some traditional medical students who may eventually transform the culture of medical education and medicine from the bottom up.

In sum, the key tension around changing the culture of medicine to better reflect the ideals of cultural competency revolves around altering the professional socialization of doctors throughout their medical education. Cultural competence optimistically imagines doctors who can engage effectively with "the Other", who provide all the appropriate health information to their patients and who engage more democratically with their patients in the decision-making process. But this rosy perception of doctors is naïve to the way that medical education continues to socialize providers, and how cultural competency tends to be a minor part of their education. Indeed, cultural competence is often taught as a one or two-semester "elective" through a knowledge-based, as opposed to practice-oriented, framework. Subsequently, providers in training, even providers of color from marginalized communities, take cues that teach them to ignore the social context and instead focus on the biological aspects of the patient. As long as medical education and the broader field of medicine remains resistant to relinquishing the authority of providers, the ideals of cultural competence will continue to be in direct conflict with the norms and values inherent in the biomedical model of knowledge.

Critiques of Cultural Competence

A final theme that emerged in about a quarter of the *JAMA* articles was skepticism of the ability of cultural competence to address health and healthcare disparities. Some authors felt that the concept of cultural competence falls short of addressing disparities because it does not emphasize community, public health, or the social determinants of health (Shortell and Swartzberg 2008; Lurie and Fremont 2009). For example, one article stated that:

> …regardless of their cultural competence or patient centeredness, busy clinicians (and insurers with which they contract) often fail to recognize instances when characteristics of a local community, such as lack of grocery stores or safe places to exercise, may be affecting a significant subgroup of their patients (Lurie and Fremont 2009:85)

Another group of *JAMA* articles claims that cultural competence will inevitably fail because it is placed in a context where the hidden curriculum and the lack of strong role models counteract the lessons in cultural competence education (Fang et al. 2000; Weissman et al. 2005; Haider 2011). In a piece titled "A Hidden Curriculum", one author reflects on how race and culture are understood in medical education:

> In the classroom, I learned that culture may be an explanation for higher rates of sexually transmitted diseases and type 2 diabetes among patients of color. In the text books, I saw what psoriasis and drug related rashes look like on white skin but what syphilis looks like on black skin. While practicing the medical interview, I was told that Latinos may say yes to all review of system complaints and that cultural competence meant minimizing some of their concerns. While studying for boards, I

> learned that the race of the patient was often a hint to his or her disease (Manning 2014).

As this quote suggests, the many ways in which bias finds its way into the curriculum means that addressing cultural competence via curriculum alone is insufficient. Thus, some articles argue that cultural competence cannot be taught nor is it something that is learned through textbooks; instead they claim that it must be experienced through immersion programs or during rounds in open and safe spaces (Ruan 2008; Manning 2014). Furthermore, others feel that culture is part of the equation, but that focusing too much on culture results in ignoring race and the racism that is at the core of many health disparities (Loudon et al. 1999; Staropoli 2004; Brooks 2015).

Additionally, the medical profession's commitment to eliminating health disparities is in question within this sample of *JAMA* articles. While some providers argue that cultural competency is not just knowledge but practice, others feel that practice within the medical institution is not enough (Flores 2000; Mechanic 2003). They recognize that reflection and being honest with one's self about personal bias or stereotypes is a must, or else cultural competency will be futile (Kagawa-Singer and Blackhall 2001). However, despite providers' level of awareness of social factors or their own biases, they are still not advocating for social change nor are they engaging in policy discussions beyond the medical setting, which some authors see as necessary (Strauss and Pollack 2001; Shortell and Swartzberg 2008; Kirch, Gusic, and Ast 2015). For these authors, there is a need to focus on practices beyond the medical institution that highlight public health and social determinants of health, frameworks that are necessary to fully address health disparities (Wong, LaVesit, and Sharfstein 2005; Cohen 2015).

Some articles express little hope that cultural competence could ever flourish in the current medical environment. The power of the hidden curriculum, the implicit messages providers receive about how to treat patients, and the core principles of the biomedical framework emphasizing the authority of the provider all fly in the face of the ideals of cultural competence. Ultimately, all four themes I identified collectively elucidate how the mission of cultural competence is systemically undercut by the established rules and principles of the medical institution, which primarily operates according to the biomedical model.

DISCUSSION

This paper investigated the discourse around cultural competence as presented by contributors through an analysis of 89 articles published between 1998 and 2015 in *JAMA.* The practice of medicine is based on specific understandings about the body, disease, and ways of knowing that focus attention to the physical body under the biomedical model. Cultural competence requires a shift to prioritizing the patient and acknowledging the role his or her cultural background plays in their understanding of an illness, their help-seeking behaviors, and in the larger context of care delivery. I found that the biomedical model that governs medicine limits meaningful adoption of cultural competence.

The ideal incorporation of cultural competence principles would mean providers prepare themselves for the challenges of multiculturalism. Practitioners would incorporate interpreters, provide appropriate information in the patient's native language and at their literacy level, and elicit patients' cultural understanding of their disease (Brach and Fraser 2000; Betancourt 2005). A culturally competent provider would place the needs and priorities of the patient above the provider's own assessment and concerns (Carillo et al.

1999; Saha et al. 2008; Teal and Street 2009). The doctor-patient encounter would therefore be characterized by shared decision-making where the patient becomes a partner. A culturally competent provider would be receptive to acknowledging how his or her own biases or stereotypes may affect their delivery of care and decision-making processes (Geiger 2001), as well as how the patient's social-cultural context may be affecting their decisions and behaviors (Chin 2000). The core principles of cultural competence seem to offer an opportunity to transform the delivery of care into a more equitable and responsive healthcare system, especially for nonwhite, non-English speaking populations.

The medical profession is attempting to translate the underlying assumptions of cultural competence into the practice of medicine by delivering information in a culturally appropriate manner. This theme reinforces the perspective that health inequities occur at the individual level and should be addressed by medical providers giving the "right" information to patients. Individual responsibility is a prevailing discourse in medicine that focuses on patient compliance, emphasizing the individual's behavior rather than the social and cultural processes that affect all patients' behaviors. This approach to cultural competence reproduces the notion of the body as the proper object of regime and control, aligning with the biomedical model. Regardless of what topic needs to be communicated in a more culturally responsive manner, such a lens ignores the social and contextual locus of sickness. Larger structural issues are overlooked or replaced by information delivery concerns.

Second, the lack of clear guidelines as to how patients identify and increasing recognition of intersectionality makes it difficult for providers to take their patients' cultural background into consideration when making decisions. Cultural competence is often approach in a one-dimensional way emphasizing either race or gender or class. However,

patients are complex beings with race, gender, and class often intersecting. Additionally, the biomedical model presupposes the race-less, gender-less universal body in contrast to cultural competence, which requires more cognitive investment and attentiveness to each individual case. The tension between providers' universal approach and their patients' complex background emerged. The lack of scientific evidence behind patients' alternative conceptualizations and approaches to health and disease minimizes the likelihood for providers to agree or even acknowledge their patients' unique requests or needs. Providers aim to reduce risk and uncertainty in their delivery of care but increasing patient participation and granting patient's requests is perceived to increase uncertainty and risk.

Third, our healthcare system emphasizes physician authority and promotes a practice of medicine that relies on a romanticized patient based on the universal body. The culture of medicine invariably produces providers who rely on this biomedical model regardless of their original backgrounds. Therefore, diversifying the workforce would do little to reform the existing care system. Furthermore, increasing the training around cultural competence would also do little to transform the practice of medicine if the fundamental culture of medicine is not addressed. If the fundamental culture of medicine is not changed, neither diversifying the workforce nor increasing training around cultural competence will transform the practice of medicine. The goal moving forward should be re-defining the culture of medicine so that it promotes structures, practices, and norms that support the practice of culturally competent providers.

