Inspecting Silence:
The Impact of Biomedical Culture on Health Inequalities
Observed Through a Critique of Cultural Competence Education

A Division III Thesis
Presented by
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Preface

I spent my childhood summers in the countryside of Japan, living in my grandfather’s house connected to his in-patient clinic. In the middle of the night I was often woken by sounds of a screaming woman, followed by high-pitched cries of a baby taking its first breaths. After school I would wander into the office and help organize medications or help pass out lunch to patients. I frequently found myself in the examination ‘rooms’ (separated by curtains) holding the hand of a patient in labor or having an OBGYN exam. Inevitably, I was also kicked out of many examinations as not every patient felt comfortable with an eight year-old wandering through the clinic. Such experiences helped create a certain degree of familiarity with the clinical setting, illness, pain, biomedicine, and days in the life of a physician.

Until I moved to Tokyo at age twelve, I spent every summer in Japan. I grew up in a predominantly black, working to middle-class neighborhood in south Atlanta as a child of a Japanese mother, and white father, and one of two Asians in the entire school. Interestingly, I identified with and was included in the black ‘side.’ There was no Asian community. Racial distinctions and discussions were framed as black or white. The ‘black southern culture’ of our tightly knit community became my world, with an intermittent life in Japan every summer. My parents tell me I used to ask, “Why are there so many white people on TV when there aren’t that many in America?” Little did I know I would end up finding ‘that many white people’ in Japan.

Once I moved to Tokyo, my daily routine consisted of commuting to my largely white, upper-middle class ‘international’ school, ironically named the American School in Japan (ASIJ). At ASIJ, a degree of tension existed between some of the
Japanese/mixed Japanese students and the American (mostly white) student community. I located the source of this tension and my personal frustration with how the American students and their ‘expatriate’ parents created not only a physical ‘Little America bubble’ (an expensive section of downtown Tokyo where mostly American expatriates reside) but also cultural space, from which they rarely ventured out. From my perspective outside of that ‘bubble,’ it seemed as if their every ‘American’ need (from unusually large housing by Tokyo standards to American food and products) was met by the company or government that employed them, resulting in many things, including a view of Japanese culture as expendable and tokenized. Seeing one of ‘my sides,’ the American side, exoticizing and treating ‘my’ Japanese ‘side’ in such racist ways made me question issues of privilege, cultural commodification, and cultural difference. At the same time, I existed very much in between those ‘worlds’ both in Atlanta and in Tokyo and thus started to develop my own sense of cultural fluidity and multiplicity of identities.

Moving back to the US in 2002 to Hampshire College, a predominantly white environment, provided me with another opportunity to recognize the discomfort I have often felt throughout my life in most spaces, and to politicize it by addressing discrimination. Involvement in the student of color community provided me with the language to talk about those issues and organize around them to strive for social justice and address the fluidity of culture and identity.

During my first year of college, I returned to the clinical setting when I traveled to El Salvador to set up rural clinics with American physicians. There, I found myself questioning communication barriers between physicians and patients. The experience made me critical of how the American biomedical agenda to ‘heal’ disregarded local
cultural practices as ‘subjective’ and secondary to treating the person’s body. We ‘marched into’ Arcatao, a mountain village made up of a little over one hundred people, with forty American physicians, college students, Peace Corps members, and other volunteers (again the group was predominantly white). The physician in charge set up temporary clinics in Arcatao and neighboring village schools without any regard for the infrastructure and cultural interface in providing biomedical care that local community health members spent years establishing. The ‘help’ we were providing, from my perspective, seemed to disrupt the work that had been done in terms of community health, but I cannot speak for the local officials or the community’s needs. My impression was that the American physicians did not really try to work with local efforts or understand cultural practices surrounding biomedical care. The experience raised many personal ethical questions surrounding standard of care issues and matters of access as well as how physicians choose to interact with patients who do not speak English. Two years later I expanded upon these questions when working in the Emergency department at Bellevue Hospital, a large public hospital located in New York City, for a summer.

While at Bellevue, when I was not observing open-heart surgery, taking EKGs (electrocardiograms), irrigating wounds, or gathering research participants, I spent most of my time talking with patients as they waited hours on end to be tended to. I listened to them share their life stories, explain in great detail the nature of their ailments, and complain about the care (or lack thereof) they were receiving, in the hospital. That summer at Bellevue, I realized how inefficient the US healthcare system is and just how complicated it is to provide ‘good’ care. Having hundreds of patients walk through Bellevue’s doors daily, it was virtually impossible to please everyone, considering the
different interests held by patients, clerks, personal care assistants, nurses, and physicians. One party or another usually seemed dissatisfied or frustrated as various worlds collided, with people speaking different languages and having different values and priorities.

Following that summer, I entered a medical anthropology class and public health/biomedical ethics class with many questions about miscommunication, time, money, and cultural difference. My final paper in the ethics class entitled, “Conflicts of Interest: How HMOs [Health Management Organizations] Affect Physicians’ Fidelity to and Respect for Autonomy of Patients” addressed how reimbursement procedures affects patient care. The final paper for my medical anthropology class was the foundational work I did for this thesis. Entitled, “Creating a Foundation: Recognizing ‘Othering’ to Begin the Path Towards Cultural Competence,” it addressed the ‘Othering’ process that can occur through cultural competence education that ends up distancing the patient even more. The paper focused on how biomedicine does not acknowledge having its own culture and instead points to culture as belonging to others, and therefore something to be observed, studied, and memorized. Using that paper as a launching point for further questioning, I started thinking about what role the culture of biomedicine plays in cultural competence education. These questions eventually led to the conception of my Division III.

Upon receiving funding¹ for my Division III project, I was able to conduct interviews with medical students, resident physicians, and other physicians across the

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¹ Funding provided by Hampshire College’s Foundation for Psychocultural Research Program in Culture, Brain, and Development and Hampshire College’s School of Natural Science
United States in the summer of 2005. The purpose of the interviews was to better understand the culture of biomedicine in order to appreciate how it helps shape cultural competence education. I must admit that I entered into the data collection process with my own biases and assumptions about the culture of biomedicine. I made the major error of holding a static notion of biomedical culture and using stereotypes to oversimplify the patient-physician interaction. After my first interview I quickly realized the inappropriateness and irony in the situation of assuming certain characteristics or behaviors on the physician’s part. There I was critiquing cultural competence education and how it presents cultures as static, yet I was doing the same thing in my approach to the culture of biomedicine. Thus, I had to check myself to see if I was acting according to behavior I was advocating in my research, namely, to enter into a relationship acknowledging/questioning my own assumptions, considering how my sociocultural and economic background influence my thinking, and acknowledging that the other person's experiences are just as valid as my own.

Part of the learning process included basic logistics in getting hold of physicians to schedule interviews. I found out just how busy physicians and medical students are as I was scheduled interviews during their lunch breaks, after class, or before work. Yet all of the individuals I spoke to seemed to have a good grasp of time management, a trait several interviewees attributed to time constraints during residency.

In the end, with each interview I came to realize the complexity of interactions occurring not only in the interview itself, but also between the interviewee and other healthcare professionals, the patient, and non-medical people in their lives. The interviews reminded me of how culture cannot be isolated as a reason or source per se,
but that culture is part of a dynamic system. It was impossible to tease apart what was
‘learned’ behavior from growing up in the U.S., from what was gained through medical
training, from what derived from the individual’s personality. I found that attributing
cultural patterns or values to a specific label was not the point. My project was more
about listening to individual stories and starting to see patterns in biomedicine that
affected the interviewees in similar ways. Though chapters three and four focus on
certain themes, the interviewees brought up numerous more key examples and ideas that I
was unable to present due to limitations of time and space limitations. I am so grateful to
those who shared their experiences with me. I have come to respect physicians more
since entering into this project. I now recognize how the power structure in which they
work imposes limitations on them, and yet they continue on.
Introduction

Stepping into the emergency room at Bellevue Hospital in New York City, one sees patients from practically every ethnicity, socioeconomic class, gender, race, and sexual orientation. The summer I spent volunteering there I witnessed both the most horrific and most beautiful sides of human interactions in my life. All of this took place in the orderly chaos and unique cultural setting of a public hospital. Physicians and patients alike often found themselves frustrated, misunderstood, and feeling disrespected. This work is the product of reflecting on the interactions that result from the intersection of culture, health, and the human body – where narrowly defined ideas and preconceptions often collide.

As the patient population in the United States becomes increasingly diverse the biomedical establishment, commonly referred to as the medical profession, has created a tool for making these cross-cultural encounters more ‘successful.’ Likewise, there is a growing emphasis on the need to bridge the gap in health disparities between different racial and ethnic populations. The proposed idea to teach physicians how to be ‘culturally competent’ practitioners by expanding their awareness of ‘other’ cultures by increasing their knowledge base, communication skills, and understanding of others. Advocates hope that successful implementation of these skills will increase efficiency and improve patient satisfaction and compliance, which will eventually translate into better health outcomes.

Currently, the spotlight within the biomedical establishment and related fields of academia is turning to the topic of how to create ‘culturally competent’ physicians. Enormous amounts of resources are being directed towards this movement due in part to
the new official requirement\(^2\) that American medical students demonstrate an understanding of diverse cultures and how that affects perceptions of illness and health. As critiques are exchanged and new curricula are put together, the movement continues to evolve rapidly. While understanding how necessary such programs are in biomedical education, I continue to wonder: “Why is everyone so invested in this topic when there are so many other issues in health care that are in dire need of attention?” A plausible answer is that cultural competence is the biomedical establishment’s bandaid for larger social issues that they are either not ready, willing, or able to address. This in turn allows the underlying structure that perpetuates inequality and power imbalance to stay intact. Instead of looking at reasons for inequality in health care such as social stratification, lack of adequate social policy, and more efficient physician reimbursement methods, cultural competence movement has emerged as a technical fix for the problem.

This thesis is not presenting an argument against cultural competence education, nor do I mean to attack the integrity of the American biomedical establishment. Rather, I am attempting to understand what is happening below the surface that keeps such programs from achieving the goals officially set out for them. I am convinced that examining the unintentional side effects of such curricula shed light on how the project functions, and subtly or not so subtly, maintains authority and power. The following pages introduce the theoretical framework and points of reference that function as the backbone of the thesis.

\(^2\) The Liaison Committee on Medical Education set a new requirement for medical schools in order to provide better care for diverse patient populations. Refer to Chapter 1, pg 18.
In The anti-politics machine: “Development,” depoliticization, and bureaucratic power in Lesotho, James Ferguson write about how development experts diagnose the ‘problem’ of Lesotho in superficial terms so that it is within their scope of power to fix, instead of looking at the political economy involved in creating poverty. Ferguson also notes that development programs may be implemented with certain stated intentions that are quite different from the result they actually achieve.

Furthermore, Ferguson argues the structure of the institution carrying out the projects may produce adverse side-effects. He examines how interests “can only operate through a complex set of social and cultural structures so deeply embedded and so ill-perceived that the outcome may be only a baroque and unrecognizable transformation of the original intention” (1990: 17).

Ferguson’s introduction refers to Foucault’s genealogy of the prison. According to Foucault prisons were created as a space for criminals to become ‘normal,’ law-abiding, and hard-working citizens who can transition smoothly back into society. Yet prisoners have difficulty being accepted back into society, are more likely to return to prison, and are labeled ‘delinquents.’ Foucault’s point is that while this may seem like failure to the planners, if considered in terms of a different “strategy,” it was successful. As, “For the constitution of a class of ‘delinquents,’ Foucault argues, turned out to be very useful in taming ‘popular illegalities’ and transforming the political fact of illegality into the quasi-medical one of pathological ‘delinquency’” (Ferguson, 1990: 20).

Ultimately what this example points to is, “that planned interventions may produce unintended outcomes that end up, all the same, incorporated into anonymous
constellations of control – authorless ‘strategies,’ in Foucault’s sense – that turn out in the end to have a kind of intelligibility” (Ferguson, 1990: 20).

This analysis can be applied to the case of cultural competence education. Planners have the best intentions, but due to the larger social and cultural context of the American biomedical establishment, cultural competence is liable to reproduce the following power dynamic: Othering the patient, distancing the patient from the physician, and pathologizing culture. As Ferguson points out,

intentional plans are always important, but never in quite the way the planners imagined. …intentional plans interacted with unacknowledged structures and chance events to produce unintended outcomes which turn out to be intelligible not only as the unforeseen effects of an intended intervention, but also as the unlikely instruments of an unplotted strategy. (pg 21)

Ferguson refers to an “unplotted strategy” which in the case of cultural competence education mask other biomedical or social issues. In creating unintended side-effects, cultural competence education ends up drawing attention away from the very things that may in fact be contributing to health disparities. If one of the main purposes of cultural competence is to ostensibly help decrease health disparities, then the irony is that cultural competence programs allow the biomedical establishment to ignore the institutionalization of power that creates the barriers that perpetuate health disparities. Taking a step back, it is also important to acknowledge that the biomedical establishment exists in the context of American society and therefore those in the biomedical field are not spared from the cultural influences of Western society and all the discrimination that has been historically ingrained in its citizens. Therefore, cultural competence education is taking place within the matrix of power structures of the biomedical establishment as well as American society, which in turn influences the programs in different ways that are often left unrecognized.
One example of an unintended side-effect of cultural competence education that subversively helps certain power dynamics to continue is naming culture as ‘the cause of the problem.’ In *Stories in the Time of Cholera: Racial Profiling During a Medical Nightmare*, Charles Briggs and Clara Mantini-Briggs refer to how the *indígenas* (indigenous) culture and therefore population gets ‘blamed’ for a cholera epidemic in Venezuela. In identifying the problem as an epidemic that occurred due to *indígenas’* cultural practices, the government, public health department, epidemiologists, and biomedical establishment alike were able to transfer responsibility and locate ‘the problem’ outside their own purview. They therefore denied their own complicity in perpetuating the larger social context and circumstances that led to the outbreak. As Briggs states,

> the health education programs provided public health and other institutions with a powerful screen memory that hid not only their own role in creating the conditions that fostered such high rates of morbidity and mortality—and deplorable everyday conditions—but also the role of national and international political-economic forces. –pg 119

In this way, the idea of culture can be manipulated to explain the health problems that result from social phenomena such as racism, sexism, classism, and heterosexism. Sometimes the manipulation may be intentional, sometimes not. Cultural competence education itself is a vital part of medical education, yet at present, people within the biomedical establishment sometimes use culture in a similar fashion, a way of ‘explaining’ social injustices and power inequality.

In his essay titled “Insurgent Multiculturalism and the Promise of Pedagogy,” Henry A. Giroux points out that ‘culture’ should be recognized as a power structure that racializes relational dynamics. Though Giroux speaks mainly to issues of race, his
analysis is applicable to all sources of discrimination and power imbalance (such as socioeconomic class, gender, sexual orientation, and ethnicity). It is important to recognize that the biomedical establishment claims the power to name what is normal and what is Other, what is healthy and what is unhealthy thus in need of biomedical ‘help.’

As Giroux states,

Differences in this sense must be understood not through the fixity of place or the romanticization of an essentialized notion of history and experience but through the tropes of indeterminacy, flows, and translations. In this instance, multiculturalism can begin to formulate a politics of representation in which questions of access and cultural production are linked to what people do with the signifying regimes they use within historically-specific public spaces. –1994: 339

Cultural competence education is developed within this social structure and the culture of biomedicine and thus it can reflect the culture’s unintentional racializing of people, problems, and the concept of culture itself. Biomedical control and blame are displaced by taking Others out of their cultural and historical context and putting them into a power-laden framework of understanding.

Using the themes presented by Ferguson, Briggs, and Giroux as a launching point, the following chapters will examine how these theories apply to cultural competence based on primary literature and physicians’ experiences. The first chapter will look at the history and discourse of cultural competence in order to contextualize the subject and understand how the language and approaches reflect historically situated ideas. Building on this, the second chapter will focus on debates in current academic biomedical literature regarding the shortcomings of cultural competence and the direction in which such programs need to go. The third chapter will center around the data collected from interviews with medical students, residents, and experienced physicians about their opinions and their peers’ attitudes toward cultural competence classes. The fourth
chapter will go more in-depth into the interviews by looking at how physicians perceive and experience the culture of biomedicine and how it affects the implementation of cultural competence education programs. Finally, I will conclude with how cultural competence serves as lens to examine the culture of biomedicine and the implications for what is necessary for future programs to succeed.
Chapter 1: 
The Purpose of Cultural Competence Education

As the US patient population is becoming increasingly diverse, more attention is being given to the need for US physicians and other health care providers to learn engaging methods of communicating with their patients. Though patient-physician communication has been written about and studied within medical schools for decades, the idea of cultural competence only entered into the biomedical arena over the past twenty years, especially in the fields of children’s mental health, psychiatry, and nursing (Ochoa et al., 2003; http://gucchd.georgetown.edu/nccc/; Cross et al., 1989; Suh, 2004; Vega, 2005).