Becker and colleagues' (1961) book, *Boys in White,* was a significant contribution to understanding medical school socialization, but there has yet to be an updated understanding of the current student culture in medical schools in such a systematic in-depth way. Crandall

(2003) found that undergraduate medical education does not prepare future physicians to understand how culture influences a patient's perception of illness and disease or how these perceptions affect treatment and, ultimately, quality of care. Despite the acquisition of knowledge and skills around cultural competence, transformation is especially limited by the current education and practices of medicine. Cultural competence defaults into methods for making doctors more effective in their existing practice rather than transforming that practice.

Cultural competence has been introduced to the field of medicine as an important strategy to address health disparities; however, by reducing cultural legacies to superficial and stereotypical cultural differences, the profession merely pay lip service to the mission of cultural competency and continue to go about their work without interrogating the roots of the inequalities in health. One can think of the prevailing cultural competence discourse as "domesticating" the politics around health and healthcare disparities. The medical profession avoids the larger structural factors involved – namely racism and economic inequality – in health disparities that continue to go unaddressed in medicine.

CONCLUSION

The institution of medicine is at a crossroads. Growing health disparities, poor quality of care, and high costs demand physicians to reconsider their approach and practices. The adoption of cultural competence offered great promise, but after sixteen years of institutional commitment there has been little to show on the efficacy of this approach beyond self-assessment of potential biases. This study took the approach of understanding the operationalization and practice of cultural competence for and by the medical profession. While some scholars have argued that the institution of medicine is losing professional

authority and prestige, referring to this as the disappearance of the golden age of doctoring (Haug 1976; McKinlay and Stoeckle 1988), this study instead finds that the institution of medicine and its attendant biomedical model remain powerful and capable of resisting the integration of cultural competence, especially the more transformative features of cultural competence.

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TABLES

Table 3-1: The Biomedical Model and the Cultural Competence Framework

	Biomedical Model	Cultural Competence Framework
Assumptions	1. Dichotomy between mind and body 2. Illness reduced to bodily disorders (biochemical or neurophysiological) 3. Doctorate of specific etiology: each disease is caused by a specific identifiable agent 4. The body is an object of regimen and control: responsibility of individual to restore health	1. Culture is a matter of ethnicity and race 2. Culture is possessed by the Other 3. Providers lack familiarity with the Other. They should be aware and knowledgeable. 4. Practitioners have discriminatory attitudes towards the Other. They should avoid stereotyping and generalizations.
Provider's Role	1. Elicit and honing facts relevant to a medical diagnosis 2. Precise application of a set of decision rules for active therapeutic intervention 3. Interrupt frequently; pays attention to physical or biomarker data 4. Controls information exchange: Paternalistic relationship with patient	1. Use of interpreters to address language and literacy barriers 2. Prioritize and elicit the patient's needs 3. Engage in shared decision making with patients 4. Receptive to identify his/her own biases and stereotypes 5. Understand patients social-cultural context affects decisions and health outcomes
Patients' Role	1. Patient's physical body is the focus 2. Passive participant of the encounter 3. Receives information to improve health	1. Patients' social and cultural aspect is the focus 2. An active participant 3. Contributes key information and knowledge
Approach to Health and Disease	Isolating information between the sick body and sick person to deliver effective care.	The patients involvement and background is critical in delivering effective care

COMPARATIVE CASE STUDY ANALYSIS OF CULTURAL COMPETENCY TRAINING IN U.S. MEDICAL SCHOOLS

ABSTRACT

Objective: Sixteen years have passed since the Liaison Committee on Medical Education (LCME) mandated cultural competence training in U.S. medical schools. Still, there remain multiple challenges to implementation including curricular constraints, debates around the conceptual boundaries of cultural competence, and evidence supporting the efficacy of such training. This study explores how medical schools implement cultural competence training for their students using comparative case study analysis.

Methods: Fifteen regionally diverse public and private medical schools in the United States participated in the study. We conducted 125 interviews with 52 administrators, 51 faculty or staff members, and 22 students. We led focus groups with an additional 196 third and fourth year medical students. Interviews were recorded, transcribed, and imported into NVivo 10 for qualitative data analysis. Queries captured topics related to student preparedness to work with diverse patients, engagement with socio-cultural issues, and participants' general perception of pre-clinical and clinical curriculum.

Results: Three categories emerged concerning cultural competence training: formal curriculum, conditions of teaching, and institutional commitment. At the formal curricular level, schools offer a range of courses collectively emphasizing communication skills, patient-centered care, and community based projects. Conditions of teaching emphasize integration of cultural competence into the preclinical years and reflection on the delivery of content. At the institutional level, commitment to institutional diversity, development of programs, and degree of prioritization of cultural competence varied.

Conclusion: Even with the LCME mandate, there is tremendous variation in how medical schools approach cultural competence topics. These fifteen schools identify longitudinal and experiential learning as important beyond the integration of cultural competence content into the curriculum. While LCME standards have started the conversation and transformed aspects of medical education for students, further research is needed to help clarify effective approaches to cultural competency training.

Key Words: Medical School, Training, Cultural Competence, Socio-Cultural, and LCME

INTRODUCTION

In the United States, inferior health outcomes have repeatedly been documented for African Americans, Hispanics, American Indians, and some groups of Asian origin (Smedley, Stith, and Nelson 2002; Brummer at el. 2016; Fiscella and Sanders 2016). These inferior outcomes are partly attributable to racial disparities in medical treatment, which are shown to exist in multiple areas of the healthcare system, including differences in utilization of cardiac diagnostic and therapeutic procedures (Harris, Andres, and Elixhauser 1997; Schulman et al. 1999), prescription of analgesics for pain control (Todd, Samaroo, and Hoffman 1993; Todd et al. 2000), treatment of pneumonia and congestive heart failure, and utilization of specific services covered by Medicare (Gornick 2000). Racial/ethnic minorities are also less likely to receive kidney transplants or surgery for cancer compared to White patients, even when controlling for insurance status, income, education, severity of disease, age, hospital type, and comorbidity (Bach et al. 1999; Malek et al. 2010).

Over the past decade, 'cultural competence' has gained significant traction as a strategy to improve patient quality of health care and address racial/ethnic healthcare disparities (Betancourt, Green, Carrillo, and Park 2005; Campinha-Bacote 2002; Cohen and Goode 1990). In 2000, the Liaison Committee on Medical Education (LCME), the organization that oversees U.S. medical education, introduced a requirement that faculty and students demonstrate "an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases and treatments." This original mandate does not offer additional guidelines; therefore, schools have flexibility in meeting the requirement. Recognition of the importance of cultural competence has led medical schools to include curricular components on patient-provider

communication (Perloff et al. 2006; Teal and Street 2009), the impact of stereotyping and bias in decision-making (Crandall et al. 2003), the social determinants of health (Seeleman, Suurmond, and Stronks 2009), and the diverse cultural understandings of health and illness (Flores and Welch 2000; Juckett 2005).

Compliance with the LCME requirement has proven to be challenging given the increased complexity of medical training curricula (Chun 2010; Rapp 2006), questions about the conceptual boundaries of cultural competence (Beach et al. 2005; Fernandez et al. 2012; Jenks 2011; Tervalon and Murrary-Garcia 1998), and a lack of evidence proving the effectiveness of such training (Betancourt 2005). Despite these obstacles, the LCME mandate continues to expand, now listing requirements for inter-professional and professionalism education. Yet, little is known about the ways in which medical schools have enacted this mandate. As part of a larger study, we explored how medical schools are implementing cultural competence.

METHODS

Study Design and Setting

In the parent study, we administered an internet-based survey to 4603 senior medical students at 84 medical schools in 2011-12 (see Williams et al. 2015). Based on these survey results, we categorized schools into two categories: those showing evidence of bias in medical decision-making and schools that did not. We then purposefully selected schools in each group based on achieving variation in attributes such as geographical location and institutional type (e.g., public vs. private). Medical students were presented with clinically equivalent clinical care vignettes to document if their treatment decision changed based on a random selection of the patients' race, gender, and class. Details on these survey methods

have been published elsewhere (see Williams et al. 2015). We narrowed our selection of schools for case studies to those from either end of a distribution of schools, and, through secondary analysis, we refined our school selection to represent variation by geographic region and self-categorization as private or public. At that point, we asked administrators at each of the selected schools to participate in our study. If participation was declined, we replaced that school with a similar one.

Data Collection

Prior to each site visit, the research team gathered secondary data on the school including their mission statement, the composition of the school, and any other information available via the internet. Two to three study team members participated in each site visit during a minimum four-day period, conducting interviews and focus groups and taking field notes. We conducted six to ten key informant interviews with purposively selected faculty (e.g., Dean of Undergraduate Medical Education), one to three purposively selected staff (e.g., Director of Admissions), and one to three purposively selected clinical level medical students (e.g., underrepresented minority students). We also conducted at least two focus groups of six to ten 3rd and 4th year medical students at each site. Interviews and focus groups followed semi-structured guides designed to focus on aspects of the institutional and training context. They were recorded and transcribed with personally identifying information removed. Participants received a gift card for their time. The study protocol was reviewed by the University of New Mexico Institutional Review Board and determined to be exempt. We also obtained approval from the Institutional Review Boards at each participating school to conduct the case studies.

Data Analysis

Four team members reviewed the transcripts of the first three case studies to begin the analysis while also iteratively refining the data collection processes. The team then independently coded the transcripts of one case study (CS). After meeting to resolve differences in codes, the process was repeated for two additional case studies to develop a final coding structure (see Appendix A). All team members then analyzed the remaining case studies using Nvivo 10. For this particular sub-study, the qualitative analysis was based on the comparative method (Creswell 2007; Merriam 1998; Stake 1995, 2010). Specific queries were identified to capture aspects of the curriculum and students' training. These included pre-clinical and clinical level queries focused on preparing students to work with diverse patients, engagement with socio-cultural issues, and participants' general perception of both the formal and informal curriculum. We then specifically reviewed each case study to understand the school's efforts to integrate and teach cultural competence topics.

Once these queries were complete, we compared our findings with The Tool for Assessing Cultural Competence Training (TACCT), developed by the American Association of Medical Colleges in 2005 (see Table 4-1). The TACCT instrument was used as we reviewed the curricular elements for individual schools. We compared courses and topics discussed in the transcripts to the TACCT domains to see how schools met the LCME requirements.

RESULTS

A total of fifteen public and private medical schools representing different geographical regions participated in this study (see Table 4-2). We conducted 125 key informant interviews, and focus groups with 196 clinical level medical students (see Table 4-

3). Overall, we did not identify a consistent definition or application of cultural competency across the set of schools. Only two schools offered a course labeled "cultural competence." The remaining thirteen schools had a range of methods to address cultural competence. We organized our findings regarding major approaches and features of cultural competence in the following three categories: Formal Curriculum, Conditions of Teaching, and Institutional Commitment.

Formal Curriculum on Cultural Competence Training

Most of the schools emphasized communication skills with diverse patients, patient centeredness, and community project experiences as primary pathways to teaching cultural competence. We grouped the schools' approaches into these domains.

First, twelve medical schools focused on communication training in regards to treating minority populations. The communication training among our sample was geared towards increasing students' ability to work with diverse populations. For example, one school promoted communication to enhance cultural sensitivity when working with Spanish-speaking populations. We heard the same at another Southern school:

> I think they get equipped. If they are not used to communicating with people of different racial backgrounds, they get used to it [here]. (CS 11: Faculty KI)

These schools also highlight communication with diverse populations in regards to retrieving psychosocial history, social history, and spiritual history. At a Northeastern school, a student said, "I think we have cultural competence courses, even though they may not be called that. In the first and second year, we have communication courses where they teach us really well" (CS7: Student FG).

A smaller number of schools (N=3) focused on patient-centered care topics in the curriculum. These training elements have students interact with patients from non-dominant backgrounds to reduce their tendency to stereotype when making decisions and to promote their grasp of diverse cultural understandings of health and illness. At one school, during the first three years they teach what physicians and patients bring to the medical encounter, the process of medical care, understanding the patient's context, and gaining exposure to cross-cultural topics and social determinants of health topics. At another school, they have patients and physicians interact, giving the class an opportunity to hear from individual patients about their personal experiences giving students exposure to the psycho-socio-cultural context of care during the preclinical years.

Finally, half of the schools required their students to complete a community project, which administrators claim helps "get students out of their comfort zone" and afford students the opportunity to work with underserved populations in their communities. All but two of these community based projects occurred during the first two years. One school had students go into the community prior to starting classes in their first year and return to that setting during clinical years. Additionally, some schools required students to pair up with a clinical mentor for their community exposure and assigned them to underserved settings in order to maximize their experience and clinical skills working with diverse patient populations.

Conditions on Teaching Cultural Competency-Related Topics

Our data further suggests that schools consider non-curricular elements when implementing cultural competence training. Participants emphasized the importance of paying attention to and reflecting on *how* such content is taught and *when* topics are

presented during student's training. Faculty and students brought up longitudinal integration, tone of delivery, and the importance of experiential learning.

A small number of schools (N=5) taught cultural competence throughout all four years of medical school, but many only do so in the first or second years (N=10). For example, a school teaches basic concepts such as definitions during the first year and requires their students to start a relationship with a community health clinic. In the second year, students continue building that partnership. Finally, in the fourth year they return to that location for an additional four weeks of service and learning. Both of these curricular elements were purposefully extended beyond the pre-clinical years based on the recognized long-term value.

Participants also discussed how attention to tone, framing and context were instrumental in delivering cultural competence topics. In several schools, faculty have discontinued use of the term "cultural competence" and instead seek to frame these concepts in ways directly relevant to clinical training. One faculty key informant explained,

> … when you label it cultural competence, they sort of cross their arms and roll their eyes [laughter] … but if you say now we're looking at interventional cardiology, oh by the way um…if you have this group, and if you have this group here's what they get, students, in my experience, are much more interested in that. (CS 8: Faculty KI)

Additionally, both faculty and students expressed resistance to the presentation of cultural competence in a "finger wagging" manner; that is, in such a way that implies all students are biased. As another faculty member observed,

> There was a lot of pushback to the very direct, upfront addressing of the issues, and now those issues get integrated. (CS 10: Faculty KI)

Faculty at several schools found students were less defensive and more receptive if they integrated the concepts of bias and stereotyping in ways more closely related to the practice of medicine.

Therefore, faculty key informants at several schools refuted an approach to cultural competence focused on the acquisition of a knowledge-based inventory. Instead, the importance of experiential learning is increasingly recognized as an effective strategy to teach cultural competence. As one instructor noted, “It’s not going to make them culturally competent by going and listening to a seminar” (CS 9: Faculty KI).

Institutional Commitment to Meeting the LCME Standards

Lastly, faculty and students voiced the importance of institutional commitment as another perceived dimension of cultural competence training. Participants talked about the level of commitment demonstrated by their institution through devoting resources to infrastructure supporting diversity and the development of programs promoting service to the underserved. Some schools had existing or newly created leadership roles and/or departments designated to increase awareness of and address issues of diversity and culture such as the Office of Diversity. Other schools had leadership positions, even at the dean level, to engage in diversity and cultural issues. About half of the schools had designated staff addressing diversity and culture initiatives institutionalizing the school’s commitment. One school even had multiple leadership positions that addressed race and culture.

Schools also supported cultural competence through the implementation of programs that actively foster commitment to serving diverse patients and promote the cultivation of culturally specific skills by students. One school developed a program for select students interested in working with the Latino population, actively putting them through a curriculum

geared towards increasing culturally sensitive and linguistically competent providers. Five schools had created a track for students interested in working in certain populations or areas, including rural communities, primary care, or with racial/ethnic minority patients. These formalized programs inform admission decisions, dictate curricular content, and promote the institution's commitment to graduating medical students invested in addressing health inequities.