This chapter explains why cultural competence is important and how it has evolved. The first section focuses on reasons why cultural competence education matters within the biomedical field. Building upon this, the next section will look at racial and ethnic health disparities and the implications for cultural competence education in helping decrease such disparities. The following section will outline major concepts about the dynamic interaction between culture and biomedicine introduced by medical anthropologist, Arthur Kleinman, which are used by most cultural competence courses and commonly referred to in academic literature (Tervalon & Murray-García, 1998; Fox, 2005; http://www.medscape.com/viewarticle/513607; Tervalon, 2003; http://www.calendow.org/reference/publications/pdf/cultural/TCE0217-2003_A_Managers_Gui.pdf; Denberg et al., 2003; http://www.ahec.hawaii.edu/lit.htm; Betancourt, 2003; http://www.amsa.org/programs/gpit/cultural.cfm; Kleinman et al.,

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3 I was unable to locate information about the specific history of the cultural competence movement.
The final section will look at past and present cultural competence curricula to examine how they have evolved from a ‘cookie-cutter’ stereotype-based curriculum to more current approaches that attempt to address the flexibility of culture, and more than just learning about the ‘patient’s culture.’

Reasons Cultural Competence Education Matters

The overarching goal of cultural competence or cross-cultural education is to provide the most appropriate and sensitive care that meets the healthcare needs of the patient no matter what the patient’s race, ethnicity, gender, sexual orientation, or spoken language (Betancourt et al., 2005). A commonly quoted definition of cultural competence is taken from Terry Cross and colleagues’ article “Towards a Culturally Competent System of Care: Vol. 1” (1989).

Cultural competence is 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. The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, or religious group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural difference, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. (Cross et al., pp. iv. and v.)

While Cross and colleagues created this definition in the context of children’s mental health, it has been widely adapted in cultural competence literature, curricula, and online resources.

Cultural competence education is important for multiple reasons. First, it is important for physicians to understand that patients may interpret their symptoms and illness differently from biomedical physicians, which Arthur Kleinman refers to as the
differences in explanatory model (Kleinman, 1980). Differences in explanatory models can lead to communication barriers and ultimately limitations in the amount of biomedical care given to the patient (Kleinman, 1980). This is linked to another cause for attention to cross-cultural education: the inability to communicate with and provide adequate care to patients due to sociocultural differences can lead to low patient satisfaction and adherence to the prescribed regimen, resulting in poorer health outcomes (Betancourt et al., 2005; Weissman, 2005).

One of the major factors currently emphasized in biomedical academic journals are the health disparities observed according to socioeconomic status and race (Kawachi et al., 2005; Green et al. 2002). Statistics show that there is a health gradient, meaning the lower one’s social status, the poorer one’s health and the higher an individual’s social status, the better health they enjoy (Kawachi & Kennedy, 2002). Data has also shown that there are “striking disparities in health based on race and ethnicity even when corrected for socioeconomic status and other factors” (Green et al. 2002: 193). Cultural competence education is viewed as a means to help decrease health disparities and improve health outcomes (Smedley et al., 2003; Green et al, 2002; Brach and Fraser, 2000).

4 At the same time it important to acknowledge that ‘adherence’ and ‘compliance’ are more complicated issues that involve power in the patient-physician interaction. One interviewee referred to the necessity to recognize the physician’s own ‘agenda,’ which usually involves having the patient choose the biomedical regimen the physician sets out for the patient because it is expected to be the most ‘effective’ treatment (interview 29). The scope of this thesis does not cover the topic of biomedical authority within the context of ‘compliance,’ but it is deserving of more attention in another paper.
Cultural competence is important on an institutional level as well. Currently there are accreditation standards for medical schools set forth by the Liaison Committee on Medical Education stating that,

The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient.

(http://www.lcme.org/standard.htm)

Despite these new regulations, in the year 2000, only one medical school out of 125 had a separate class designated for cultural competence (Suh, 2004). Some academics have also started to recognize the need to implement such programs not only for clinical practice but also on the health services management level in order to decrease health disparities (Dreachslin et al., 2004).

Health care management organizations and companies that provide insurance for physicians are also starting to emphasize cultural competence training for the physicians they cover as a “business and quality imperative” (Betancourt et al., 2005: 500). In an article by Joseph Betancourt and colleagues examining managed care, government, and academic perspectives on cultural competence, the authors found that managed care “informants” thought that cultural competence may improve health outcomes and “help control costs by making care more effective and efficient” (Betancourt et al., 2005: 500). Betancourt and colleagues also presented the health insurers’ perspective of marketing cultural competence as a means of increasing the “member market share” (Betancourt et al., 2005: 500. Simultaneously, in reference to the applicability of cultural competence training for staff physicians of managed care organizations, the companies “acknowledged resistance to training, given providers’ perception of cultural competence
as a ‘soft science’” (Betancourt et al., 2005: 500). In order to convince physicians to take cultural competence initiatives more seriously, managed care organization informants “recommended that training be standardized and evidence-based” (Betancourt et al., 2005: 500). In terms of motivating physicians, according to the American Medical Student’s Association, the “Michigan Physicians Mutual Liability company underwrites malpractice policies so that doctors receive a 2-5% premium reduction if they take a seminar on cultural diversity” (http://www.amsa.org/programs/gpit/cultural.cfm).

Racial and Ethnic Disparities in Health Status

In 2003 the Institute of Medicine (IOM) published Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, a collection of studies assessing the quality of care U.S. racial and ethnic minorities as well as non-minorities receive. The U.S. Congress requested the IOM to carry out an assessment and evaluation of sources of racial and ethnic disparities in health care, which includes discrimination, stereotyping and bias at the physician or patient, institution, and health system levels (Smedley et al., 2003). In addition, Congress asked the IOM to provide recommendations for methods to eliminate health disparities (Smedley et al., 2003).

The comprehensive report points to evidence of racial disparities through a literature review. While one would hope that disparities are decreasing, some are actually increasing: for example the average life expectancy of an African-American man in 1960 was 61 compared to his white counterpart at 67 years. In 1996 the average life expectancy of an African-American male was 67, while the average for the white male was 74 years old, an increase of the gap to 7 years from 6. Research has indicated a racial difference in types of care received in cardiovascular related problems (Smedley et
al., 2003). Likewise racial disparities in distribution of coronary revascularization procedures have been associated with higher mortality rates among African Americans (Peterson et al., 1994). Similarly, differences in the care African Americans receive compared to whites have been connected to higher death rates for African Americans in other diseases such as cancer (Smedley et al., 2003). Higher death rates amongst ethnic minorities have also been noted for diseases such as diabetes, end-stage renal disease, and kidney transplantation (Smedley et al., 2003). Also, African Americans are less likely to receive antiretroviral drugs for HIV compared to non-minorities (Moore et al., 1994). At the same time African Americans are 3.6 times more likely than whites to be subject to amputation (Gornick et al., 1996). As pointed out by Smedley and colleagues, though these studies highlight health disparities, they are limited to the comparison of African Americans to white Americans.

In light of the health disparities that exist and are shown through such statistics, several interventions are recommended in *Unequal Treatment*, including systematic strategies implementing policies and changes in the health care system, patient education and empowerment, and cross-cultural (cultural competence) education. While Smedley and colleagues recommend implementing cultural competence education in undergraduate (medical school) and graduate medical education (residency), there is very little literature about the extent that it is currently (as of 2001) taught in medical school curricula (Smedley et al., 2003). Part of the difficulty of carrying out the recommendation is the lack of a standardized curriculum within the cultural competency movement (Vega, 2005). Also, while there have been recommendations of using cultural competence education as a means for decreasing health disparities, critics argue that
current application of such curricula and research of the subject remain quite vague (Dreachslin et al., 2004; Brach and Frasier, 2000; Betancourt, 2004).

Although there is not one set standard for cultural competence curricula, a common point of reference is the work of psychiatrist and medical anthropologist Arthur Kleinman. In the 1970s he published an influential book on the connection between culture, health, and illness through his research in Taiwan and later China. While Kleinman’s work is influential in the fields of medical anthropology and social medicine, individuals in those fields have been discussing the importance of the link between culture and health before Kleinman’s work. I have chosen to provide an overview of the major points of his work because he is the most cited within cultural competence literature and programs.

Arthur Kleinman and the Foundation of Cultural Implications of Health and Illness

*Illness vs. Disease*

One could say the beginnings of cultural competence curricula started with anthropologists and sociologists highlighting the importance of recognizing how culture affects biomedicine and patient-physician interactions. In his 1978 article co-authored by Leon Eisenburg and Byron Good, Arthur Kleinman refers to the differences between disease and illness and how confusion between the patient and physician occurs when the patient’s understanding differs from the physician’s. Disease is something treated, “in the Western medical paradigm [as] malfunctioning or maladaptation of biological and psychophysiologic processes in the individual; whereas illness represents personal, interpersonal, and cultural reactions to disease or discomfort” (Kleinman et al., 1978: 252).
As illness is identified and experienced within a social structure, it is therefore culturally constructed. The individual perceives and copes with the illness and subsequently takes on the ‘sick’ role within the context of how illness is defined and shaped. (Kleinman et al., 1978). Kleinman says that western medicine tends to look for and treat the disease while overlooking illness (Kleinman et al., 1978). But for the patient, the illness may be more significant than the disease itself. It is this disjuncture that can lead to confusion as well as patient dissatisfaction and distrust of physicians. Kleinman emphasizes the need to pay attention to both illness and disease and therefore to both the idea of healing and curing (Kleinman et al., 1978). In order to communicate effectively with the patient, physicians need to look at social and cultural meanings and their influences on illness.

**Clinical Reality**

The clinical reality, as Kleinman refers to it, is also culturally constructed through designated institutions and practices that are meant to find out ‘what is wrong’ with the patient. The patient’s understanding of her sickness constitutes her reality, which is culturally shaped. Likewise, the clinical reality exists in the context of the culture of biomedicine. It is through a set of actions shaped by biomedical practices such as the patient interview, diagnosis, and prognosis that the physician experiences and interacts with the patient.

For particular episodes of sickness, different domains yield explanatory models that are used clinically to ascertain what is wrong with the patient and what should be done. Through diagnostic activities and labeling, health care providers negotiate with patients’ medical ‘realities’ that become the object of medical attention and therapeutics. We shall refer to this process as the cultural construction of clinical reality. It is crucial to recognize that patient-doctor interactions are transactions between explanatory models, transactions often involving major discrepancies in cognitive content as well as therapeutic values, expectations, and goals. Clinical realities are thus culturally constituted and vary
cross-culturally and across the domains of health care in the same society. Social and economic factors influence clinical reality, but we focus here on its cultural determinants. (Kleinman, 1978: pg 254)

In this manner the clinical reality is shaped through cultural practices and creates the physician’s own framework of understanding sickness.

British medical anthropologist Cecil Helman refers to a similar definition of disease and how it may differ between the physician and patient. In Culture, Health, and Illness Helman points out how “phenomena relating to health and sickness only become ‘real’ when they can be objectively observed and measured under these conditions” (Helman, 2000: 79). In becoming a physician one is enculturated into biomedicine; as Leon Eisenberg states, “models ‘are ways of constructing reality, of imposing meaning on the chaos of the phenomenal world’ and once in place, models act to generate their own verification by excluding phenomena outside the frame of reference the user employs’ (Helman, 2000: 80).” Using the biomedical explanatory model as a point of reference, physicians must “‘decode’ a patient’s discourse by relating symptoms to their biological referents in order to diagnose a disease entity” (Helman quoting Byron Good, 2000: 80). Thus relating to the patient is limited to understanding him or her through the biomedical framework unless the physician is trained to comprehend the patient’s own culturally constructed perspective that can often differ from the clinical reality. It is important for physicians, as they approach patients, to understand that,

The ways that lay and medical EMs [explanatory models] interact in the clinical consultation are influenced not only by the physical context in which they occur (such as a hospital ward, or doctor’s office), but also by social class, gender, and age of the two parties involved. The power invested in clinicians by virtue of their background and training may allow them to mould the patient’s EM to make it fit into the medical model of disease, rather than allowing the patient’s own perspective on illness to emerge. (Helman, 2000: 86)
Part of being culturally competent requires not only recognition of the clinical and patient’s reality, but the power difference that occurs within the interaction. This will be expanded upon in the following chapter.

**The Explanatory Model**

Kleinman refers to the explanatory model (EM), which is how an individual explains and finds social meaning in the experience of a particular episode of sickness (Kleinman, 1980). The point of miscommunication or misunderstanding may be the result of the variation between the patient and physician’s explanatory models. Kleinman makes a point of recognizing that an individual’s explanatory model is not static and has a “multiplicity of meanings, frequent changes, and a lack of sharp boundaries between ideas and experience” (Helman quoting Kleinman, 2000: 85). It is crucial to acknowledge the social and cultural context of the individual’s explanatory model because it influences how someone interprets and reacts to sickness. In order to understand the patient’s expectations of the biomedical interaction and the end results, the physician needs to try to understand the patient’s explanatory model. Kleinman especially emphasizes how acknowledging the patient’s explanatory model is an effective way to gain understanding of someone’s cultural practices or at least how the patient’s social context might be contributing to certain behavior.

Kleinman writes about a 60 year old white Protestant female patient whose family worked in the plumbing business. She kept inducing vomiting and urinating frequently in her own bed. The hospital staff were confused and frustrated by her behavior and sent her in for a psychiatric consultation. Upon asking the patient why she was behaving in the manner she was and what it meant for her, she explained that she was told by the
team taking care of her that she was in the hospital due to ‘water in the lungs.’ She had a concept of two pipes leading out of the lungs and so she was trying to get the water out of her lungs through vomiting and urinating it out of her system. Once the team understood her logic, they were able to communicate to her what their understanding of the body was—that it was much more complex and that the proper steps were being taken so that she did not have to induce vomiting. This is just one example of how the patient’s explanatory model of her sickness and body may differ significantly from the physician’s and why it is important to understand what the patient’s thinking is.

In order to facilitate clearer communication, Kleinman created eight key questions for physicians to elicit the patient’s explanatory model (Kleinman, 1980). These are meant to facilitate a greater understanding of the patient’s perception of her sickness as well as to recognize expectations in order to facilitate smooth communication and compliance. Part of the function of the questions is to also help the physicians note their own ideas and clearly communicate their frame of understanding of the sickness to the patient.

1.) What do you think has caused your problem?
2.) Why do you think it started when it did?
3.) What do you think your sickness does to you? How does it work?
4.) How severe is your sickness? Will it have a short or long course?
5.) What kind of treatment do you think you should receive?
6.) What are the most important results you hope to receive from this treatment?
7.) What are the chief problems your sickness has caused for you?
8.) What do you fear most about your sickness?

Upon eliciting the patient’s explanatory model, it is also important for the physician to let the patient know her answers to the questions. This opens up the lines of communication. Gaining understanding of the other person’s perceptions of the situation creates a
launching point for negotiating care and recognizing what the patient and physician’s goals are in terms of treatment and outcome.

Reflections on Past Approaches to Cultural Competence

In the past, cultural competence was seen as knowing about a patient’s culture through a set of characters or “facts,” often stereotypes, assigned to a particular racial or ethnic group (Smedley et al., 2003). In a few cases, similar methods of memorizing a set of information about a specific population are still the main approach (http://www3.baylor.edu/~Charles_Kemp/welcome.html). As just one example, a textbook entitled Transcultural Health Care: A Culturally Competent Approach published in 1998 is separated with a chapter designated to each respective ethnic group including African Americans, the Amish, Appalachians, Arab-Americans, Baltic-Americans, Brazilian-Americans and the list continues on (Purnell and Paulanka, 1998). Each chapter breaks down the culture and values of the designated group in a quite comprehensive fashion ranging from common foods and folk practices to blood transfusion and organ donation. In the health-seeking beliefs and behaviors section in the African American chapter the authors relied on a study conducted in 1974 as their source on three major themes emphasized in the African American belief system:

1. The world is a very hostile and dangerous place to live.
2. The individual is open to attack from external force.
3. The individual is considered to be a helpless person who has no internal resources to combat such an attack and therefore needs outside assistance.