DISCUSSION

We sought to understand how medical schools are addressing the LCME cultural competence requirement. Through qualitative content analysis of transcripts at fifteen medical schools, we identified the most prominent formal curricular elements that characterize such efforts as well as the conditions by which these activities are offered. This included the degree to which cultural competence programming is integrated across the training environment, attention to the "tone," and the range of institutional commitment. Overall, we found a high degree of variability in cultural competence training in terms of both content and approach, although our data reveal certain general patterns that emerged that may have implications for understanding broader trends and assessment.

Previous documented efforts in cultural competence training have emphasized teaching the "do's and don'ts" (factual knowledge) for caring for patients from diverse backgrounds (Betancourt 2006; Betancourt 2003; Fraser 1991). Critiques of this approach have observed that providers may draw upon broad cultural assumptions and potentially overlook intracultural diversity (Kai 2001; Shapiro et al. 2006). Instead, our findings suggest that medical schools may be moving away from a "follow the manual" approach and embracing a more practical framework (Gregg and Saha 2006; Koehn and Swick 2006). We

found an emphasis on training elements that students perceive to be more directly applicable to their training needs such as clinical communication skills, patient-centered concepts, and conducting community-based projects. This format is consistent with a growing trend toward experiential learning in medical education (Maudsley and Strivens 2000; Worley, Esterman, and Prideaux 2004).

Further, it is well documented that cultural competence teaching is often concentrated during the first or second year and in some cases even during the first week of entrance into medical school (Flores et al. 2000; Furman and Dent 2004; Beach et al. 2005). Our data suggest an increasing recognition of the importance of integrating cultural competence courses and related experiences over the four years of medical education training. Longitudinal cultural competence training has been documented to be critical (Kripalani et al. 2006; Rapp 2006) as the acquisition of relevant skills is understood to be the result of long-term exposures and experiences. Faculty engaged in cultural competence efforts consistently indicated that dedicating only a brief training period prior to the start of clinical rotations is unlikely to yield meaningful benefits (Loudon et al 1999; Kripalani et al 2006). We found several examples of medical schools using multiple opportunities to reinforce cultural competence knowledge, attitudes, and skills throughout the medical education curriculum.

Our findings may also have implications for assessment and evaluation activities. The Tool for Assessing Cultural Competence Training (Lie, Boker and Cleveland 2006; Lie et al. 2008) and other tools (Mason 1995; Dolhun, Munoz and Grambach 2003) have led to a checklist type of assessment and over-use of self-reported, self-evaluation assessment technique and strategies. Although the LCME continues to expand and clarify its standards to

facilitate schools' ability to better prepare and assess students, an institutional framework remains absent. Others have called for a shift in medical education assessment from the individual level to an institution-wide accountability system (Amin 2012). Multiple reports have recognized the importance of upper level administration and government supports that encourage institutional buy-in around cultural competence (Kripalani et al. 2006; Murray-Garcia and Garcia 2008) for faculty and students. Support from medical school deans and a commitment from course directors have been shown to facilitate implementation of cultural competence training (Murray-Garcia and Garcia 2008). Additionally, having a group of faculty or a physician champion(s) builds more regular discussions and opportunities to engage with multicultural issues (Rogers 1983). Institutional learning environments already addressed in the literature are institutions' ethos, teachers, modeling, processes, and policies (Admin 2012).

The current study is not without limitations. It draws from a relatively small number of case studies, and provides a cross-sectional view of cultural competence training. It is possible, therefore, that there are other configurations and approaches to cultural competence that were not identified here. However, our sample was designed to include medical schools from different geographic regions and a mixture of public and private. We reached data saturation with this sample and our findings are consistent with broader trends in medical education and cultural competence training current in the literature.

CONCLUSION

In the sixteen years since the original 2000 LCME mandate for including cultural competence in medical school training, there still remains a high degree of variability in approaches to this challenging and important need as well as uncertainty about "what works."

(Crosson 2004; Beagan 2003). Among our diverse sample of medical schools in the U.S., there was no clear definition of cultural competence. While the goal of cultural competence has remained mostly unchanged--to ensure providers are prepared to deliver high quality care to culturally and linguistically diverse populations—we have documented that a “one size fits all” approach with regard to curricular components and style of presentation does not exist. In addition to formal content delivered through standard classroom formats such as lectures and workshops, our study indicates that other features of this effort such as longitudinal integration, tone of content delivery, and experiential learning are potentially important aspects of this process that require further assessment. Collectively, these and other areas of inquiry will be needed to refine and enhance cultural competence training to ensure that desired outcomes are aligned with the spirit of this mandate.

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TABLES

Table 4-1: AAMC 2005 Tool for Assessing Cultural Competence Training (TACCT)

TACCT Content Domain	15 Medical Schools Approach
(1) Rational, Context, and Definition **A. How cultural issues affect health, quality of care, costs, and consequences.** **B. Define race, ethnicity, culture, culture of medicine** **C. Self-assessment/reflection of own culture, bias, assumptions**	Through Courses
(2) Key Aspects of Cultural Competence **A. Epidemiology of Population Health** **B. Patient-Family Center** **C. Information on Community of Patient**	Through Community-Projects
(3) Understanding the Impact of Stereotyping on Medical Decision Making **A. History of Stereotyping** **B. Information on Bias, Stereotype, Discrimination, and Racism** **C. Effects on medical decision making**	Through Reflection Opportunities
(4) Health Disparities and Factors Influencing Health **A. Epidemiology of health disparities** **B. Social-cultural factors underlying health disparities** **C. Demographic patterns of healthcare disparities** **D. Collaborating with Communities to Address Health Disparities**	Through Courses and Community-based Projects
(5) Cross-Cultural Clinical Skills **A. Knowledge, respect, and validation of differing cultures** **B. Eliciting a culturally valid social and medical history** **C. Communication and interviewing skills** **D. Working with interpreters** **E. Problem solving skills**	Through Courses, Community-based Projects and Reflection Opportunities

Table 4-2: Medical Schools Overview (N: 15)

Medical School Case Study #	AAMC Regions	Geographical Region	Public vs Private
1	West 1	Southwest 1	Public
2	South 1	Southwest 2	Public
3	Midwest 1	Midwestern 1	Private
4	Northeast 1	Northeastern 1	Public
5	West 2	Northwest	Public
6	Midwest 2	Midwestern 2	Public
7	Northeast 2	Mid Atlantic	Private
8	South 2	Southeastern	Private
9	Midwest 3	Central	Public
10	West 3	Western 1	Public
11	South 3	Southern	Public
12	Midwest 4	Midwestern 3	Private
13	Northeast 3	Northeastern 2	Private
14	South 4	Eastern	Public
15	West 4	Western 2	Public

Table 4-3: Medical Students Demographics (N: 196)

	Focus Group Participants Demographics
Sex	51% Female 49% Male
Race	67% White 22% Asian 4% Blacks 7% Other
Class	11% Lower SES 79% Middle SES 10% Upper SES

Table 4-4: Medical Schools and Training Elements around Cultural Competence

Case Study Num.	Communi-cation with Diverse Patients	Patient Center Care	Commu-nity Project	Longitu-dinal Training	Institution-al Commit-ment	Population Specific Track
1	X		X			
2	X	X				
3	X		X	X		
4	X		X	X	X	
5	X		X	X		X
6		X	X		X	X
7	X					X
8	X		X	X	X	
9	X					
10	X			X		X
11	X		X			
12		X			X	
13						
14	X				X	X
15	X				X	

APPENDIX A: CODING TREE OF KEY INFORMANTS AND FOCUS GROUP

PARTICIPANTS

1. SCHOOL CONTEXT/ORIENTATION

3D. Core Values (Mission Statement)
3E. Evaluation and Responsiveness (Internal, External)
3F. Views of School (competitive)
4A. School's service orientation
4B. Commitment to Diversity
4C. History of School and/or Curriculum

2. PRE-CLINICAL CURRICULUM

6A. Formal (E.g. Reflective curriculum, Courses, Mode of Instruction)
6B. Use of Standardized Patients
6C. Diverse Patients (Exposure, Comfort, Confidence)
6D. Communication Skills
6E. Professionalism/Ethics
6F. Small Group Dynamics
6G. Reflective Component
6H. Views/Experience of formal curriculum

3. ENGAGEMENT WITH SOCIAL ISSUES

7A. Efficacy of CC
7B. History of CC
7C. Description of CC (Who/What/When)
7D. Tone (E.g. Softer Approach vs. Finger Wagging)
7E. Preferences for Classroom vs. Experience
7F. Students Reactions
7G. Ideas for Future Courses/Lectures
7H. Perception of Formal Curriculum in Preparing Students to work with Diverse Patients

4. CLINICAL

8A. Configuration/ Organization of Clinical
8B. Views/Experience of Clinical
8C. Discussion of Patients served (E.g. Social Distance)
8D. Reflection in Clinical (Formal and Informal)
8F. General Relationship/Hierarchy
    8F1. Staff
    8F2. Peer Community
    8F3. Residents
    8F4. Attending
    8F5. Pressure to Conform to Faculty Values

5. STUDENTS

9A. General Perspective on Students (Values, Beliefs)
9C. Life Experiences/Prior Experience (E.g. Immature, Lack of Experience)
9D. Perspective on Marked Students/Minority students
9F. Volunteer Work/Service Orientation

6. FACULTY/STAFF

10A. General Perspective on Faculty
10B. Views/Values of Mentorship
10C. Faculty Training

CONCLUSION CHAPTER

The *Attempted* Transformation of the Medical Profession and Medical Education: The Surface Jurisdictional Claims of Cultural Competence in Medicine

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The rise of various social movements stemming from the civil rights era advocate for a transformation of the medical profession's narrow biomedical model. The medical profession is undergoing a period of scrutiny, driven by evolution in our thinking about health and about roles and responsibilities for health professionals (MacLeod and McCullough 1994). This dissertation develops empirical and theoretical insights about cultural competence in medicine. I have shown that the medical profession's specific mode of adopting cultural competence stymied its potentially transformative aspects. Instead of systematically reforming the bio-medical model around the more democratic and patient-centered ideals of multiculturalism, cultural competence was integrated mainly at a provider-level in the form of attitudes, knowledge and skills to be acquired by individuals. First, this decision allowed leaders in the profession to make and maintain a jurisdictional claim to be legitimate and effective in equitably treating minority patient populations. Second, this avoided any far-reaching changes to the structure of the profession that could further endanger their claims to legitimacy and cultural authority. The high degree of organization and cultural authority of the biomedical framework that influences both the structure and culture of the medical profession accounts for this outcome. Therefore, I argue that the medical profession's adoption of cultural competence is a *surface jurisdictional claim*. In each of the three empirical chapters, the idea of cultural competence in medicine is constantly shifting with flexible conceptualization, operationalization, and implementation practices centered at the clinical-encounter level.

In this conclusion chapter, I will first provide a summary of the each of the dissertation chapters before discussing the limitations of each. I then expand on the

sociological contribution of this dissertation and cover critical topics in need of future research. I conclude with the policy implications of my work.

SUMMARY OF CULTURAL COMPETENCE AS A PROFESSION'S PROJECT

The dissertation is comprised of three empirical manuscripts covering the conceptualization, operationalization, and implementation of cultural competence. I choose to focus on these three because they are also the major areas by which I could understand why, how, and with what consequences the medical profession makes a jurisdictional claim on cultural competence. Substantively, the dissertation answered core questions about what the concept of cultural competence means within the medical profession. Theoretically, it considered the jurisdictional terrain of the medical profession and its changing nature concerning the adoption of cultural competence.

The first chapter charts the conceptualization of cultural competence as a legal jurisdictional claim. The medical profession not only made public statements about being committed to cultural competence via a range of publications, but they actually changed educational standards to reflect the adoption of cultural competence. This chapter examines one of the original standards in medical education passed by the Liaison Committee on Medical Education, which is the accreditation body of all U.S. medical schools, and illustrates the built-in flexibility that has led to a range of interpretations and a constant expansion of the conceptualization of cultural competence. The second chapter addresses how the medical profession operationalizes cultural competence, which relates to the profession's workplace jurisdictional claim. I analyze what it means to be a culturally competent provider as discussed by the medical profession in the Journal of American Medicine Association publications. The medical profession's adoption of cultural

competence affected a set of provider-patient standards, but the intention was to transform the practice of medicine. The final chapter investigated the manner in which U.S. medical schools implemented cultural competence training for their students, who are future medical providers. The implementation of cultural competence remains diverse and illustrates the importance of each medical school's context, culture and structure. Each of the chapters read as a standalone manuscript asking three different research questions utilizing different datasets and diverse methodologies. Together, however, they provide a cross-sectional snapshot of the medical profession jurisdictional claim to cultural competence.

These chapters map onto Abbott's (1988) three primary forms of jurisdictional claims, including legal jurisdictional claims, workplace jurisdictional claims, and professionalization jurisdictional claims. I captured three areas that the medical profession's adoption of cultural competence affects: policy, practice, and the socialization process of medical providers.

Although the dynamics I have described regarding medicine's surface jurisdictional claim vis-à-vis cultural competence are important, this story takes place against a larger backdrop. Models of healthcare organizations can also promote or hinder cultural competency (Brach and Fraser 2002). Specifically, the United States political economy has long constrained progressive policies and financial incentives that are unclear or inconsistent with social justice principles. For-profit healthcare systems are at odds with many if not most of the dictates of cultural competence that would require time and attention to patients' realities. Non-profit healthcare organizations are established under the premise that managing care would lead to improved healthcare delivery and health outcomes. For example, both Kaiser Permanente and Harvard Pilgrim Health Care enact specific models of healthcare to

improve access and continuity of care while controlling for costs (Brach and Fraser 2002), but they too face challenges. A body of literature is emerging around understanding and critiquing different models of health care organizations, and combined with the passage of the Affordable Care Act, that provides a number of opportunities to be innovative and transform health care systems.

LIMITATIONS AND REFLECTIONS

The first chapter had a number of limitations starting with the data. The original aim of the chapter was to understand the mandate itself, but interviewees' memory recall was problematic. Additionally, the LCME restrictive database provided me with limited access to their archives. I was only able to get a copy of all the standards since 1993. To compensate, I collected reports, briefs, and published literature about cultural competence, but such content did not make it into the chapter because it was too historical for a publishable manuscript format. If I could go back, I would have disregarded the questions that relied on memory recall and instead focused more on their interpretation of the mandate. Instead of relying on a snowball-sampling framework, I would have involved my superiors for a special request from the LCME to obtain a defined sample population. Regardless of these pitfalls, I presented a compelling manuscript on interviewees' perspectives on cultural competence before and after the 2000 mandate that revealed an expanding conceptualization of what cultural competence training meant in medical education.

The second chapter had a number of limitations as well. One limitation is that I focus on articles published solely in JAMA. After an extensive search via PubMed, the best option was to select one journal. A range of journals emerged in the broader search that were more specialist, non-U.S.-focused, and/or captured other professions such as nursing. The final

sample included a mix of publications from peer-reviewed journals and commentary pieces. It would be important for future scholars and journals to solicit more opinion pieces that can lend to a better understanding and assessment of the culture of medicine. Finally, the analysis of the articles yielded many intriguing themes that I was unable to pursue fully within a manuscript format paper. For example, the discussion on diversity and workforce emerged multiple times, but was not directly pertinent to the practice of medicine. I would urge scholars to investigate other journals' discourses of cultural competence that can shed light on the underlying assumptions of the medical profession. Despite these shortcomings, this article provides insights on the organizational and cultural assumptions embedded in the medical profession.