These assumptions are not only shocking and steeped in racist notions about how African Americans think, but also attributes quite dramatic ideas to the entire population. This is just one example taken from one of the more recent publications, which continues to
break down culture and belief systems into uncomfortable assumptions that are grossly over-simplified. Past materials presented ideas in an even more overt stereotyping of populations, but there is little point in quoting the endless methods that believed they were increasing culturally sensitive knowledge through essentializing and compartmentalizing populations in such a manner.

The method of becoming more “knowledgeable” about particular cultural practices designated to a population has been criticized more recently as defining culture as static (Taylor, 2003; Tervalon, 2003). An obvious problem with a more dynamic approach to culture is that it would be unfeasible due to the sheer amount of information a physician would be required to learn (Denburg, 2003). Also, one cannot attempt to “own” a culture by learning a set of definitions or behavioral rules that supposedly apply to a certain population. Memorizing a list of traits is not only inadequate, but also inappropriate to simply take the approach of learning a “piece” or “artifact” of culture here and there and claim cultural competence. Such behavior reinforces stereotypes by encouraging physicians to make assumptions based on the appearance or ethnic identity of the patient. The ‘learn a list’ approach also denies the dynamic interactions between individuals, their environments, and experiences that allow for fluid personal and cultural identities.

Lumping people together who share one similarity ignores how dynamic culture and identity are (Wear, 2003). An example is a patient who is an older male Chinese immigrant who speaks a limited amount of English and lives in a predominantly Asian urban neighborhood being labeled and ‘read’ as “Chinese” and therefore being categorized as having the same or similar cultural views as a young, queer identified
female Chinese American who was born and raised in the US and has lived in predominantly white suburban neighborhoods. In this way, being prepared to visually identify and act on someone’s ethnic background is not the most appropriate way to relate to patients. It could actually have a negative effect on patient-physician relationships and interactions in that it may offend patients to have physicians make certain assumptions about them. Such “culturally competent” practices could also affect the physician’s choices in the treatment for the patient, possibly leading to a poorer health outcome.

Instead of being a certain body of knowledge that has a “discrete endpoint,” cultural competence, as defined by Melanie Tervalon and Jann Murray-García, should include humility and commitment to “a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves” (Tervalon, 1998: 118). This approach has been adopted to a certain extent in widely used curricula (http://www.amsa.org/programs/diversityres.cfm). The following chapter will expand on the debates regarding different approaches in cultural competence curricula.

Cultural competence programs which incorporate ideas similar to Kleinman’s concept of explanatory models and clinical reality coupled with appropriate discussion of the history of racism, sexism, and heterosexism within the U.S. could create a deeper awareness in physicians that could ultimately lead to a decrease in health disparities. Yet in their current state, the curricula offer limited sources and facilitation of recognizing one’s own explanatory model and still focus mostly on the patient’s culture as defined by a few select specialists. It is ironic how cultural competence is meant to assist in decreasing health disparities, when at the same time many currently used approaches end up reinforcing institutional racism.
Chapter 2:  
Current Debates and New Approaches to Cultural Competence Education

This chapter introduces the current discussions occurring in academic medical journals regarding the direction in which cultural competence education should head. There are numerous articles both online and in journals raising interesting questions about how to improve cultural competence education, and even more articles and editorials published about the importance of cultural competence programs. In this chapter I focus on my sense of key ideas for changing cultural competence education.

The first section on current basic concepts of cultural competence education will briefly summarize three of the most common approaches and is meant to reflect the vast majority of the literature on cultural competence in medicine. Most of the cultural competence literature revolves around how to make materials accessible and applicable to clinical settings in order to constructively change physicians’ behaviors. The literature maintains a safe distance from addressing the social power structures that actually help perpetuate static notions of culture and place blame on ‘culture.’

The second section on contextualizing the patient and physician’s social location will examine the main critiques of the cultural competence movement that I believe are important. Using the critiques as a foundation, I examine the discourse of cultural competence and how it contributes to the ‘unplotted strategies’ that result from its application, such as maintaining biomedical authority through distancing the patient and blaming ‘culture’ for patients’ health ‘problems.’ The push for locating the patient and physician in their social contexts is important not only in order to learn how culture influences individual understanding of health, but also how structural inequality and the discourse of cultural competence can lead to distancing the patient as the ‘other.’
The third section considers biomedicine as the ‘culture of no culture.’ Building upon the previous section’s topic of Othering, here I examine how biomedicine is portrayed as having no culture. The section will focus on what gets legitimized in biomedical terms as ‘culture’ is seen as ‘subjective’ and in opposition to the ‘objective’ biomedical agenda. The power dynamics involved with the authority to legitimate some views and invalidate others is also addressed.

The fourth section on the politics of cultural competence education looks at organizational interests in implementing cultural competence education. The section examines health management organizations’ interest, the biased language biomedicine often uses in cultural competence programs, and the mixed messages the biomedical establishment sends out by claiming cultural competence education is important, yet not investing much more than policy. The section builds on the previous sections to demonstrate how biomedicine has the authority to define what is important and ‘necessary’ and what is expendable in medical education and ‘competence’.

The fifth section on the efficacy of cultural competence education will address the disconnect between constructive pushes towards improving cultural competence programs as represented in academic literature that I present, and studies demonstrating how much residents actually retain and apply in the clinical setting from what they learned in cultural competence programs. There are good points being made about how to improve cultural competence education. Still, there is a lack of emphasis on such programs in medical schools and residency programs.

Current Basic Concepts of Cultural Competence Education
Joseph Betancourt, a senior scientist for the Institute of Health Policy and program director of multicultural education at Massachusetts General Hospital, summarizes three conceptual approaches to cross-cultural education (Betancourt, 2003). The first is the awareness/sensitivity approach, which encourages providers to demonstrate professionalism through “humility, empathy, curiosity, respect, sensitivity, and awareness of all outside influences on the patient” (Betancourt, 2003: 561).

This approach is supposed to facilitate the development of humility and respect through “exploring the impacts of racism, classism, sexism, homophobia, and other types of discrimination in health care; determining whether producers have ever dealt with feeling ‘different’ in some way and how they have dealt with that; attempting to identify—using patient descriptors or vignettes—hidden biases the student may have based on subconscious stereotypes” (Betancourt, 2003: 562). According to Betancourt (2003), this method is used primarily in the early first and second years of medical school.

The second is the multicultural or categorical approach that emphasizes increasing the provider’s knowledge of cross-cultural issues. According to Betancourt (2003) the newer approach moves away from “if Mexican they believe this,” or “if patient is Hmong, don’t do that” and instead focuses on evidence-based factors such as incidence/prevalence rates among groups and historical factors that influence health.

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5 I was unable to find a syllabus for any medical school’s cultural competence curriculum and therefore do not know how reflective of medical school curricula Betancourt’s (2003) article “Cross-Cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation” is. However, it does reflect the academic literature I have read and also cultural competence programs as described on continuing medical education websites.
behaviors. Betancourt (2003) states that this approach is used throughout undergraduate medical education.

The third approach focuses on cross-cultural communication skills such as eliciting the patient’s explanatory model (Betancourt, 2003). The approach is based on being aware of particular social issues, cross-cultural issues, and health beliefs and then applying that information to the clinical interaction (Betancourt, 2003). This method is supposed to focus on the individual patient instead of applying broad rules and generalizations (Betancourt, 2003). Betancourt recommends the practicality in applying this approach to clinical years (Betancourt, 2003).

While this is just a brief summary of the main approaches to cultural competence, often taught in combination with each other, it reflects the vague terms used to describe cultural competence programs. There is also a safe distancing from ‘culture’ that subtly comes through the language used, as cultural competence becomes an extra task, or to some—a luxury. Cultural competence classes only scratch the surface, which is a start, but does not address historical discrimination and power involved in biomedicine’s discourse of ‘culture.’

Contextualizing the Patient and Physician’s Social Location

Many cultural competence programs emphasize the need to understand the patient’s socio-cultural contexts and some even ask physicians to recognize their own social contexts, yet few actually address the political implications of such

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6 In the academic literature the four years of medical school is commonly referred to as undergraduate medical education. The following four years (though it varies by specialty) of clinical training once one receives her MD, called residency, is referred to as graduate medical training. Medical education is often thought of as ending in the first four years of medical school but usually continues for at least four more years of training.
contextualization (Crandall et al., 2003; Betancourt, 2004). Thus, a major recurring critique is the necessity to dig deeper and address the need for physicians to place themselves and the patient in a larger social, cultural, economic, and political context (Green et al., 2002, Suh, 2004; Wear, 2003; Singer, 1990; Kleinman et al., 1980; Denburg et al., 2003). As a vital part of a more holistic approach, physicians must understand their own social context as well as the patient’s social context, to acknowledge the power dynamics of their relationship, and to take action based on this knowledge (Green et al., 2002). Part of recognizing differences in a positive manner is to also realize what contributes to their formation. Therefore, “class, racial, and sexual stratifications of capitalist society, and thus national and global political economics must be the frame of reference for examining social relations relative to health and health care” (Singer, 1990: 180). Thomas Denburg and colleagues refer to this full context as the “social location,” defined as:

one’s position in society relative to others and is based on an amalgam of characteristics that include not only race and ethnicity, but also gender, age, immigration status, language(s) spoken, neighborhood of residence, length of time and number of generations in the United States, educational attainment, income, occupation, religion, and prior experiences within racism. (Denburg et al., 2003: 103).

In pointing out the importance of social location, Denburg and colleagues identify the need for physicians to recognize that biomedicine too has “a definite body of knowledge, set of practices, strengths, non-evidence-based biases, and inherent limitations” (Denburg et al., 2003; see following section on Biomedicine’s Culture of No Culture). Therefore cultural competence education is not only important for factors of communicating with immigrant and ‘minority’ patients, but is necessary in crossing communication barriers that span the physician-non patient relationship (Denburg et al.,
Cultural competence is needed as a means to communicate with all patients (Denburg et al., 2003).

Social location is also key to recognizing the social factors that may have brought a patient to his state of health and circumstances. In *Stories in the Time of Cholera*, Charles Briggs and Clara Mantini-Briggs demonstrate how if the larger social issues are not acted upon or even noted, then ‘culture’ ends up being blamed for the health outcomes that are a result of social issues.

When the concept of culture is used to characterize racialized populations, its capacity to essentialize, exoticize, totalize, and dehistoricize is powerfully unleashed, reducing complex social phenomena to timeless sets of premodern traits that purport to provide a self-evident and exhaustive interpretation applicable to all ‘bearers.’ Because cultural and overtly racial discourses are both capable of achieving these affects, even invocations of culture that are anti-racist can racialize populations effectively, and they wield their power without enabling target populations to make the sorts of appeals to liberal sentiment that would be prompted by overt public attributions of biological or intellectual inferiority. (Briggs, 2003: 314)

Briggs warns how certain discourses that claim to be anti-racist can inadvertently create politically loaded generalizations about specific populations’ ‘cultural’ practices. The discourse of ‘culture’ in cultural competence education can politicize bodies as problematic, distant, and seen as the ‘other.’

As a function of finding the patient and physician’s social location it is important to recognize how through cultural competence discourse, the patient is often turned into the ‘other’ to be studied and ‘figured out’ (Canales, 2000). This is another shift in cultural competence education: to take a more anti-racist and anti-Othering approach that requires self-reflection that assists the physician in addressing biases such as racism, classism, and heterosexism, in a more concrete fashion (Tervalon, 2003; Tervalon and Murray-García, 1998; Wear, 2003; Murray-Garcia et al., 2005; Crandall et al., 2003).
is important to address the “historical context of longstanding social inequalities in the United State” in order to “show students how the complex relationships of historical forces, economics, politics, geography, legal, and cultural systems affect health care delivery systems, influence health status, and shape health outcomes” (Tervalon, 2003: 572). Similarly it is necessary for physicians to recognize their social location particularly in the context of the patient-physician relationship so as to “re-examine and redirect their often-inappropriate assumptions of superior knowledge and their often-inappropriate exercise of power and control with regard to issues of culture and health care” (Tervalon, 2003: 574).

Physician Jann L. Murray-García, and colleagues (2005) provide step-by-step advice for dealing with the variety of reactions students may have when learning about white privilege, the history and social consequences of racism, and how white culture dominates biomedical culture. Though the authors specifically refer to white privilege specifically, their approach is also important in terms of biomedical privilege. It is necessary to help physicians recognize their social location in a professional context, which they are not used to acknowledging due to “lack of self-awareness, combined with the tradition of being the ‘studier’ and not the ‘studied,’ as ‘the unexamined privilege of the unnamed’”(authors quoting sociologist Troy Duster; Murray-García et al., 2005: 697).

If cultural competence does not take heed of such recommendations, it is in danger of allowing physicians to perpetuate the patient as the ‘other’ and ‘culture’ as something to be ‘owned,’ compartmentalized, and problematic. Murray-García and colleagues’ approach is important because it brings in issues of power and authority in
terms of what is ‘normalized’ racially speaking (i.e.: white seen as the norm) which then can be pushed further into questions of biomedical authority and what is considered ‘real’ or valuable in biomedical terms.

**Biomedicine’s “Culture of No Culture”**

Recognizing the social and cultural context of both the physician and patient entails the physician realizing her place within the culture of biomedicine, and the effects this culture has on the patient-physician relationship (Taylor, 2003; Murray-Garcia et al., 2005; Fox, 2005). The Othering process that can go on in cultural competence education not only distances the patient from the physician but also fails to address how biomedical culture influences the physician’s attitudes and explanatory model. There is a need for physicians to reflect on how they belong to this distinct culture and profession that “can be seen as a healing ‘sub-culture,’ with its own particular world view,” and how this affects the way they view the patient and the patient’s interpretation of an illness (Helman, 2000: 79). Janelle S. Taylor presents the notion of biomedicine seeing itself as “a culture of no culture” (Taylor, 2003: 555).

When considering the need to understand and respect another person’s culture, several questions arise: What constitutes understanding? Is it that simple to respect another person’s culture if it conflicts with one’s own ideas of ‘truth?’ Taylor examines the “confidence in the truth of medical knowledge that underwrites physicians’ special power to alleviate suffering” (Taylor, 2003: 556). Thus, “medical knowledge is understood to be not merely ‘cultural’ knowledge but real knowledge,” and so biomedical understanding is not questioned or introduced as a cultural framework in cultural competence curricula (Taylor, 2003: 556). Physicians need to get rid of the
notion of ‘culture’ as only applying to and influencing Others, which may include all patients.

The idea that biomedicine is acultural, and the bigger concept that science is objective, de-contextualizes the physician and assumes authority and normalcy on the part of the biomedical establishment. This leads to Othering and also places the ‘problem’ of miscommunication on the patient, who is perceived as being ‘different.’ The socially and culturally (biomedically) constructed norms, which physicians have come to know as reality and ‘truth,’ are put into question by patients more frequently today. Donald Joralemon states that the “most successful form of authority is that which rests on the willing consent of those under its domain” (Joralemon, 1999: 64). It is often when this authority is questioned or hindered that physicians feel uncomfortable with or frustrated by a patient, leading to miscommunication and misunderstanding that may be attributed to ‘cultural differences.’

Directly related to the discourse of ‘culture’ belonging to Others and biomedicine being acultural, Delese Wear presents a theoretical approach based on Henry Giroux’s concept of *insurgent multiculturalism*, which takes the emphasis off of learning about another’s culture, and instead focusing on how power is unequally distributed (Wear, 2003). Wear finds working towards developing a respectful attitude, cultural sensitivity, and behaving accordingly are ‘reductionistic,’ and ‘biologize’ “the cultural aspects of health, illness, and medicine” (Wear, 2003: 550). Instead of allowing the focus to remain on individual physicians’ or patients’ attitudes, it needs to turn towards the foundations of unequal power created and maintained by the larger structures and institutions, both governmental and biomedical (Wear, 2003). Such an approach goes far
beyond improving communication skills or increasing sensitivity, and spans into questioning the “power that allows some groups, but not others, to acquire and keep resources, which would also include the rituals, policies, attitudes, and protocols of the very institution educating them” (Wear, 2003: 551). Therefore, it is important to examine the authority behind defining ‘culture’ and to understand the function ‘culture’ has politically as a subtle method of control and legitimization of biomedical voices while repressing ‘subjective’ ones. This approach digs deep below the surface to examine not only the racism and biases that exist in patient-physician interactions but those that are interwoven into the medical institution, which serves as a reflection of larger American society’s unequal distribution of power that fosters discrimination and poor health.