The third chapter also has some significant limitations. First, the parent study was conceptualized around trying to understand the socialization process behind biased decision-making. While there is strong evidence showing the association between cultural competence and bias, these are still distinctive areas of research and curriculum. Second, the term cultural competence was not used very often at the medical schools we visited. Instead, a range of other words and terms related to cultural competence were used. This made it difficult to pinpoint what training was implemented to address cultural competence. Therefore, the analysis was not where and when cultural competence gets mentioned, but instead about what areas, such as race, gender, and class, are important to understand when working with vulnerable or marginalized populations. Although there are limitations, the data was still comprehensive enough to allow me to assess the implementation practices of training about cultural competency.

One aspect of the dissertation that I would have liked to expand upon was the racial perspective. Cultural competence could have been approached from a racial formation project theory, which explores how concepts of race are created and changed (Omi and Winant 1994). Omi and Winant (1994) argued that race shapes American politics and is at the center of the American experience. With cultural competence, we have a case study where the racial discourse is replaced by a cultural discourse. They wrote, "Most theories are marked by a tendency to reduce race to a mere manifestation of other supposedly more fundamental social and political relationships, such as ethnicity and class" (pg. 2). I would add culture to that list, but would need further analysis to map the racial formation of cultural competence.

Another fruitful mechanism by which to analyze cultural competence would be using a colorblind ideology perspective. Colorblind racism appropriates elements of traditional liberalism (work ethic, rewards by merit, equal opportunity, individualism, etc.) for racially liberal goals (Bonilla-Silva 2006). Bonilla-Silva argues that whites often use "culture" to explain blacks' position in this country and do not perceive discrimination to be a central factor in shaping blacks' life chances. Cultural competence in a way focuses on "culture" as independent of "race", but further analysis would be fruitful to tease out that relationship. Scholars have already criticized cultural competence because it has "a tendency to equalize oppression under a 'multicultural umbrella', unintentionally promoting a color-blind mentality that eclipses the significance of institutionalized racism" (Abrams and Moio 2013). Cultural competence is concerned with race, but culture has become perceived as separate from race and in some ways more important to address. It would be fruitful to further pursue how culture is used as a proxy or euphemism for race in the medical profession.

Overall, in retrospect I would have liked to have covered more ground to assess thoroughly the medical professions adoption of cultural competence but given the hybrid dissertation approach each chapter focused on a specific aspect of medicine. I approached each manuscript as a case study illustrating something larger about the medical profession. This dissertation begins to scratch the surface of a much larger project concerned with the evolution and implementation of cultural competence in the medical institution. I am not an expert in the sociology of social movements but this project could have benefited from such perspective. Despite my approach, I gained a diverse set of methodological skills and engaged with the material critically about the bigger picture of a medical profession from a medical sociology perspective. It would have been ideal to integrate more sociology of race and ethnicity but the nature of my analyses and interpretation of the data kept pointing to the sociology of the profession. I illustrated one profession's attempt to undergo a transformation via the adoption of cultural competence to improve quality of care and address disparities.

THEORETICAL IMPLICATIONS: THE SOCIOLOGY OF THE MEDICAL PROFESSION

The theoretical implications of this dissertation speak to the idea that the content of a profession's work defines the very structure and culture of the profession. According to Abbott (1988), the work performed by professionals in a given field has implications for the identity, structure, and mission of a given profession. In this dissertation, I illustrate how a profession under the right conditions can strategically de-couple the nature of the work performed with the structure and mission of the medicine. The structure and culture of the medical profession around the biomedical model I find have presented challenges to the adoption of cultural competence work. The biomedical scientific framework continues to govern the approach and practice of medicine as well as the very organization of the medical

profession. I introduced the following theoretical concept, *surface jurisdictional claim*, to illustrate the manner in which professions make claims to a task, cultural competence in this case, but only adopted elements that do not disrupt the cultural authority of the medical profession. Due to the high degree of legitimacy and cultural authority of the biomedical scientific framework, which has governed the approach, practice and organization of the medical profession, the profession has been reluctant to commit fully to the ideals of cultural competence. Regardless of the 'inauthenticity' of adopting cultural competence, such process has thus far been sufficient to maintain the authority and legitimacy of the medical profession.

The medical profession's response to increasing diversity in the patient population and the associated widening health disparities led them to adopt cultural competence as a strategy to mitigate these specific challenges. The challenges to the legitimacy of the medical profession came from a range of diverse populations starting around the civil rights era. Scholars from a range of disciplines have demonstrated the profession's lack of attention to social-cultural issues, which have become increasingly apparent in explanations of health disparities that emphasize problems in the clinical encounter. The profession's high degree of autonomy provided them with the ability to define and approach cultural competence in their own terms. Therefore, the medical profession acted rationally and defensively to a degree, shifting attention away from systemic reforms at the institutional level and framing cultural competence as a strategy to be pursued at the clinical level. The medical provider was conceived as the foci of intervention through cultural competence training reform that would theoretically improve their knowledge, attitudes, and skills when meeting with diverse patients, thereby addressing the needs of diverse communities. As introduced into medical

practice, cultural competence represented a misalignment between health care systems and marginalized vulnerable populations. Little work beyond the CLAS standard that requires having interpreters available has occurred at the systems level. The primary focus remains at the provider level. This dissertation brings to the front a number of issues worth further contemplating concerning *who* the medical profession serves, *how* the medical profession serves, and *why* medical profession serves.

Inclusion of Difference in Medicine to Address Diversity

The concept of cultural competence has come to apply to a wide range of marginalized social groups. The expansion of "difference" in medicine expanded beyond the original concerns with racial/ethnic health disparities, raising a host of questions about the meaning and consequences of myriad identities as they intersect with the institution of medicine. Throughout the dissertation cultural competence is used to refer to a range of diverse identities thus the medical profession's cultural competence policies, practices, and training respond to all kinds of groups and populations. It potentially becomes a meaningless concept with no group being well served.

The focus on racial and ethnic populations notably decreases as the reader moves from the first empirical paper to the last one. In the first paper, racial and ethnic health disparities as reported by policy actors in medical education was a core aspect of the cultural competence agenda. In the second paper, cultural competence touched on a range of identities beyond racial/ethnic populations including firearm culture and single parenting culture. In the final chapter, the focus on racial/ethnic health disparities is entirely missing. Instead, medical schools are using a back door approach to increase students' exposure to diversity by having them engage in community-based projects or having students be part of

small group self-reflection activities primarily focused on bias. The direct relationship between cultural competence and racial/ethnic health disparities seems to be disappearing.

The original idea behind cultural competence was to close the "gaps" of serving racial/ethnic minority patients. The motivation behind the jurisdictional claim of cultural competence was for the medical profession to meet and address the needs of racial/ethnic minority populations, which has yet to pan out and quickly expanded to other marginalized groups. The work on cultural competency training has even expanded to include the deaf patient population (Thew, Smith, and Chang 2012). The medical profession is acutely aware that its current conceptualization and approach to health and illness may be not serving the needs of a diverse patient population adequately. The medical profession's commitment to cultural competence as documented in this dissertation is achieved largely through modifying provider-level knowledge, behavior, and experiences for *any* and *all* diverse patient populations.

Furthermore, how diversity is understood and approached in medicine is critical to cultural competence. Difference or indifference assumes a location from which one is looking at the other; it also assumes that something or someone is normative. The perspective that defines "normal" is often localized to a position of privilege or power, which reveals how efforts in cultural competency may actually reinforce the "otherness" and marginalization of disenfranchised groups and individuals (Wear et al. 2012). Most of the traditional cultural competence curricula and programs were based on traditional models of cross-cultural education that were motivated primarily by the desire to alleviate barriers to effective health care for immigrants, refugees, and others on the sociocultural margins. The idea was that immigrants' unfamiliarity and potential discomfort with mainstream American

practices and institutionalization, and physicians unfamiliarity and discomfort with immigrant beliefs and behaviors, led to a "cultural distance" between immigrants and the Western health care provider from whom they sought care (Gregg and Saha 2006). Advocacy for culturally competent health care grew from the ranks of community-based organizations targeting ethnic-specific populations (Chin 2000). The cultural competence movement in medicine, however, began to address it, primarily by educating physicians about minority cultures, culture-specific beliefs, and their potential impact on health and health care in order to reach a compromise within biomedicine. The medical profession's view and orientation towards addressing diversity has been an "add-on" approach. Medical schools enroll more diverse students, train students in social topics, have expanded efforts to increase community engagement, and have increasingly provided interpreters and materials in different languages. These policies and actions, however, have had little to do with re-designing the health care system itself. The structure and organization of the medical profession and medical education system remains fundamentally unchanged. As a way to appear to be meeting demands for cultural competence, the medical profession in a way has prioritized the knowledge and skills of providers over transforming the structure of medicine.

A major question moving forward is how cultural competence can address the interplay of diverse identities, especially as our understanding of health disparities becomes more complex at the intersection of race/ethnicity, class, sexuality and, increasingly, immigration status. Kimberle Crenshaw coined intersectionality to describe overlapping social identities that create a whole that is different from the components identities. The intersectionality framework thus does not prioritize an identity but instead examines the intersections of various identities to understand injustices of social inequality that occur on a

multidimensional basis. Cultural competence often takes a categorical approach, focusing on identities in silos; yet it may be fruitful given the increasing diversity of our nation to have medical students understand how multiple identities can create unique axes of social oppression and/or social advantage that impact health and health outcomes. Thinking about differences in medicine through a silos lens is no longer sufficient.

FUTURE RESEARCH AGENDA IN CULTURAL COMPETENCE AND MEDICINE

The cultural authority of medicine centered on the biomedical model remains a strong foundation that governs the organization and practice of medicine. As one reads from the first chapter to the last chapter, the reader becomes more aware of the larger cultural-structural factors that necessitate further attention by scholars. In the first chapter, cultural competence training became synonymous for being a "good doctor", yet the idea of a culturally competent health care system is largely overlooked. In the second chapter, the culture of medicine and an examination of biomedicine's assumptions are significant challenges for cultural competence. Finally, in the third chapter, the leadership and instructional organization of medicine emerged as critical. Criticism of medicine has a long history, mainly centered in the charge that medicine privileges molecular biology and technology, while being prone to neglect the personal and social-cultural dimensions of health and illness. The challenges with integrating cultural competence are not just the biomedical knowledge framework, but also the more informal "culture of biomedicine" that is problematic.

Critically examining the culture of biomedicine means creating a research agenda on examining the effects and consequences of the biomedical model on subsets of the population and on the institution of medicine itself. We have yet to fully understand the full

extent and consequences of the current ideology supporting the biomedical framework. In order to increase attention at the health care system, more evidence is needed to document the assumptions of the current organization and structure of medicine. This dissertation has revealed the need for more sociological analysis on the attempted cultural transformation of the medical profession.

Our culture derives many of its ideas about the body from the Western biomedical model. A sociological perspective on health and illness does not take this model as truth. Rather, the medical model of the body and its diseases are seen as socially constructed realties that are subject to social biases and limitations. Furthermore, the biomedical model has implications on the structure and organization of medicine. This is what some have referred to as the "culture of medicine" (Lock and Gordman 1988). The culture of medicine captures the often taken for granted structure of medical practice during the medical encounter and during the organization of the medical institution itself. The medical profession's jurisdictional claim is in the area of health and illness. Cultural competence would ideally enhance the efficacy of the medical provider's biomedical model by expanding the framework to encompassing more emphasis on social and cultural factors. Therefore, the critical tension is not necessarily only with the assumption of the biomedical model itself, but also with the very organization and structure of both the medical encounter and the organization of medicine that derive from the biomedical model. I therefore urge more research on the culture of medicine to better understand the mechanisms and challenges of adopting cultural competence.

The culture of medicine as a theoretical framework is starting to gain some recognition into the medical education literature. In 2008, Boutin-Foster and Colleagues

published a viewpoint titled Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence. They argued the culture of medicine reinforces certain assumptions and practices. Talking about the White Coat provides an excellent segue to a discussion of stereotypes and biases in the doctor-patient interaction. Studies have shown that wearing a white coast is associated with patient trust and confidence in their physician as well as their willingness to disclose personal matters to their physicians (Wear 1998). Additionally, patients describe doctors who wear their white coast as being more hygienic, professional, authoritative, and scientific (Gooden et al. 2001). Doctor talk is another important element of the culture of medicine. Anspach (1988) described key elements of medical discourse. One element is depersonalization of the patient or the separation of biological processes from the person. Finally, the manner in which doctors conceptualize health is critical. Whereas the patient's explanatory model may be derived from social and cultural experiences, the physician's explanatory model derives from the content of the medical school curriculum, the medical school environment, and the interaction with peers and mentors (Boutin-Foster, Foster, and Konopasek 2008). The discussion of the culture of medicine shifts the focus on the cross-cultural encounter from the patient as the "deviant other" to examinations of both the patient and physicians, which may help to minimize the tendency for othering.

Rarely does medical training focus on the culture of medicine. Most of the time students do not have the time or any formal sanction to critically analyze the profession and institutions of care, which shape treatment choices, quality of care, and research practices (King 1996). Furthermore, medical training rarely considers how medical culture may contribute to processes that evolve into institutional or averse racism and sexism in clinical

practice (Whaley 1998). Both the charismatic hero physician, who are leaders in social medicine (see Farmer 1999), and the less publically known academic and community physicians, who are to be commended for their commitment to improving the quality of care provided to the underserved or to ethnic minorities, work within a biomedical knowledge frame (Good et al. 2005). Although tempered with a social medicine perspective and a cultural competence perspective, these physicians also employ the medical gaze in their daily clinical work and practice. Studies over several decades find that the "medical gaze" soon becomes the dominant knowledge frame through medical school, that time and efficiency are highly prized, and that students and their attending physicians are most caring of patients who are willing to become part of the medical story they wish to tell and the therapeutic activities they hope to pursue (Good et al. 2005). Narrative forms of the culture of medicine are ingrained; they have historical depth and substance and make for continuity of professionalism despite changes in practice environments. The culture of medicine emphasizes the dismantling of patients' life narratives and the reconstitution of patient concerns and experiences of illness and associated social context into medically meaningful narratives that allow physicians to determine a diagnosis and formulate plans for therapeutic actions and procedures. "Good doctors" engage patients in these clinical stories, teaching, guiding and helping patients own what is happening. These narratives smooth the working of what a colleague of Goode calls "the medical machine" (Good et al. 2005). There is no secret about the depersonalized medical interactions between doctor and patients characterized by physician's interruptions, patients' failure to articulate their problems, and a depression asymmetry between patient and physician needs (e.g. Beckman and Frankel 1984).