It is interesting to reflect on how the discourse of ‘culture’ can legitimate some voices and silence others. ‘Culture’ is perceived as ‘subjective’ and therefore is not valid by the ‘objective’ perspective of biomedicine. ‘Culture’ is then pathologized along with the specific population it designates. In reference to a cholera outbreak in Venezuela, Briggs points out how the authority of public health officials’ scientific voice was perpetuated by the spread of media stories about how indigenas’ unhygienic lifestyle and general under nutrition led to their susceptibility to cholera.

These statements (indigenas were more susceptible to cholera and disease due to poor hygiene and under nutrition) medicalized the political economy of hunger, reducing it to a physiological mechanism, just as they presented morbidity and morality from all infectious diseases as a question of immunology. Any consideration of inadequacies within the health care system was erased. (Briggs, 2003: 220)

Thus ‘culture’ and those Others having ‘culture,’ are ‘medicalized’ or ‘pathologized’ in order to become controllable in biomedical terms.
Alexander R. Green and colleagues point out that cultural competence programs lack education about social factors such as socioeconomic status, “illiteracy, immigration experiences, religion, social stressors, and social support networks” (Green et al., 2002: 194). Thus, “failing to address these important areas risks inadvertently teaching future doctors to view culture as the explanation for what are fundamentally social issues,” a dangerous road to go down (Green et al, 2002: 194). It allows for the perpetuation of social inequality and institutionalized forms of discrimination by letting individuals avoid responsibility and instead dismiss the problem as ‘cultural.’ Thus, the unplotted strategies are those that help maintain structural inequalities. Ferguson (1990) uses the notion of the decentered conception of power as a means to analyze how power cannot be located in a person or place.

Using a decentered conception of power, a number of recent studies have shown how the outcomes of planned social interventions can end up coming together into powerful constellations of control that were never intended and in some cases never even recognized, but are all the more effective for being ‘subjectless.’ This theoretical innovation makes possible a different way of connecting outcomes with power, one that avoids giving a central place to any actor or entity conceived as a ‘powerful’ subject. (Ferguson, 1990: pg 19)

In this fashion cultural competence education can provide a crucial perspective for improving patient-physician communication and understanding, but in overlooking structural issues of power affecting both parties, the tensions will remain and be reinforced.

The Politics of Cultural Competence Education

Building upon these critiques, it is important to take a moment to re-examine the function of cultural competence education and the organizational motives behind its implementation that are not always obvious. As pointed out earlier, the academic literature emphasizes the need to improve communication in order to improve patient
compliance\textsuperscript{7} (Suh, 2004; Weissman et al., 2005; Smedley et al., 2000). While it may seem like a conspiracy theory, it is worth noting that skillful communication is also necessary for obtaining consent, which is a major legal and ethical factor. Also, according to academic literature, patient compliance is vital for gaining the expected biomedical health effects outcomes as well as diagnosing and treating patients in a timely manner (Betancourt, 2003, 2005). If patients do not take their medications because they either choose not to or do not understand how to take them, this leads to poor health outcomes by biomedical standards and increased costs on the medical system. Therefore, there are time, money, power, knowledge, and professional respect at stake.

Different institutions have various incentives for investing in cultural competence programs. From the managed care perspective, it is a matter of appealing to more customers, improving the quality of care in order to gain customer satisfaction, and controlling costs by increasing communication efficiency (Betancourt et al., 2005). The federal government’s interests revolve around cutting costs through decreasing health disparities by having culturally competent physicians (Betancourt et al., 2005). Thus, it is important to keep in mind that, “the motivations for advancing the issue of cultural competence—and the approaches different stakeholders are taking—vary depending on mission, goals, and sphere of influence” (Betancourt et al., 2005: 503).

There have also been formal critiques of the ‘hidden curriculum,’ or subtle messages cultural competence programs send to students. Melanie Tervalon, a

\textsuperscript{7} The idea of compliance is deserving of further examination and is presented as stated by academic literature. The function of presenting it in this manner is to demonstrate how cultural competence is used as reason to legitimize furthering the biomedical agenda without paying thorough attention to the power dynamics involved in the patient-physician interaction and even the use of the term ‘compliance.’
pediatrician, consultant, and teacher, points out that it is important for educators to check and point out the language used in reports of health status and differentiate between biological, cultural, and social classifications in biomedical research (Tervalon, 2003). The language itself used in medical literature can be discriminatory in nature, sending subtle messages about certain populations and establishing a connection between race and biological conditions that are actually a result of social factors (Turbes et al., 2002). Similar to the idea of Othering the patient, the language used and indirect messages sent through curricula may convince students that the Other is a burden by requiring more resources, whether it be translators or cultural competence program financing, which can lead to animosity towards the patient who requires ‘more attention’ than a ‘normal’ patient. This again can be linked to how ‘culture’ can be blamed for the health ‘burden’ of certain populations and subsequently pathologizes those populations.

Frederic Hafferty, a professor of behavioral science who has written about medical socialization since the 1970s, inspects the hidden curriculum that lies within the structure and learning processes of the biomedical education (Hafferty, 1998). Hafferty “asks educators to recognize medical education as a cultural process and therefore as something that is constantly buffeted by external forces and by problems of internal integration” (Hafferty, 1998: 404). Medical schools are sending messages about what is valued and is not valued through investing in certain kinds of research and designating specific classes as electives instead of requirements (Hafferty, 1998).

When applied to cultural competence education, it is important to note how much emphasis is put on these classes compared to other medical classes, the attitudes of the instructors that teach them, and the medical institution’s investment in such programs. It
is a form of exercising power to define what are the necessary knowledge and attitudes to
become a successful physician. Hafferty asks medical educators to “acknowledge their
training institutions as both cultural entities and moral communities intimately involved
in constructing definitions about what is ‘good’ and ‘bad’ medicine” (Hafferty, 1998:
404). In this way competence, or what is a ‘good’ physician, is socially constructed
within the biomedical establishment and often leaves cultural competence out of the
picture (see Chapter Four).

There is also a necessity for the biomedical establishment itself to become
culturally competent (Brach & Fraserirector, 2000; Dreachslin et al., 2004). Dreachslin
and colleagues (2004) review ways for reducing racial and ethnic health disparities based
on changes in public policy, clinical practice, and organizational behavior. Statistically
speaking, there is a need to employ more people of color within the health care system
within management roles if it is to be representative of the US population (Dreachslin et
al., 2004; Brach & Fraserirector, 2000).

Research on the Efficacy of Cultural Competence Courses

A common point of criticism is the biomedical institution’s lack of commitment
demonstrated towards cultural competence programs in terms of efficacy evaluation
(Betancourt, 2003; Price et al., 2005; Weissman et al., 2005, Brach & Fraserirector,
2000). Evaluating cultural competence curricula has proven a difficult task due to the
vast array of teaching material and approaches, but also because of variations in
evaluation methodologies that are not objectively comparable (Price et al., 2005).

To date, one of the most widely cited reviews of cultural competence has been
published by Joel Weissman and colleagues, who conducted a large survey of resident
physicians’ preparedness to provide cross-cultural care (Weissman et al., 2005). The authors collected self-response surveys from 2,047 resident physicians across the US from varying specialties (Weissman et al., 2005). The study found residents’ attitudes toward cultural competence education and their level of preparedness varied between specialty, with emergency medicine and general surgery residents significantly lacking in both respects (Weissman et al., 2005). This indicates that cultural competence education is emphasized and implemented to different degrees depending on the specialty (Weissman et al., 2005). Other findings indicated that there was little or no cultural competence training after medical school (Weissman et al., 2005). Furthermore, “residents indicate that they do not have the time nor the mentors to deliver effective cross-cultural care, and are not evaluated on their ability to do so” (Weissman et al., 2005: 1065).

Surprisingly, there was not a significantly higher level of preparedness among those trained in cultural competence compared to residents who had not been trained (Weissman et al., 2005). The authors note the “residual skepticism by the faculty regarding the value of cross-cultural care may complicate the successful administration of this challenging curricular development” (Weissman et al., 2005: 1066). Finally, the authors conclude that their findings “highlight a need for significant improvement in cross-cultural education to help eliminate racial and ethnic disparities in health care” (Weissman et al., 2005: 1066).

Senior scientists at the Institute for Health Policy and instructors at Harvard Medical school, Elyse Park, Joseph Betancourt, Joel Weissman, and colleagues (2005) conducted a more recent study on a smaller scale of residents’ perceptions of their
preparedness to provide culturally competent care. The data was collected through focus groups and personal interviews with 68 residents across the United States. In presenting the results, the authors propose looking at cross-cultural education as a two-step process where the residents first learn the cross-cultural frameworks-knowledge and professional attitudes, and then are taught to apply the “specific skills and practices in a time-efficient, ‘culturally competent’ manner” (Park et al., 2005: 879).

The residents the investigators interviewed only had a vague understanding of the meaning and standards of cross-cultural care despite receiving formal training. Instead most of their ‘cultural competence’ was gained through ad-hoc learning skills through interacting with patients (Park et al., 2005). The authors also point out how the residents had the sense that the biomedical institution endorses cross-cultural cultural care, yet the residents felt that there was inadequate support from the institution in residents’ pursuit of becoming ‘culturally competent’ physicians (Park et al., 2005). The residents in turn saw this as the biomedical institution implicating how low a priority cross-cultural education is as there was lack of support, evaluation, time, and resources invested in such programs (Park et al., 2005). Thus, residents expressed concerns about how “realistic it was to be able to practice ‘good’ cross-cultural care in today’s health care environment” (Park et al., 2005: 879).

The investigators conclude that the residents received mixed messages about cultural competence training as they were told, by the biomedical institution, and most believed, that such care was important…yet they received less than optimal education on this topic, perceived only a moderately supportive educational climate, and felt that even if they had been taught formally how to proceed, their clinic schedules provided little time to implement their training. –Park et al., 2005: 880
The authors end with the suggestion of further investigation of ways to overcome such institutional and systemic barriers in order to provide high quality care to diverse patient populations (Park et al., 2005).

**Conclusion**

This chapter has looked at several ideas about how cultural competence education needs to recognize and incorporate finding the patient and physician social location as a means of understanding power dynamics that affect the patient-physician interaction. As part of this, it is important for biomedicine to be aware of how it is cultural instead of examining and creating a discourse of ‘culture’ as something utilized to define and politicize patient populations. Charles Briggs uses,

> Arjun Appadurai’s rich phrase, incarcerated by culture—unable to escape the constraining effects of a rigid and narrow worldview—and institutions are taking advantage of this strategy for containing bodies and the politics of race. (Briggs, 2003: 314)

As Weissman and colleagues’ (2005) study and Park and colleagues’ (2005) study demonstrate, despite the academic literature that is proposing some new challenging concepts to incorporate into cultural competence education, there is a disconnect between the literature and the actual practice of it within biomedical educational settings. The question then remains of what is going on in medical schools and cultural competence programs that leads to this disconnect? Chapters, Three and Four, build on the critiques presented in this chapter as well as the studies on the efficacy of cultural competence education. The chapters are centered around data collected from interviews with medical students, residents, and other practicing physicians. The interviewees’ voices speak to the disconnect between the cutting edge critiques in the academic literature and what is actually taught and emphasized in medical schools’ cultural competence classes. In
doing so, the interviewees’ experiences and perspectives also demonstrate how ‘culture’
is seen as something deserving attention, but belonging to others and therefore
nonessential for actual biomedical competence.
**Chapter 3: Perceptions of Cultural Competence Education**

Building upon the critiques of cultural competence education in academic and scientific literature, this chapter will provide more personal interpretations, experiences, and thoughts on cultural competence programs and classes. The purpose of this chapter is to allow the voices of the interviewees speak for themselves, as a reflection of how the cultural competence courses did or did not affect them and their peers. Through looking at these reflections and opinions of individuals, the chapter brings the critique down to a personal level, highlighting constraints of the course, general student body sentiment towards it, and honest opinions about what is important. Chapter Four will examine what interviewees said about the culture of biomedicine. There is overlap between these two chapters as medical education helps form and enculturate students into biomedical culture, but this chapter focuses mainly on the actual topic of cultural competence education in the context of the medical school educational experience.

The first section looks at a few examples of cultural competence education curricula and the details of the classes taken by the interviewees. The second section presents the interviewees’ personal opinions as well as their peers’ thoughts about cultural competence classes. The final section contextualizes cultural competence in medical school curricula and examines why cultural competence tends to fall to the bottom of the list of priorities for students.

The data provides insight into a few individuals’ perspectives and is not meant to speak for all physicians, as the sample size is very small (10). There is, nonetheless, a lot of overlap in the sentiments and ideas about topics such as time constraints,
reimbursement issues, and medical education-specifically residency, hierarchy in biomedicine, and emotional distancing from patients and friends.

Methodology

The study consisted of a convenient sample. The sample “snowballed” from the first few initial interviews and recommendations from key contacts in the field of medicine. In order to keep complete confidentiality participant locations remain anonymous. There were a total of 10 interviews, eight interviews in person and two phone interviews. The participants were located across the United States. Two participants were medical students, two were resident physicians, and the remaining six participants were practicing physicians or fellows. Six out of the ten participants were women and two participants were people of color.

Interviews were open-ended and guided by questions focused on the participant’s medical training experiences, perceived changes in identity, differences in social interactions with non-medical people, hierarchy within the biomedical system (medical student, intern, resident, attendings), cultural competence education, patient-physician communication, and time constraints surrounding patient care.⁸

Interviews ranged from 30 minutes to two hours in length and all were audio recorded. Verbal consent was received from participants. The interviews were usually conducted in private offices, but some were done in cafes. The research topic was presented to participants as a qualitative study on the culture of medicine and cultural competence education. Participants tended to have a positive response to the topic initially and showed interest. Only one or two participants seemed uncomfortable or

⁸ For a list of general questions refer to appendix 1
irritated by the end of the interview due to questions posed during the interview. The general feeling was that participants were excited and relieved to finally talk about their medical training experiences and personal opinions about the biomedical system.

Due to the nature of convenient sampling and the small sample size, the data may be skewed towards those who may be a little more interested in the topic of biomedical culture than their peers. This is because the research topic was presented up front when asking for volunteers and also many participants expressed interest on the topic upon the beginning of the interview. At the same time, participants may have chosen to volunteer their time because a peer requested they participate in the study.

The interviews were very open-ended and therefore reflect what the physician thought was pertinent to addressing the research topic. In the process of allowing participants to share their stories and opinions, the format of the interview inevitably varied from person to person. This could pose a problem in that there was not one strict set of questions for the interview, which makes it difficult to compare the data across the board. At the same time, the variation in responses and different directions the interviews took speak for how each individual’s experience is unique and how biomedical culture has a profound effect on each person in different ways.

**Select Examples of Cultural Competence Classes**

All the interviewees were asked if they had any cultural competence education while in medical school. The variety of answers was a little surprising as they ranged from vague and contradictory responses such as:

I mean we had this ‘patient, doctor in society’ class, we took the whole year in the first or second year of medical school. It was the second year I think. And it was all about those touchy feely kinds of things. –interview 74
to details about a field trip:

There was a day our first year where we went to a Chinese sort of medical school in the Twin Cities. If you wanted you could have the different things done…and that was really interesting to experience those techniques and learn what they were first hand. So that was really interesting and I think people really liked that. I think that was mandatory. There was a bus and everybody spent the day there, and everybody went on that and everyone seemed to like that. –interview 84

Most physicians who had been out of medical school for several years struggled to conjure up memories of the “doctoring class that they have that kind of teaches you ‘everything else’ but really what it teaches you how to do effectively is communicate with patients” (interview 98). One fourth-year medical student painted the most vivid picture of one example of a cultural competence curriculum. As she described the class, she recalled how her peers came to dislike the cultural competence class due to a guest speaker insulting the class by saying that physicians are all really left-brained. The course she described included not only cultural competence material but biostatistics, researching medical literature, medical legal issues, Medicare, Health Management Organizations (HMOs), and how financing affects medical practice. She then continued to reflect,

And some of those things are just tedious to learn. It also was more cultural. We read the Spirit Catches You and You Fall Down. And we had different kinds of healers come in and talk to us. I remember sort of a shaman being there, and they’d brought in patients with different diseases. So there were also some very good things about ‘Physicians in Society,’ but the biostatistics, and some of the lecturers’ personalities made it the class that everyone loved to complain about. And then in year two you continue that class, and in year two there was a health disparities project, so you’re in a group. And you get assigned a topic like teen pregnancy in the Latino population, but basically different health disparity things. A lot of them relating [to] the Twin Cities, which has a Hmong population and the Somali population is really huge and so some of them are related with health concerns of those populations. So you’re supposed to go out into the community and find resources that deal with the problems in that community then write a paper about it, and come up with a project to combat the disparity. –interview 84
A physician recalled her experience of learning about ‘culture’ several years earlier while she was in medical school, and had a course called ‘Physicians in Society,’ which dealt with some of those issues. It was a course that spanned all four years of medical school. It was most intense the first and second years where it was every week. It dealt with a range of issues of social, cultural, and economic aspects of care in general. –interview 24

As pointed out, the classes varied in content but usually were comprised of a concoction of topics crammed into one class that touched on everything from pharmaceutical companies to reimbursement and insurance issues. Issues of cultural competence were scattered in between these topics, and not a single medical school the interviewees attended had a course solely dedicated to cultural competence. This demonstrates how medical schools are adhering to the Liaison Committee on Medical Education’s new accreditation standards requiring medical schools to teach students how to care for diverse patient populations, but have a great deal of leeway in how schools choose to comply.

Classes varied from a three hour seminar about culture included in a larger elective class that addressed other non-hard science topics to classes similar to ‘Physicians in Society’ and other all-inclusive courses that lasted up to four years of medical school. The courses usually started in the first year, which was also the most intensive year compared to following years, if the course continued beyond the first year at all. It was a bit surprising to hear the range of topics taught in the classes, such as physical exams. One physician responded to a question of whether he found the course useful by describing specific aspects he found useful:

That specific course...was pretty useful, especially in terms of learning how to do a physical exam, and thinking about how patients might feel or think about your interactions from a patient’s perspective, videotaping yourself and seeing
how we interacted with patients. So yeah, it was helpful. … Cultural competence was dealt with in that same general course, which [at his medical school] was called intro to clinical medicine. Cultural competence is a difficult one to teach because, I think, I mean there are so many cultures and in a city like L.A. you’re going to be exposed to people from all different cultures, and you also don’t want to stereotype people. We did focus on that a bit, but I think the underlying message that we got that they tried to convey was some humility and sensitivity. That’s kind of the bottom line I think in cultural competence, and then as you practice in certain settings you gain some understanding of things. – interview 29

As reflected in the literature, and in his response, the focus seemed to be on humility and sensitivity, though to what capacity it was emphasized is not quite clear. In the next section he also shares his opinion on how much humility he believed his peers and colleagues to actually have in practice.

One very perceptive physician who finished medical school many years prior was able to clearly recall what he learned from the course he took at one of the nation’s most prestigious medical schools.

Yes, we did [have a course addressing cultural competence]. And I was actually really appreciative of that. We covered some of Arthur Kleinman’s stuff on explanatory models and I think thinking about things in terms of Explanatory Model (EM) really helped. One is, we explored some non-medical EMs but then, it helped me to [understand] more about medical EMs and the fact that a lot of our EMs are unphysiologic. … We have explanations for things that just aren’t true and we use them because we need to explain what’s going on and we don’t have a better one or whatever the real one is, is too complicated. And what I sort of realized is we need something to hang our hat on, and we’re doing it all the time. We’re doing it just the same as the patient. Now there’s a little more sophistication, there’s a little more knowledge, there’s a little more understanding. I don’t want to say it’s all based on nothing, there’s a lot of ‘truth’ inherent in our explanations. But a lot of times we don’t know what is making something work or not work. So yes, we covered that. And yeah, I don’t have a whole lot to say about it actually. We covered it and I think that people were or weren’t receptive to it in medical school. And if they were, they thought it was cool. We covered all sorts of other interesting things: stages of change, this sort of transtheoretical model. We did some social science stuff and it was nice. You know at first I thought it was a little stupid, but as time went on, I realized how important it was when I started seeing patients. … You’re taught these things mechanistically at the beginning and hopefully that provides a little bit of a theoretical framework that you build your models in creating a good relationship. –interview 56
This physician had a particularly strong grasp of concepts introduced in cultural competence classes compared to all other interviewees. In that way I believe what he retained from the course throughout the years is an exception, which might be affected by his work in the field of public health. Several other interviewees who also had Masters in Public Health pointed out their approach and mentality towards biomedicine set them apart from most other physicians.

**Attitudes Toward Cultural Competence Classes**

The data I collected through personal interviews with medical students, residents, and physicians confirm Weissman and colleagues’ (2005) findings that there is a lack of enthusiasm towards cultural competence classes, lack of appropriate mentors and instructors, and a general need for improvement of curricula for achieving their goals. One interviewee (29) summed up the take-home message of cultural competence education that medical school tried to convey was developing a sense of humility and sensitivity (interviewee’s emphasis). Upon being asked if his colleagues ‘got the message’, he responded that:

> A lot of people don’t show that much humility. A lot of people have a difficult time being questioned by a patient on something. And in terms of cultural competence, I would say, in general, in practice, most physicians probably aren’t that good with cultural competence. -interview 29

Following this response I asked why he thought this was the case, and he replied in reference to his colleagues that:

> They tend to not dig too deep beneath the surface to see what’s going on for somebody, like what’s their social background, what’s their living situation like, what are their concerns, what are their worries, what parts of their life may be different than the physician assumes it is…[they need to be] looking at and trying to understand what might be going on with this patient, and physicians tend to

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9 Refer to Chapter Two for study details.
not, most doctors I don’t think tend to focus on that, and I can cite you literature on that. –interview 29

In an interview with a research fellow who sometimes serves as an attending physician, or head physician who oversees the resident physicians, I asked if there was an emphasis on cultural competence education at the medical school he attended. He said:

Not really, they certainly brought in at least the topic of treating different cultures through the doctoring class they had, it’s a longitudinal class they had that goes 3 years with the option to go 4 years. They had some standardized patients that were very culturally different that you had to relate to. –interview 98

Later on in the interview when I asked if he felt that cultural competence classes overgeneralized at times, he said:

A little bit. I don’t think any one person can know all different cultures, so you end up generalizing a lot.

This reply was followed by the question of whether the classes ever emphasize questioning one’s own assumptions, or if it is left out of the picture. He was prompt to respond that:

It’s kind of left out of the picture. No, I never remember anyone talking about your own assumptions, why you do this for one person and not another.
- interview 98

The faculty and instructors’ attitudes towards the curriculum can be vital to the success of the class and influence the students’ interest and enthusiasm towards it. When asked about the student body’s attitude towards the cultural competence course offered, one medical student responded:

I think there are different kinds of students. I think there’s a minority of students that get into it. I would say a quarter of people like it, well probably less than that. Then there’s a portion of people who probably would like it but their hands are tied by time constraints. And then there’s a portion of a few people who just really hate it. I felt the classes that were like that, I felt that the people needing it, were old school doctors trying to be in touch with their feelings and trying to cultivate self-awareness but who had actually been trained out of having self-awareness. I mean I wanted to go and I was really into it, and would try to go to it but I didn’t feel safe with the people facilitating it. I didn’t feel like they had
the self-awareness to sit with their own feelings. I guess what I noticed is that they’re encouraging you to make yourself vulnerable but you actually get attacked when you do it. Instead of just listening they try to counsel you out of feeling it. –interview 68

Another medical student spoke about her experiences in her cultural competence class in a similar example of how instructors’ attitudes and approaches can often hold the key to student interest levels.

It’s interesting because it was the class that everybody hated and it was the class that everybody skipped. Some of the sessions were really good. There was a woman who really insulted the class in her lecture and that kind of set a poor tone for ‘Physicians in Society’ for my class. She said something about how physicians are really left brained and not creative, and she really made this generalization. Everyone in the class was furious because everyone in the class had some type of English or philosophy or language major, and so they were furious that she was saying everyone was left-brained and weren’t philosophical. It made a lot of people mad and so people just kind of hated ‘Physicians in Society’ from that point on. …So there were also some very good things about ‘Physicians in Society,’ but the biostatistics, and some of the lecturers’ personalities made it the class that everyone loved to complain about. (interviewee’s emphasis)–interview 84

A common comment about the attitude of peers towards cultural competence classes was the lack of attendance as pointed out by the same medical student:

I rarely skipped ‘Physicians in Society’ but in second year I would say 75% of the class skipped ‘Physicians in Society.’ Occasionally, my class has 155 students, and so it’s just geared towards seating that many students, but then there’d only be 20 people in the room. And that’s so sad because they would work to get lecturers to come and then it would be a really poor turn out. So that’s just kind of frustrating I think. –interview 84

When I asked her about her peers’ general thoughts surrounding issues taught in cultural competence courses, she responded saying,

People would try to blow it off, but they would try to say that they didn’t find it worth doing because it wasn’t worth doing the material, they would say they couldn’t stand the class due to that one woman who made that comment or they couldn’t stand the class because they didn’t like the instructor, who was different from that woman who talked to us that one time. And there was some kind of feeling of I don’t need this because I am already culture-sensitive. I have a feeling that that…and I don’t know if that’s true or not, but there definitely was an attitude of I don’t need this class because I am already aware of all these issues. -interview 84
Thus, those who were interested were naturally drawn to the class and more often than not invested at least some time and energy to learn more. Yet it is likely and somewhat ironic that the students who most likely could have benefited from the course were not attending due to the idea that it was either unimportant or they were already adequately culturally sensitive.

Similarly, a physician who also does work in public health responded to the question of whether the student body at his medical school was enthusiastic or apathetic towards the course:

> It varied. Some people were interested in the stuff. But it was also the butt of a lot of jokes. Some of it was just so high faluting, you know, we had trouble understanding why it would matter. Particularly my colleagues who are more, just like, give me the scoop - down and dirty practical thing I need to know to pass my board exams, those people were probably not so interested in this and blew it off as much as they could. But that wasn’t universal. I would say there were a number of people that were interested in this stuff. I wasn’t interested in everything. I did the reading I liked. Some of it I did, some of it I didn’t. And some of it stuck. And the part that stuck I’m very grateful for, particularly because it gave you the ability not to judge. It gives you the opportunity to be what they talked about the participant observer, we did learn about that too. To not judge the patient. It doesn’t help to judge, you know, it never helps. You have to make decisions, but you won’t get [anywhere] clinically if you belittle, or you don’t even have to say anything you just have to act like you’re belittling and then the trust is gone. You really have to make sure they understand that you may not agree on everything but you’re there to help and if they don’t want to come back, they won’t come back. And that’s their choice. –interview 56

Again this physician applied the knowledge he gained from his course, including understanding the patient’s EM and his own biomedical EM, in an exceptional way that was not really reflected to the same extent in other interviewees’ responses.

In terms of usefulness, the responses varied from not useful at all to useful if anything ‘stuck.’ When asked if she thought the class was helpful, one physician who attended one of the top medical schools in the U.S. replied:
It was useful to hear patients, we heard a lot about patients’ perspectives of care, and to get to understand that perspective. I think that was the major usefulness of it. … There were certain aspects that were useful and certain aspects that weren’t, that I didn’t find specifically useful. It was a nice survey. It didn’t really go into depth on any one issue. –interview 24

Her response, as well as others, make one wonder just how much attention is being paid to cultural competence curricula as well as the learning environment medical schools are providing in support of the class.

**Mixed Messages from Medical Schools: Cultural Competence Falling to the Wayside**

Medical school seems to be sending a mixed message that formally emphasizes cultural competence yet in reality provides inadequate time for students to take such ‘touchy-feely’ courses seriously when the main focus of the curriculum is on basic science. This is not to say that medical school should be centered around cultural competence education, but in what Hafferty (1998) refers to as the ‘hidden curriculum,’ the medical school may be sending out messages that contradict one another, leaving little room for medical students to fully engage in the cultural competence class. The following quote exemplifies the confusion surrounding the significance of cultural competence education in medical school. When the physician was asked if she had any cultural competence courses at her medical school, she replied:

> You know, I think we did. I don’t remember them particularly, but I think we did. I don’t remember. It was so long ago. But I know that they emphasize that a lot in our medical school teaching. I think all the medical schools do. … I think I went. –interview 74

The response appears contradictory, with the help of a little lapse in memory, in that she cannot even remember if she took any cultural competence courses yet is able to clearly state there was a strong emphasis on it at not only her medical school, but all other medical schools as well. The interviewee who made this statement also had a Masters in
Public Health (MPH) and supposedly the MPH medical students “were all about understanding different cultures and working with communities and things like that” (interview 74). Though interviewees’ responses varied in terms of recalling details of their cultural competence courses, the general sense was a bit vague. Of the ten interviewees, the only one who could paint a vivid picture of their cultural competence course was a current medical student.

A common recurring challenge that the interviewees pointed out as the main ‘complaint’ or problem with cultural competence classes was that they didn’t have time even if they were interested. One physician could hardly remember if she even had a class on cultural competence, only that it was one or two sessions of a course about patient-physician interactions. Reflecting on the idea of cultural competence classes, she responded:

> You know, the problem with those kinds of courses is they’re usually not that useful especially when you’re taking something like anatomy and really stuff that takes a lot of studying. So you’re sort of annoyed you have to go and talk about these issues, and we’d talk about them in a group. Although I see the value in that education I think that maybe, I don’t know how effective a course it is. I’m not sure exactly how to teach it. –interview 21

Another key point she makes is the contrast between the cultural competence, or patient-physician interaction course, and the basic science courses. The learning style contrasts, creating a disjuncture she describes. When I asked her if she thought the idea of cultural competence was good but there were issues in demonstrating it well, she replied:

> I think the idea and the intention was great. I don’t know the best way to teach those kinds of things. I don’t know if the traditional classroom is the best way. I think almost the environment has to change, but I don’t know how you go about changing culture. I’m not sure. Maybe you can answer that question when you grow up. You can tell us. –interview 21
She makes reference to culture, which in the interview implied the medical school and biomedical culture.

Elaborating on her ideas of changing the environment in which cultural competence is taught, she suggested it would be more useful to have students spend time abroad to give them a better perspective of not only how to interact with patients from ‘other’ cultures, but to gain an understanding of their own personal world views. Having done work abroad and being shaped by those experiences, she responded in reference to her peers’ attitudes towards the class:

I think everyone blew it off. And I’m probably the most pro-that kind of stuff, and even I didn’t go and think it useful, so that’s a problem. –interview 21

This opinion came up time and time again as interviewees referred to themselves being the ones ‘more into’ material related to cultural competence. Yet consistently they referred to how even they were either uninterested at certain points or unable to go due to time constraints, unappealing content, or poor instructors.

A paradoxical emphasis in the patient-physician interaction course one medical student took was how to communicate effectively with patients.

They try to teach you, and that’s kind of year one I guess and a little bit of year two, they try to teach you how to interview a patient, how to talk to a patient. I know we were taught to ask them about kind of their social history. And they really, really push for open-ended questions which I think is really important. They really push it at the beginning of medical school but by the end of medical school, nobody cares so much about open-ended questions any more. And during your off days, they just want you to get specific info as fast as you can, during your clinical exams with fake patients. –interview 84

Her comment speaks to how time constraints even play directly into patient-physician interaction training. There is irony in the shift from the ideal- asking open-ended questions to the reality of getting to the point and only asking for the information the physician needs.
Another physician who took ‘Physicians in Society’ at a different medical school mentioned how it was inherently a ‘touch-feely class’ differing from anatomy and other “hard-core basic science” courses that require “memorizing lists” (interview 24). When asked whether she thought the method of learning was too different or if basic science courses got prioritized, she responded:

Well, our basic science courses definitely got prioritized which I personally think is somewhat appropriate in medical school… –interview 24

The interviewee also pointed out that the interest level and time invested in the class depended on the individual’s personal interest, whether it leaned towards basic sciences or more towards the cultural competence class. Speaking to the lack of importance of cultural competence classes compared to other basic science courses, another interviewee stated:

Yeah, I think that’s what it was. We had so much work to do and so much class, that you cut corners. –interview 74

As pointed out by several interviewees (24, 74), basic science courses were prioritized due to students being overworked in medical school. Students were trying to take in so much information as it was that cultural competence courses or non-core academic courses had to be left by the wayside to get work done. An interviewee spoke about how her class was required to do a group project combating health disparities\(^\text{10}\) that is quite comprehensive when considering taking multiple other ‘hard-science’ courses.