A research agenda focused on the health care system would be necessary to expand the cultural competence lens. Health is moving from a strictly disease-centered model towards a patient-centered model. In the disease-centered model, health care providers make all treatment decisions based largely on clinical data from various tests. In the new patient-centered model, patients become active participants and receive services that focus on their individual needs and preferences (Dreachslin, Gilbert, and Malone 2006). Health care providers are embedded in larger systems and structures that govern and dictate delivery of care. With the implementation of the Patient Protection and Affordable Care Act, millions of minority populations have access to health care; however, the stability of enrollees in employer-based and publically funded health plans (Medicaid and Medicare) varies. Kaiser Permanente is an example of a patient-centered healthcare group that has been successful in expanding its market. First, Kaiser has been able to expand its Chinese membership in San Francisco through creating an all-Cantonese speaking adult primary care unit (NCQA 2006). Second, they are currently expanding their Latino membership as a result of a physician-patient language concordance program throughout Southern California (NCQA 2009). The top five health care systems with regards to diversity and cultural competence as reported by DiversityInc in 2011 and 2012 are as follows: Henry Ford Health Systems, University Hospitals, Cleveland Ohio, Cleveland Clinic, Mayo Clinic, and Massachusetts General Hospital (Mass General). Diversity management and cultural competence are priorities for not only health care organizations, but also for health insurances (Dreachslin, Gilbert, and Malone 2006).

Moreover, taking one step further, sociologist Howard Waitzkin has been instrumental to our understanding of the larger health institution. In his book, *Medicine and*

Public Health at the End of Empire, he argues that the "empire" is in decline and alternative approaches to health services are gaining ground. In particular, his analysis is concerned with social medicine that focuses on the political, economic, and social structures affecting health (2011). Cultural competence has set up an alternative mode to the biomedical model, but it has yet to be determined to what degree cultural competence will or can transform the health care practice and delivery system. The cultural competence of health care organizations ultimately rests on the policy marketing, planning, and oversight of top-level administrators and directors (Nashimi 2006). I would encourage a new body of research on cultural competence and the larger shifting landscape of medicine towards social medicine. There are currently conferences held all over the U.S. and a growing network of medical providers and allies advocating for the social mission in medicine, which in part emphasizes culturally competent approaches.

Cultural competence emerged from a rich history of multiculturalism that affected virtually every profession in the United States, yet in the medical profession, the transformative power was muted and neutralized as a result of the deeply embedded and adopted biomedical model. The adoption of cultural competence remains flexible and diverse in medicine. I theorize this may be because the principles of cultural competence are in direct tension with the tenants of the biomedical model and the organization of medicine. I call for more sociological analysis beyond the clinical encounter level on the effects of the biomedical model in medicine.

POLICY IMPLICATIONS: A MORE RADICAL VIEW OF THE CULTURAL COMPETENCE FRAMEWORK

Based on my analysis I would like to step into a role as a person concerned with policy. It is imperative to re-conceptualize cultural competence at the health care systems level by increasing the communication and collaboration across various stakeholders in medicine. When I make claims about the potential benefits of cultural competence, I am highlighting some of the features that I suggest hold considerable promise in terms of health and social outcomes.

Re-Focusing Efforts on Cultural Competence at the Health Care Systems Level

Health care systems rely on the training occurring in medical schools today to increase the workforce level of competence to work with diverse populations. However, as one of the dissertation chapters pointed out, the bottom-up approach is almost impossible given the deeply entrenched culture of medicine itself. Medical providers are embedded in larger systems of health care that are organized and structured in certain ways, which often are not conducive to the provider's practice of being culturally competent. As an optimist, there may be an increase in the use of such cultural competence frameworks at the health care system level because of the challenges to the medical profession.

As the medical education arena continues to develop, it first seems imperative for the profession to devote time and energy into specifying the differences among many terms used to capture the teaching of various social sciences topics. For example, an article by Satterfield et al. (2014) recently published used the term social and behavioral (SBS) issues captured 30 different topics under the four headings of health behaviors, social/cultural factors, mind/body factors, and behavior change counseling. In an article by Betancourt

(2006) titled “Cultural Competence and Medical Education: Many Names, Many Perspectives, One Goal”, he wrote, “Call it what you will, the field of cultural competence aims quite simply to assure that health care providers are prepared to provider quality care to diverse populations.” However, as my dissertation has documented, there remains a wide range of perceptions and interpretations that have led us to a crossroads. The term cultural competence has become a panacea for the multiple and interwoven problems in health care.

The confusion in writing over definitions and theories of cultural competence arose mainly in writing that lacked theoretical intent. After reviewing, an extensive body of literature the most comprehensive theoretical model to address health disparities via cultural competence at a systems level was proposed by Betancourt, Green, and Carillo (2003). They published a comprehensive framework that addresses sociocultural factors at the organizational level (leadership/workforce), structural level (process of care), and clinical level (provider-patient encounters). This model furthermore linked each level to actual health disparities outcomes. At the first level, re-structuring the organization of medicine allows the medical profession to have leadership that design and workforce that carries out the mission to address health disparities and be aware of addressing the systemic disparities. At the second level, re-designing the structure of the payment and rules of how medicine functions is critical to increasing access and ability to providing the care that is needed by vulnerable populations. Finally, at the third level, re-orienting the interaction between patient and providers and family/friends can minimize errors, enhance communication, and increase satisfaction for both parties. Together, the medical profession’s commitment to address health disparities is possible via changes to the organization, structure, and clinical level of current modern medicine.

Recently, Metzl and Hansen (2013) published an article that has received considerable attention titled, “Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality.” This framework expands the concept of cultural competence beyond purely an individual clinical level focus. The authors argue that training in five areas can increase attention to forces that influence health outcomes. First, recognizing the structures that shape clinical interactions; second, developing an extra-clinical language of structure; third, rearticulating cultural formulations in structural terms; fourth, observing and imaging structural interventions; and fifth, adopting into medical education curricular and structural interventions that can provide participant observation opportunities for clinical trainees. It is imperative for medical students and professions to be aware of the larger social-cultural factors that shape the conditions in which people of diverse backgrounds live, perhaps just as much as awareness of the socially constructed nature and organization of medical practice itself is also critical. While Metzl and Hansen (2013) describe a shift away from pedagogic approaches, the level of intervention nevertheless remains at the training of medical providers.

Constant updates to the theoretical framework of cultural competence are rolled out, but again only at the patient-provider level. Recently, Cultural Competence 2.0 was developed by Wear and colleagues in 2012. They argued that there was a strong need to add a more critical and expanded focus on learners’ attitudes and beliefs. This framework adds a dimension that examines the social positon of U.S medical students. They also draw upon the work of Bourdieu and use the concept of *habitus* to argue for the importance of understanding what the clinician brings to the patient-provider encounter and their developmental stage. This 2.0 version furthermore considers the countertransference, which

defines the conscious or unconscious emotional response to a patient. Wear et al. (2012) understand this as a means to address providers' bias within cultural competence training. However, such a model remains within the clinical encounter and patient-provider interaction, and ultimately reinforces the responsibility of the provider to engage in self-reflection and change the institution of medicine from the bottom up. I urge policy makers to re-direct their efforts at the structure of the medical profession to support changes that promote physician behavior changes and allow them to integrate social and cultural factors into the practice of medicine.

The needs of diverse people and communities cannot be addressed by medicine as currently practiced within a profit-driven, complex and fragmented healthcare system. In the United States, access to insurance and other health resources are disproportionally distributed. Healthcare is still a commodity distributed in the marketplace rather than a fundamental social right (Epsing-Anderson 2008; Waitzkin 2000). Historically, social policies have attempted to equalize the distribution of resources, but the particular features of the U.S. welfare state limit such progressive policies. For example, the lack of a national health care system has been argued to be a reflection of the larger U.S. political context (Quadagno 2006). Political conditions in America allow powerful stakeholder groups to mobilize against national health insurance or any government programs that might compete with the private sector and result in a more equitable distribution of resources (Esping-Andersen 2008; Skocpol 1996). In sum, sociologists have illustrated the importance of our political economy in shaping the organization and financing of the American health care system. Of importance here for my case is the need to address the delivery of care within existing structures that contradict cultural competence principles (Dreachslin, Gilbert, and

Malone 2013). Coordinated, patient-centered and culturally competent policies that promise ways to re-organize the healthcare delivery system cannot simply ignore these larger problems.

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