We didn’t carry it out but we were supposed to come up with the project. The research we had done on the disparity and the attempt to reduce disparity. And that project everybody hated. And group work in general is challenging for medical students, who are very self-motivated and driven or they wouldn’t be medical students, and telling them to work in a group of like 8 people to work on a group paper…it was probably a good exercise for everybody. –interview 84

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\(^{10}\) see page 49 first paragraph, interview 84
When I suggested it seemed like a lot of work to balance when already over-loaded with other courses, she quickly replied:

Exactly, that’s part of the problem people had with it was just, we’re already trying to take all these tests and all these things. Year two gets more clinical, which is much more focused on diseases and organ systems, things we’ll actually need to know, although it’s impossible to know [what we need to know]. – interview 84

Reflecting on a conversation she had with a professor who taught Physicians in Society she mentioned that the professor,

said that it’s hard because it’s probably the most important class because it talks about costs, talks about biostatistics, finances, and different cultures. It just talks about important issues that will be hard for you later on after you know all the medicine, but people don’t think about them because they’re so focused on the test and focused on learning the disease. And so that’s the class to blow off because it seems like the easiest and it seems like the one to blow off. But she said that, later on [students] realize that was the important class, but then it’s too late. You can’t have the perspective until you’re done, out practicing, when you think, boy I wish I had [been there] the day that we’d talked about Somali culture, I wish when I had the Somali patient sitting in front of me and I can’t quite figure out what’s going wrong and I don’t know why I’m not communicating well with her and you know I’d paid more attention in that lecture. So I think it’s something that in retrospect you’ll look back in and think it was probably important—probably more important than my other classes, but you know, I had a lot going on. (interviewee’s emphasis) –interview 84

Cultural Competence in Residency

If the value of cultural competency education seems to be more appreciated in retrospect by physicians facing crucial sociological issues after medical school, then it would make sense for cultural competency to be addressed during residency. However, there was little if any training during residency, and residents lacked role models for applying culturally-competent care. When asked if attendings gave him guidelines to communicate with patients during residency, one physician simply replied, “No, not in residency” (interview 29). Continuing about how open-ended questions are emphasized
at the beginning of medical school, but quickly turned into very directed questions, I asked the medical student if the attendings emphasized one method or another.

I think that when I see them work, they’re so busy that they don’t ask open-ended questions very much. They may start that way but they very quickly [switch]. They may start each visit with “Oh, what’s going on, what are you doing here?” but then they get very very focused and cut out a lot. They’re under time pressure, so it’s hard to fault them. But most of the physicians I’m working with, their model is pointed questions, direct questions. And that’s often what I get. The amount of feedback you get on certain rotations is variable, so mostly you learn by, you do get feedback and of course you get evaluated and graded in every rotation, but there’s often not that time to really talk about everything, so a lot of what I learn I learn by watching. And not only this is how you do it, but in my head, this is how I don’t want to do it. –interview 84

Almost all of the interviewees said that there was little or no guidance on how to communicate with patients from their attendings during residency and they were left to learn on their own. One interviewee responded to the question of whether they basically have to figure things out for themselves:

Yeah, we’re pretty much left to do our own thing. Or to, and this is where I kind of think, thinking about the education that goes on in medicine is kind of useful, because you’re kind of left to learn from the people that you respect. So what I would do, there would be certain attendings that I thought, wow, they’re really great at what they do, I like the way they talk to patients, I like the way they do this or that. I’m going to copy them. So that’s how I learned. But almost never, I mean really rarely will the attending ever say, “Why don’t you try this, or don’t do this.” –interview 29

These responses and others reflect how cultural competence programs are often left out of residency training, where physicians are learning to make decisions as physicians in the clinical setting and developing their professional identities.

The Necessity of Cultural Competence Education

Not all interviewees commented about the importance of cultural competence education, but those who did recognized that it is a necessary class for medical education. However, in its current state it is not always effectively implemented. One physician who does research on health disparities points out how cultural competence courses are
taught according to an ideal without recognizing the reality of physicians’ situations in medical school and practice. When asked if he thought cultural competence classes were useful, he replied:

Yes, it’s useful for a paradigm for what you do, but the problem is that it’s not necessarily always practical. The University ended up teaching to an ideal rather than to the realities of what’s been created out there. I mean, the amount of patients I see, or even family medicine or internal medicine doctors see, it’s just too much. So really what needs to be taught is how to see patients effectively quickly. –interview 98

While he speaks to time constraints and the necessity to see too many patients as a hurdle to achieving culturally competent care, it is interesting that his proposed solution is that cultural competence courses should actually be teaching efficiency. The idea of efficiency is brought up in several interviews and indirectly brought up in all of the interviews in reference to the need to just get to the chief complaint and deal with that problem in order to get the patient discharged. The heavy emphasis on efficiency in biomedicine will be discussed in more detail in the following chapter.

It is also interesting to hear how cultural competence education is somewhat expendable when considering the amount of contact a physician will have with patients from a ‘different’ culture. Speaking to the significance and necessity for cultural competence, a medical student referred to how:

There are people in my class that I wouldn’t want to be my doctor or trust with my life. There are people who probably wouldn’t want to be someone’s doctor if they can’t communicate well and don’t understand the culture, so that’s frustrating. And people probably don’t like working with translators. It’s hard, it takes longer. There are probably people who will go out of there way to set up practices in the suburbs so they won’t have to use interpreters and will be physicians for people just like them. So maybe some people don’t need Physicians in Society if they’re not going to be interacting with any people like that. –interview 84
The interviewee’s reference to ‘people like that’ speaks to the Othering process that cultural competence education can end up encouraging\textsuperscript{11}. Likewise, cultural competence is isolated as only being about the patient’s culture and how different it is from the physician’s understanding of the world. At the same time the interviewee problematizes the luxury of ‘avoiding’ having to ‘deal’ with ‘those’ kind of patients.

During one interview I brought up the issues of racism, sexism, and heterosexism and how they may affect physicians’ interactions with patients. The physician who does HIV work responded saying:

Well, I think that when it comes to issues of gender and race and sexual orientation, that in general, those issues are not a huge problem as long as a person fits into a narrowly confined norm. I think in general, it’s okay to be any race, male or female, gay or straight, as long as you act like a white heterosexual person in the suburbs. So as long as you fit that norm, it’s fine. But if you alternate too much into something a little too alternative, it’s not very accepted by a culture that’s pretty conventional. Conventional, but you know, well educated and exposed to lots of different types of people, but essentially conventional. … If an attending is male or female, nobody cares, and there’s not power differential between having a male or female attending, but they all kind of act the same. Or gay or straight, I think the same thing is true. And racial things too. –interview 29

His packed response speaks to multiple issues. His reference about race not being an issue as long as you “act like a white heterosexual person in the suburbs” is his way of talking about institutional racism. As he explains, all those varying from that “narrowly confined norm” are not ‘accepted’ by biomedical culture. Most likely this is something he came to note from personal experience and not from a cultural competence course that addressed institutional racism and white privilege. The comment about the lack of power differentials between male and female attendings is also interesting. The role of gender in biomedicine is not the focus of this paper but is worth noting as yet another source of

\textsuperscript{11} See chapter 2.
power dynamics that affect patient-physician interactions as well as interactions with colleagues.

When I asked the interviewee if he thought medical education encouraged the kind of mentality that ‘you are okay if you act like a white heterosexual person in the suburbs,’ he replied:

Yeah, I think it’s kind of the unspoken message, that that’s the goal of health care is to become like that. That for people to prosper, be stable and have children…that’s sort of our goal for patients, is to get them to that state. – interview 29

Again his reference to the unspoken message of physicians’ jobs being that of producing patients ‘like that’ speaks quite powerfully to institutional racism in biomedicine. His comment itself also racializes health implying that healthy individuals are those who are “white, heterosexual and from the suburbs”. Our discussion continued about how the goal of biomedicine is to bring patients to the ‘normal’ state of health as productive and reproductive citizens contributing to society. Thus, his statement also associates the ‘productive citizen’ with whiteness.

In discussing how some physicians have communication difficulty with patients when talking about sex or sexuality, one physician mentioned there are no actual classes on how to address sexuality and certain other topics that may prove challenging. Instead physicians are left on their own to figure out effective communication methods. I then inferred that if there are no concrete studies presented in the literature about what methods are most effective, physicians are left without any guidelines whatsoever. He quickly responded:

No, there’ve been studies. There’s been a lot of work done on physician-patient communication. But it’s not where the emphasis goes in medicine. We tend to emphasize more concrete things. We tend to focus more on which medication works rather than…which medication will the patient actually take and what it’s
like for the patient to take the medicine and how to overcome or deal with whatever barriers may stand in the patient’s way because no medication works if the patient doesn’t take it. But we tend to I think, give more, in our journals, they get more real estate, more printer’s ink, talking about more, you know, within HIV, which combination of antiretroviral drugs is going to be more effective. - interview 29

In a different interview I asked another physician if he found it easier to treat patients from a similar ethnic, racial, or socio-economic background. His response was:

It’s funny that you mention that because it’s true that if someone shares my ethnicity or they share things, the chances are on average, statistically speaking it’ll be easier for me to communicate with them and we’ll have more of a shared frame. But there’s just, that gets swamped by the human aspect, the individualized aspect. Because what happens is you deal with some people that theoretically should share your frame that are completely the most difficult patients you’ve taken care of. So what do you make of that? You’re sort of like, okay, all rules are thrown out the window. They say rules are made to be broken, well it’s true about these things too. The statistical generalizations that we can make about these things don’t explain most of the variability in the interaction, they explain a small chunk of it. I have some wonderful therapeutic bonds with people…we have completely disparate backgrounds and we do okay because there’s a trust and a willingness on the part of the patient to adhere to what they think is right. –interview 56

It was interesting to find that most interviewees stated that it was in fact easier to interact with patients from a similar ethnic, racial, or socio-economic background. When another physician was asked the same question about finding it easier treating patients from a similar background, he replied:

You know I do unfortunately, and I think the literature kind of bears that out, that doctors treat patients in their socioeconomic group better. I wouldn’t say it’s better it’s just that I kind of understand, first of all the language. I think that’s probably the most important thing when we talk about cultural differences. I speak Spanish, I speak Italian, but speaking them and actually being a native tongue are such huge differences in the small inflections in voice, the phrases that people choose to use, I can understand them, but I don’t always understand the nuances of that. I think that’s the biggest gap, and probably the most frustrating in LA because on any given night you could treat people who have 5 or 6 different primary languages. I think one way to obviously bridge that gap especially in LA [is that] medical students should speak Spanish. Medical schools should be looking at people that are reflections of the communities which they serve, I think that’s really important. It’s a start. –interview 98
A key factor he points to is the language barrier, while the previous interviewee chooses to not oversimplify his level of comfort with some patients of the same ‘background.’

Speaking more specifically to health disparities, a physician who also has a Masters in Public Health, pointed out how much power physicians actually have over their patients’ health.

Yeah, I think developing a sense of patience is very important. If you’re going to be a physician, you have to realize the limits of what you can do. Also realizing that you actually play a very small role in determining the health of your patients. I mean it’s sort of interesting when you look at the fact of medical care per se, I mean most of the big factors that determine health have to do with socio-economic status, education, those are the determinants of mortality. For example, if you look at Great Britain where there’s universal access to healthcare, there’s still a very clear-cut gradient in health and mortality by social class. Which suggests that simply insuring the population would not solve any major problems, there are deeper problems at root. So simply, the healthcare reform proposals that say oh, let’s just give everyone insurance or let’s have a single-payer system. That’s only really the tip of the iceberg. It’s probably a good idea that everyone has insurance through some mechanism, but I don’t think it’ll solve the deeper issues. I think that there’s deeper issues of education, how we bring up our children. –interview 56

He points to the health gradient based on social class and attributes the subsequent health disparities to “deeper issues” of education. Here he is recognizing that physicians are treating the patient towards the tail end of a problem that is largely due to social issues of inequality. The result is that physicians have very limited ability in actually ‘treating’ the patient because until those larger social issues are addressed, the patients will keep streaming in. Following his comment I asked if the discussion of health care discrimination in education could be a means of addressing the problem. He responded promptly:

And what about the social and biological effects of discrimination? I mean it’s so interesting to talk about that because here’s a certain amount of stress generated by feeling inadequate or not wanted or loved. There’s a lot of interest in this right now this whole concept of allostatic load. –interview 56
After going into the biology of allostatic load, or the mediators of stress used to track the biological consequences of stress, he states that:

…it’s an immunologic thing, and basically you can look at the stress response and it may be that some of that helps to explain why those in deprived circumstances don’t live as long as other people.

In his comment it is interesting to see how science functions to make sense of social injustices such as discrimination that are woven into US and biomedical culture.

The same physician continued to talk about the limited role of the physician in the larger scheme of the culture and structure of biomedicine and US society:

But I guess that may be this is just a maturation process, but as a physician you come to realize that you are there as a catalyst-this is my feeling—you’re there as a catalyst to help someone who wants to help themselves. You can’t really force change in a person who can’t help themselves. And worse yet, you can’t force change in somebody who wants to help themselves, but whose circumstances won’t allow them. You just don’t have enough control over the whole apparatus of our whole social structure to make a difference. So in some sense medicine is like a manifestation of our culture. I mean physicians are people, and they tend to come from the upper echelons of society, still. Whatever patterns of discrimination exist in medicine in terms of healthcare disparities, simply reflect what exists at large. I guess it would be unreasonable to be any different because physicians may be particularly gifted at remembering things and you know, may do well on tests, and may be very disciplined and be able to stay in an educational system for a long period of time. But we shouldn’t expect that they’re going to be any more or less moral, or have any different feelings than other people. So I guess, that again, where is the start, is it really changing medicine or is it the underlying foundations of our culture that are the issue. You know? So, again, its just sort of adaptation that you realize you can’t fix everything personally. You have to make that difference in your role, whatever that role might be. And that little bit makes a difference; it’s just a building block. –interview 56

His insightful comment sheds light on how biomedical culture is itself a reflection of US society. From this it can be inferred that until the social issues leading to inequality are addressed on a larger scale beyond the walls of the hospital, health disparities are going to continue. The interviewee is able to contextualize the responsibility of physicians as individuals existing within a flawed system that perpetuates inequality. He makes an
important point that physicians are only human in that they too are influenced by and existing within US society where discrimination runs rampant. Physicians are not able to escape that enculturation purely based on the ethical obligation to not discriminate in practice. But one must be careful not to dismiss the issue as something inevitable. Cultural competence education provides the opportunity to address issues of discrimination in the clinical setting. Yet as the interviewee points out, until these are constructively addressed on a larger fundamental scale and acknowledged by the biomedical establishment and US society, physicians will merely be hitting their heads against a wall of culture and power that does not support the individual’s effort to fight discrimination.

Conclusion

In this chapter I have presented the type of cultural competence education the interviewees experienced as well as their opinions on the class’s effectiveness. One of the major inhibiting factors appears to be the mixed message medical schools send out to students by formally endorsing cultural competence education yet not investing much time in creating innovative ways of addressing the important issues. Thus, instructors, who are forced to teach a multitude of other topics in the class, are often not enthusiastic about the class, leading to an apathetic student body. Also, the work overload of medical students allows precious little time for anything else and the medical school curriculum itself, which is ‘hard-science’ oriented, does not lend itself to talking about socio-cultural issues. Likewise, there is an excess of information in the cultural competence courses, such as biostatistics, reimbursement issues, Medicare and so on, that conflate the importance of the topics addressed and leads to dismissing cultural competence material.
As reflected in some interviews, there is much room for improvement as there is limited formal discussion of discrimination in biomedicine. There appears to be little space to address the issues of institutional racism in the context of cultural competence education as it stands.

The next chapter will address specific aspects of biomedical culture that inhibit cultural competence education from being applicable in practice. The chapter will present issues that physicians have indicated impair their ability to become culturally competent physicians. I propose that the topics they bring up are often swept under the rug of cultural competence education and left unaddressed. This is because by keeping silent, the power of the biomedical establishment is officially left unquestioned allowing the maintenance of authority.
Chapter 4: Reflections on the Culture of Biomedicine

The previous chapter focused on interviewees’ specific perceptions of cultural competence education. This chapter takes a step back to look at interviewees’ perspectives on the culture of biomedicine. Here, I focus on what is valued within the biomedical establishment, concentrating on the idea of efficiency. The purpose of the chapter is to frame cultural competence education in the culture in which it is being carried out and to recognize how current cultural competence education in many cases is achieving an “unplotted strategy” of silencing physicians so that larger social issues and problems within the biomedical system do not get addressed (Ferguson, 1990). This in turn helps the biomedical establishment maintain power. I contend that the interviews affirm that the only voices heard are those that are legitimate according to biomedical values. Thus other voices and ideas are silenced or dismissed as invalid or not valuable.

This chapter will focus on the discourse of efficiency, and how the definition of competence as a physician involves not only demonstrating mastery of medical knowledge but also doing so in an ‘objective’ and timely manner. As part of the discussion I will dedicate a section to time constraints, reimbursement problems, reinforcement of emotional distancing, and expectations to be assertive, respectively. Each of these issues functions to create and perpetuate the focus on efficiency within the culture of biomedicine.\(^\text{12}\) Drawing upon the interview material, I choose to focus on

\(^{12}\text{Alternative, Traditional, or Complementary methods of healing are not included in the discussion of what is seen as legitimate in biomedical terms in this thesis, but such methods of healing are discussed as part of cultural competence education. Several interviewees (56, 10, 84, 68) pointed out the tension they faced in discussing or understanding non-biomedical methods of healing. Refer to Appendix 2 for sample excerpts from interviews discussing the topic of non-biomedical methods of healing.\);}
these patterns to represent what contributes to the matrix of biomedical culture. The last section will demonstrate how the efficiency-oriented mindset creates physicians who are apathetic about questioning or changing the biomedical establishment. This then silences individuals so that larger social issues and problems within the biomedical system and culture do not get addressed. Thus most cultural competence education programs, by not directly addressing core issues of prejudice within biomedical culture and American society, and implemented within the ‘silent’ culture of biomedicine, creates adverse side-effects that perpetuate power imbalances and inequality within the biomedical system.

**Efficiency**

Efficiency is a topic that was brought up in every interview in some form or another, more often than not, in reference to its role in the clinical setting. The goal, as interviewees state, is to get patients in and out of the hospital.

What’s your major complaint? What can I take care of? And how can I get them out of the hospital, those are the top things on my mind. – interview 74

When I asked one interviewee if she felt that her goals as a physician differed from the expectations of the medical community, she full-heartedly replied:

Yeah, oh yeah. I think that me saying that I want to have relationships with my patients, that is nothing on like the report card on being a good physician when it comes to attendings. That’s like the last thing. What they’re looking for is clinical competency, technical skill, efficiency- those are things that we are graded on. Graded in quotes. When it comes to social relationships, maybe it’s also really hard to measure. How do you measure that this clinician has a good rapport with all her patients, or they trust her. I don’t know, maybe that’s why it’s easier to be like, oh, they scored this on their boards and oh they can do this skill or not, they do this many referrals, they do this many procedures. It’s easier to measure those things I think. How many patients do they see in a day? No matter that you spent 45 minutes counseling one depressed patient. That doesn’t matter. And you don’t get paid for that either. – interview 74
In response to my question of whether he thought the feeling of ‘knowing better than everybody else’ that he thought physicians often had created challenges in communicating with patients, he stated:

Yes, it does, it definitely creates challenges. And I think there are a lot of physicians who don’t really bother communicating with the patient because they don’t really care, they don’t see that it’s their job to educate the patient why something is important. They’ll just focus on it, get it done, and move on. – interview 29

One physician explicitly pointed out how efficiency- in terms of diagnosing, treating, and getting the patient out- is what’s more important than cultural competence.

In reference to her in-patient training as a resident, she reflected back that:

We were so over-loaded with work, so over-loaded. I mean I probably saw my patients for five minutes a day. I didn’t see them outside of that at all because I was running around doing so much other stuff. And yeah, it was efficiency, it was getting the patient out, discharging them, making them happy, knowing what you were doing, making the right decisions, those things are more important than cultural competence. I think in the outpatient setting it was a little bit different. You had a little bit more time, you weren’t as pressed for time. You could do more of those social relationships. I think that’s when the cultural competency became more important because you do a continuity clinic, at least for medicine you form a relationship with that patient, for the years you’re going to be there. –interview 74

She also said that there is an opportunity to build relationships in continuity care, where cultural competence becomes ‘more’ important. She implies that in that specific clinical setting, time allows for the luxury of regarding cultural aspects in care. This demonstrates how cultural competence is seen not as something that is intrinsic to being a competent physician, but an extra trait outside of medical competence.

While responding to a question about what traits he aspired to as a good doctor, the perceptive physician who also does health economics and public health research stated the importance of remembering the balance of compassion and efficiency in clinical settings while responding to a question about what traits he aspired to as a good
doctor. He also referred to the emotional distancing that goes on as a means of maintaining professionalism in relation to the patient.

That’s why the humanities I thought were such an important training for realizing narratives and understanding that this is human experience we’re dealing with here, it’s not just some sort of machine that people are. I think the biomedical paradigm tends to emphasize the mechanistic, reductionistic approach. And that’s why I try to keep up. It makes it easier that I only do it half a day a week. A lot of people that are full time doctors get a little burnt out, especially in primary care. But that didn’t change too much, I think that was a pretty consistent theme throughout the time. I was always afraid of losing it, that just one day I would completely become covered in ice. So I tried hard not to let that go. –interview 56

One ‘radical’ medical student reflected on her experience in a stress management workshop her medical school provided. She was excited to attend and find out ways to better take care of herself amidst the daily stress of studying and clinical training.

Instead:

The way he was phrasing it, it wasn’t so much that like, he was naming all the traits that from a subjective experience one would think of in stress relieving and things one should really tune into your body and listen to yourself. But he was saying, rather than listening to your body, you look at your productivity and studying to know if you’re stressed or not. And then you would do these things not to take care of yourself or to love yourself or to be engaged in meaningful ways with your community and your life, but to make yourself more productive and to have a higher output. I think that’s a big part, so what happens is that even things that are healthy get warped in that way. –interview 68

Her statement reflects how productivity is the main focus and everything revolves around how much is being achieved in a limited amount of time. This starts during medical school and continues throughout practice according to the interviewees (56, 21, 24, 74, 29, 98). From the beginning of the interview, this particular doctor emphasized personal mental, physical, and emotional well-being as a priority, which was continually rejected within medical school. She referred numerous times to the inability of medical professors and attending physicians to feel emotion and just be present in the moment.

Instead, they try their best to make a point through any means necessary, including
invalidation of whatever varies from the information being passed on to the pupil.

Medical education from the start is very much goal-oriented and success as a student is judged based on one’s ability to reach that target without complaining or questioning.

Repeatedly, interviewees stated the goal of their job as finding the problem, dealing with it, and getting the patient discharged. It was very matter-of-fact. Efficiency was also defined in the same terms of increasing one’s ability to isolate the problem, treat it, and have the person go on his way in as little time as possible. The discourse of efficiency revolves around being objective and ‘professional’ which involves certain skills that the physician must possess and traits she must demonstrate. Interviewees pointed out numerous characteristics that demonstrate efficiency and competence as a physician.

In the following sections I will highlight a few characteristics that were brought up frequently in interviews. These include appropriate prioritization, maintaining a ‘professional’ emotional distance from the patient, and asserting one’s self and the medical knowledge one is expected to have. I believe these traits function as a means of increasing ‘efficiency’ in the clinical setting and therefore becoming a ‘better’ physician. Again, efficiency and what is considered a good physician are the biomedical definitions that value objectivity in the workplace. The fact that these definitions themselves have been subjectively created does not seem to be questioned, as meaning assigned by biomedicine is perceived as truth within that cultural framework. The tension then arises, as Janelle S. Taylor (2003) points out, that culture is seen as

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13 Without getting into the theory of performance of ritual as a means of forming professional identity I want to address what many interviewees found as key factors in their validation as physicians by the biomedical community.
something belonging to others (patients) and is not *real* in the sense that biomedical ‘fact’ and knowledge are.

**Time Constraints**

A major factor in being efficient is time management. As pointed out in the last chapter, time constraints were repeatedly brought up as a reason for not engaging in the cultural competence material. Likewise interviewees continually attributed dismissal of cultural competence in the clinical setting to the lack of time.

In a discussion about how cultural competence courses were meant to teach humility I asked one physician, who does a lot of HIV/AIDS work, if he and his peers were able to show humility. He responded saying:

…it’s not a total accident that people who end up in medical school tend to have some at least kernel of kindness and compassion. And other things may eventually get in the way of that. I think that in practice sometimes people have a difficult time or a harder time really expressing or demonstrating their compassion because they don’t know how or because the patient makes them uncomfortable, or the really easy thing to fall back on is time constraints. Or they just don’t see that it’s their job. Because of time constraints and because there’s a social worker on the case, they’re not quite going to go that extra step that sometimes I think the patient might really need. –interview 29

A physician who works in the emergency department and is researching health disparities talked about how his sense of time changed during medical school. He talked about having a lot of free time during college. According to him, in medical school, time slowly disappears along with that same level of leisure and one just learns how to manage as, “you become more efficient in your work, you become more efficient in your scheduling” (interview 98). When I asked if he found it frustrating to only have four to five minutes bedside when wanting to comfort patients but having to deal with other things, he replied:
Absolutely. Definitely. You know, you also have to prioritize constantly. So you even have to prioritize who you comfort, who you spend time with. You know, if someone dies, then you’re going to take a break from everything else to be with the family, but if maybe someone has pain, and the nurse can help them or comfort them. The ER I work in is a 28 bed ER with single physician coverage, so I’m seeing about 3.5 patients an hour...and the physician’s assistant sees upward of 4 an hour. It’s just a lot. –interview 98

He also spoke to what exactly gets prioritized in patient care, directly related to his field of emergency medicine:

It’s basically a very complicated risk stratification. So what you’re focusing on is the chief complaint and risk factors that that patient has, and that’s how you’re managing multiple patients. So on the surface, culture, socioeconomic class doesn’t really come into it, but then there are subtleties in your treatment. Say someone comes in for chest pain...you look at who they are and their risk factors and how their story sounds, the subtleties are things like do you give them pain medicines, do you implicitly believe their story, and I think those are the things where socioeconomic status changes doctors’ treatment. –interview 98

The interviewee then continued to explain that he judges the validity of a patient’s ‘story’ based on their background, and if there is secondary gain for the patient in receiving pain medications. It is interesting to see how culture and socioeconomic class are pushed aside as something irrelevant to the initial care of the patient and instead referred to as ‘subtleties.’

When another emergency medicine physician was asked if she found it difficult to balance time with patients, she quickly responded:

Well, we get pretty bitter. You won’t want to spend time with patients after a while. You’re going to be like, oh good, only 5 minutes. And a lot of people are like, I want to go into intensive care because they don’t want to talk to them. We get pretty bitter, don’t listen to me. … Yes, sometimes it’s enjoyable. I never feel like I need more time. Whatever little time you have with someone, I mean people can be a real pain too. Very few interactions are like, wow, that person was so nice and so good to me. It’s a service job. It’s kind of like waiting tables, that’s what it is, whatever kind of doctor you are. I think unless you’re like a family practitioner, where you see all your patients in some small town then it’s probably very different. But I think in emergency medicine you’re basically like a waitress, but your job is not serving food, it’s saving lives and making people feel better. –interview 21
Yet soon after when I asked her if she felt like she had enough time to comfort patients, she replied:

No, definitely not, definitely not. But I think, you just make time. You just realize when people need it or don’t need it and you just say, you know what, and you just let everything else go and I need to just stay with this person for another minute, and it’s okay. You just make the time. You never have enough time, but sometimes you just realize you have to do it. Yeah, you definitely can’t sit in there for an hour. (laughs) That’s when you’re like, okay, let’s get the social worker in here. –interview 21

Her comment resembles the general sentiment that I picked up from most of the interviewees; they will prioritize comforting the patient when a death occurs, but only to a certain point. Death seemed to be the major point at which the interviewees found it appropriate to set work aside for a few minutes to talk to the family, but they did not mention taking that time in patient care while the patient was still alive.

There were also several jokes and comments about nurses and social workers being responsible for comforting the patient in the interviews (21, 74, 29). The underlying implication of these comments is that again the physician’s primary role is to medically treat the patient and let the other staff deal with the other needs. From my very limited personal experience, I did not see social workers, nurses, or physicians spending much time comforting patients in the hospital setting, which leaves unaddressed the question of what needs do patients have and are reassurance and human interaction part of the therapeutic process that contributes to their recovery? The discussion of therapy versus treatment and how there is a differentiation in biomedical language is deserving of attention at a separate time. Yet, I bring this up because one of the main tensions for the physicians I spoke to seemed to lie in wanting to spend more time with patients in a therapeutic sense but finding themselves only able to give the minimal medical care they can provide in the limited time they have with patients.
Discussing the complexity of wanting to spend time with patients but needing to ‘get the job done and move on’ to the next patient, one physician stated:

Yeah, it’s not black and white. And certainly you get taught in med school, and I was really into this ‘Physicians in Society’ course. I was certainly on the side that thought this was a great course. No, I’m going to hear the entire psychosocial background and I want to hear all the contextual factors and these are also very important. And then you get out there and you realize that yeah, I can hear all those things, but then every other patient will be waiting two hours, and then I’ll burn out within two weeks of practice. And I can’t do it and can’t get to the things that are medically important. You can’t do that, so where are you going to fit yourself [into] that. I think it has interesting ramifications for physician job-satisfaction and what specialty they go into. I think there are a lot of physicians, and I for one am one of them, who were very interested in primary care and then got out in the primary care world a little bit and got to see what that was like and got to see this inherent tension between the constraints of time versus what the patients want to tell you and the time they want to spend with you becomes so unpleasant that it may not be worth practicing. –interview 24

She continued to talk about her internal conflict about how dedicated she is to developing a relationship with the patient and that was the reason why she initially chose to go into primary care, yet she was only disappointed with her limitations as a physician in that practice.

I was always a little unhappy. I never felt like I was doing a good job. Ironically I think I’m so committed to the cause that I don’t think I can do it. I don’t think I can do it halfway. I spent a lot of time in residency trying to be taught how to do it halfway- sort of how to get the patient out in 15 minutes, and the strategies, and getting the patient to focus. There are a lot of strategies to do that. And spending a long time, it was just me-that I obviously had a skill deficiency with this. And [I] learned some really valuable skills in trying to learn those skills that I think are really good skills to have. But [it] finally came down to realizing that even if I could do all those skills well, I really didn’t want to be that doctor. I looked at the doctors around me that were known for practicing those skills well, and I didn’t want to be them. So that was actually when I decided that I don’t want to do [primary care]. For me I didn’t see a way, I could, I couldn’t do one extreme, I would either be a primary care doctor I didn’t want to be and practice in a way I didn’t want to practice and feel bad about it, or I would practice in a way that would lead to me burning out in a very short amount of time and sort of either way it was just going to end badly. Yeah, we’ll see. –interview 24

An interesting thing about the interview with this particular physician was that initially she came across as one of the physicians she describes who is very good at
directing someone to get to their point and likes to get things done swiftly without asking many questions. Yet as the interview progressed, her tone changed (from confident and direct to slightly hesitant/unsure and subtly sad) and she seemed to become more relaxed. As part of that shift in behavior, she started to reflect on her past experiences in biomedicine and seemed to be reminded of what it was she originally wanted. Her process of recollecting that and literally struggling with it during the interview was telling of how physicians are really put in a difficult position in which, even if they have the will, there is not necessarily a ‘way’ within the current structure of biomedicine that allows for developing a relationship with patients or providing the kind of care many physicians want to. The issue of inability to function in ‘full capacity’ or working according to one’s own standard of care was an issue that came up in almost every interview. While those physicians I spoke to seemed to love their jobs, there was also a strong sense of dissatisfaction due to the circumstances in which they had to work.

Reimbursement/Monetary Issues

When talking about time constraints, all paths seem to lead to the discussion of reimbursement. Monetary issues, according to interviewees, are directly linked to the need to be efficient and see as many patients as possible. Many of the interviewees spoke of the shift in biomedical care so that it revolves around money.

One internal medicine physician bitterly commented on how many people are now going to medical school to become cardiologists, optomologists, or dermatologists. She then continued aloud to comment on the increasing popularity of specializing due to better reimbursement:

Explain this to me, the smartest students in medical school go into dermatology. Why is that? Because you make more money, you don’t have to take call, you
have office hours, you get paid a lot for procedures. It used to be that the smartest people went into internal medicine. But no more, they go into radiology, dermatology, anesthesia, where they have minimal patient contact, make a lot of money for procedures. That is how we’re reimbursed. So you know, it’s really bizarre. I think a lot of people who’re very, you know they have their goal, they want to become a dermatologist. That’s all they do, they study really hard, work in their books, do their dermatology lab research or whatever to get them into dermatology. Once they get into dermatology, then what do they do. They keep focusing, focusing, focusing, and specializing, they end up doing cosmetic nasal surgery. I’m a dermatologist who only does this. –interview 74

In reflecting on issues of who receives the most financial benefits, I suggested it would be more logical to apply preventative healthcare measures to her. The interviewee, who also does public health work, promptly responded:

Right. But that’s the thing. A lot of times we end up seeing patients after they have a disease. So we’re a little biased. Because you end up treating. I don’t think that many physicians at this point are out there to help patients. If you ask people what they do now, the number one thing is not going to be, I help patients. They’ll say, I perform surgery, I see this many patients a day, I try to get out of work by 6 o’clock every day. Those are work goals now. Yeah, helping people’s kind of fallen out of the picture, unfortunately. I mean you help them, we can do this or that, but a lot of times the things we do don’t help anyway. – interview 74

The same interviewee’s responded to the question of why she thinks physicians are constantly overworked:

Well, just because there’s too many sick patients. Too many sick patients. I think it’s overload of work, not enough time. If they hired 50 more residents, like in my program there were 30. If they just doubled our numbers, we could work 9-5 every day. Heck. But the programs don’t get enough money, the hospitals don’t have enough money to pay other people, to get more residents, not at all. And we’re cheap labor. A PA (physician’s assistant), costs $110,000. They could have 3 residents for that. We are slave labor. I mean it’s an apprenticeship in the worst sense. –interview 74

Then on a very basic level she referred to how certain procedures just get better reimbursement. She talked about how personal, more therapeutic interactions have little financial benefits, if not negative effects for the physician.

Maybe a lot of it’s [not getting measured by rapport with patients and valuing] that’s linked to being paid. Yeah, you get billed for therapy but it’s not as much
as you get billed for excising a mole or something. You get paid more to do that than you do to sit down and actually talk to someone. –interview 74

Speaking more directly to how physicians and hospitals get reimbursed, one physician who does public health and health care finance work said:

And the whole financial system especially for our Medicare patients favors admission, I mean basically we bill well on the inpatient side. So there are very few checks and balances. If the emergency department is happy to see them, they bill Medicare for the visit, so the trainees are the ones who feel abused because they’re basically working for very low pay. –interview 56

He points out how,

the other thing that I think what people don’t realize and I didn’t realize when I first started is that the people that were overseeing me are also sort of stuck with the system that they have. Now that I have an interest in health policy and health care finance and how organization and financing of health care delivery, I realize that the ridiculousness of it has to do with the fact that there are multiple different silos of money that are funneled through different systems.

He then goes on to describe how a hospital gets funding from so many different sources,

and because they receive their direction from different places, they have very different charges in terms of what their missions are and very different infrastructures and very different levels of financial lenience to do different things. So this illogical thing is really a manifestation of a much larger organizational issue. –interview 56

Along similar lines, one physician who researches health disparities brought up how it is a structural issue and that physicians are a small piece of the puzzle in providing health care.

Yeah, but I don’t know if the ways are necessarily realistic. You know, higher pay per patient, but that’s not going to happen. Because what’s happening is, in order to make profits, as you decrease the Medicare pay per patient, then that group has to see that many more patients in the same amount of time to make up the difference. So there’s constantly this drive to see patients more efficiently. And then part of that, the doctors are only a small part of that. Things like labs, and nursing ratios, and available ICU beds become much more important. –interview 98
Again, efficiency is brought up as the key ‘drive’ to see patients in a timely matter that does not lose the hospital or physician money. As one interviewee said in a very matter-of-fact and raw manner,

There are a lot of wrong things in healthcare. Then you have people complaining about how much physicians make. If they only knew. If I didn’t get paid this much there’s no way I’d be doing this work. (laughs.) No Way. I have to pay back my loans. It’s not a joke, man. —interview 74

Thus, there is the tension between the expectation to see as many patients in as little time as possible, which has become the golden standard for practicing physicians and the desire to spend more time with patients. Yet some interviewees expressed a personal expectation to be reimbursed for all the emotional, mental, and physical investment they dedicate to doing their job and even getting to that position. The somewhat bitter internist said in response to my question of how physicians might get to spend more time with patients, “I think if we got rewarded in some way” (interview 74).

Emotional Distancing

The third pattern that contributes to the drive for efficiency is the emotional distancing that occurs in order to maintain professional distance from patients. Developing too much of an emotional attachment with a patient can inhibit physicians from achieving their professional goals by affecting decision-making and putting emotional strain on the physician, as interviewees indicated (37, 24, 21, 74). Yet as demonstrated in the end of the last section, there is an inherent tension of wanting to maintain some form of compassion and attachment but having little time or energy to

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14 For interviewee comments on the politics of reimbursement and how it relates to government policy, see appendix 2.
invest. The discussion surrounding emotional distancing again revolves around how attachment to patients can lead to inefficient care. In order to be productive, one must interact with the patient in an ‘objective’ manner. Through this process that is based on the model of ‘efficiency,’ the patient herself becomes the object of examination and therefore very little is questioned about the physician’s role in the power dynamics and cultural interaction with the patient. Physicians then grow accustomed to prioritizing efficiency and moving at a fast pace. In addition, there is often not only distancing from the patient, but from non-physicians in general. This section will demonstrate how emotional distancing that occurs as part of the process of increasing efficiency and competency as a physician leads to disinterest in issues of cultural competence in clinical settings where resources (time, money, and energy) are limited.

Many interviewees reflected on their residency being the major time of change as they developed their professional role in the clinical setting. When asked if this was true for herself, one physician replied:

I think I totally changed through residency. You could say I’m harder, but I don’t really see it like that. I think I’m just compassionate. I don’t always feel the emotion right in front of me. I might see someone that’s in pain or hurting, and I might not seem like I care as much, but to get through the day you have to remove yourself a little bit. –interview 21

Another physician refers to her third and fourth year of medical school as the time she began learning “how to maintain a little bit of professional distance” (interview 24).

Emotional distancing is a means not only of professionalism, but survival in the hospital where it is literally a matter of life and death.

Another physician noted how residency affected her and her professional role as well.
Well, you certainly develop yourself as the doctor in the room. If you’re doing a cross-cover at night and you’re managing patients who are hovering around death, and you’re giving directions, I mean that sort of changes you. There’s also changes that go on, sort of the sense of authority. Both with the other professional staff- so with the nurses and with the techs etc, and then in talking with patients. Even further distancing yourself from the emotions that are going on, which is necessary. And I think that changes you in many many ways. Sort of your whole outlook on life, that it would be a whole topic of discovery and discussion about how that changes somebody. Certainly how that changes their own family dynamics or friend dynamics. –interview 24

She then proceeded to tell a story of how during internship she went to the mall with a non-medical friend. As she was waiting in line at JC Penny’s with her friend she noticed how slowly the person checking people out was.

I swear, I don’t know how she moved that slowly. I mean, I had NOWHERE to be, I was there to socialize, I wasn’t even buying anything, I was just standing in line with my friend. And I had to leave. I just could not take watching her anymore. Oh my gosh! I sort of realized, yeah I think she was slow by anyone’s standards, but my sort of inability- I could not even tolerate watching it- it was so slow. And your whole pace of life when you’re an intern, you are definitely on the rat race, and I definitely think you’re on that wheel. So if you step off that wheel, it’s uncomfortable to be off that wheel. What’s wrong? Everything’s just moving way too slow. –interview 24

Similarly she found herself frustrated when communicating with people outside the hospital:

I noticed with one of my friends who’s very, very circular, I would start to say, “What is your point? Get to the point. Get to the point.” Because I was very used to efficient communication, and if someone wasn’t efficiently communicating with me I would force them into efficient communication. So certainly outside of the hospital I started doing the same- you need to tell me what your point is. –interview 24

As she pointed out, efficiency is her frame of reference, which affects how she chooses to communicate with individuals not only in the clinical setting, but in personal socializing. She talked about ‘forcing’ people to communicate efficiently because that is what she is used to. Earlier on in the interview she also referred to how it is her job to get patients to focus and get information from the patient in an efficient manner. As her comments imply, it can lead to some distancing from others. This could lead to communication
barriers where communication in the patient-physician interaction is very much focused on the physician’s agenda. Power dynamics within the context of the patient-physician relationship will be addressed in greater detail later in this chapter.

Numerous interviewees refer to the physical, mental, and emotional strain of medical training and practice. The numbing process seems to distance the interviewees from pain but also from others who do not live under the same constant pressure as physicians.

We don’t get a lunch break, we don’t get a noon break, we don’t get to say we’re on shift change, we don’t get to say sorry my shift is over, so why are you all saying that, this has to get done, you know, someone needs to do it now, there’s no lunch break, there’s no excuse for that. And of course that’s not how the rest of the world really works. –interview 24

Her comment again recognizes the tension that exists in her lifestyle of prioritizing patients’ healthcare needs over one’s own. When asked what the ‘first thing to go’ when pressed for time, several physicians responded saying their own bodily functions such as going to the bathroom or eating. The impression I got through all of my interviews was that the patient was the interviewee’s number one priority in the clinical setting and that they had an immense amount of dedication to that priority.

Referring to how pain gets normalized in the work place, the physician who does health economics recalled his experience in residency.

It’s like you get inured to suffering, you see so much, that you can’t really appreciate it anymore. You know what to say, you know how to act, but then when you get home you’re completely emotionally void. You’ve used all your emotional energy at work that there’s nothing left for anyone else. And whatever humanism you felt like you had when you first entered medical school, which was supposed to be why you were doing it in the first place, seems to be dislodged, especially in internship, which was the hardest year in our program. And then as a resident because you’re not quite as exhausted, you start to be able to regain that first humanism. But there’s this temporary period where you really don’t care, I mean you feel like you don’t care, even though you’re busy caring all day long. You don’t have time or energy to feel. And you don’t. And then you see that the attendings are all worried about things, and you just feel like,
He describes the intense experience of residency, which demonstrates the process of de-sensitization that occurs due to constant contact with suffering and the ‘need’ to emotionally distance one’s self.

The physician who does HIV work shared honestly as he acknowledged his frustration towards non-physicians whom he finds to be less productive. His comments about finding his ‘self-righteous distancing’, so to speak, problematic reflects how he is able to critique himself and the biomedical system. This mentality of self-critique was demonstrated throughout the interview not only through this comment but his comment recognizing white-privilege within biomedicine (see chapter 3).

I’m getting off topic, but it’s also a little bit of a problem when for me personally, and again I haven’t spoken about this with other friends of mine who are doctors, but, when you’ve got stuff to do all the time and you think, at least I think that it’s important and worthwhile, sometimes I look at other people and think, they don't do anything worthwhile. And that, that’s a real problem. Because that’s just not a very fair way to view other people. –interview 29

Finally, yet another perceptive interviewee, the radical medical student, spoke to the invalidation of the ‘subjective’ experience within biomedicine in a compelling manner.

Science is really focused on being able to describe things and sort of disassemble them into their component parts and be able to name them in order to sort of understand. And I think that’s fine, but I think that there’s such an emphasis on that that I felt what was happening and what sort of is happening is this devaluing of the other way of experiencing. It really feels like any sort of subjective experience is denied as being real or valid. To the point where if anyone has any feelings that they share, or a twinkle in their eye of glee or curiosity they’ll sort of be pathologized- there’s something wrong with you about that and you’re not focusing on medicine. –interview 68

She directly indicated how biomedicine values only its own ‘objective’ perspectives and definitions and views emotion as a ‘subjective’ interference to achieving successful
biomedical competence. The reference to how feelings are pathologized demonstrates how an individual gets shut down through turning emotion into something problematic. And as she pointed out later on in the interview, one eventually learns to hide emotion or fails to acknowledge it.

Expectations to Be Assertive and ‘Get It Right’

As part of medical training, interviewees pointed out the value placed in constantly asserting one’s self. They also spoke about the expectation to jump into things and just ‘get it right’ immediately. There seems to be little space for questioning, self-doubt, or reflection when one is expected to constantly be moving ahead with a task. While there are certain advantages to this learning technique, it is interesting to think about how it trains physicians into a form of silence.

One physician stated that there is professional value placed in the ability to assert one’s self and ‘get the job done.’

And certainly to be a successful medical student and to be a successful I think physician or resident physician, you need to have a certain degree of assertiveness, and know how to walk that line between being obnoxious and getting in the way and really being assertive to get what you want, to be taught and get things done, and to know how to go to the people that will help you get it done, and not seem too needy or annoying by tagging along. It’s a very fine line.

–interview 24

She speaks to the importance of creating one’s own learning experience but also how medical students and residents are expected to constantly prove their knowledge through voicing their diagnoses.

Yet, as some interviewees (24, 29) pointed out, being assertive after a certain point can be a dangerous thing. It is a matter of finding the balance, but there seems to be a tendency to lean towards the more assertive, over-confident side of the spectrum.
And really contributing to patient care but not, when you don’t really know very much, you don’t want to be dangerous. So how do I [be] assertive, how much do I say I’m just going to do this because I know what to do, versus say I’m not going to do this because I’m a student and I don’t really know, sort of where do you walk that line between being confident but not being over-confident. … So yeah, similarly how assertively do you say, this needs to be done, I’ll just do it. Which can at some point be dangerous because you may not know you don’t know how to do that. It’s just more complex, versus if you just wait for someone to tell you to do everything you’ll end up doing nothing. So finding that line, and no one really tells students how to do it, they have to sort of figure it out on their own. –interview 24

The physician who does HIV work also discussed how there is an expectation to get things right, and how “it’s kind of scary in a way because the assumption is that you’re a physician, you know how to do all this stuff, and you might not really know how to do that much” (Interview 29). He then continued to explore the issue and point out how it is part of biomedical culture:

And there also seems I think to be…the expectation that we get things right away, and there’s also I think a cultural norm to pretend as if you did even if you didn’t. It seems to be culturally acceptable to be certain. Even if you’re not certain, you better act certain. And I think that’s really dangerous. But it’s present. And I don’t know what you’re going to do in terms of all your observations and interviews and all that, but I think that if you were to observe attendings, most attendings will give approval, like they’ll pay attention and give words of approval to those residents and medical students who seem certain. You know, and maybe they’re right when they’re certain, but being uncertain is not valued, in general, with exceptions. –interview 29

When I referred to a physician who had experience attending mentioning her expectations of residents and was to be assertive, he quickly interrupted:

Yeah, but how do you know what you’re doing when you don’t know what you’re doing. And how do you be assertive when you’re telling yourself, and I think appropriately really, the medical student is telling themselves, I’ve never done this before. I don’t know what I’m doing. How do I know this is the right way to do it? How do I make sure not to hurt the patient? But yeah, I think attendings tend to say to be assertive. –interview 29

As he states, uncertainty is not valued and actually according to interviewees, it is looked down upon. The combination of encouraging and expecting certainty while discouraging questioning or any form of hesitation can, as he states, be a very dangerous
thing. It not only can lead to physical harm to the patient, but breeds a sense of silence within the biomedical establishment. Power is maintained through muting the voices of those who want to reflect or question the structure. In addition to assertiveness, the interviewee spoke to the culture of biomedicine and how it discourages any form of challenging the system or introspection.

There’s something generally within medicine that values certainty, and you said there was an attending that valued assertiveness, and you might also call that aggressiveness...like an aggressive (smacks hands together) certainty that what I’m doing is right and the ability to back it up even if your reasoning is flawed. And...it’s just something that is in the culture. I think medicine in general sort of suffers because...we’re not able to in our culture, accept humility and lack of certainty and sort of open-minded questioning. So that’s one just kind of general theme. –interview 29

As he pointed out, there is a constant pressure to continue moving full-force into interaction and clinical care even if the physician is unsure of herself. Such emphasis discourages physicians from taking the time to reflect and double-check their actions.

**Apathy Toward Changing the System**

This section will look at how the efficient=objective=competent physician mindset creates apathy in physicians towards changing the system. Medical education and the culture of biomedicine, according to the interviewees, seem to encourage silence surrounding problems within them. There is little space to question authority and thus hierarchical power dynamics are perpetuated in which physicians’ voices and efforts to change the system are often stifled.

The very perceptive physician who also does public health work said in reference to how problematic the biomedical system is:

The thing is I always say [to] myself, how would I feel about this if I were a Martian landing on earth, trying to understand this new place called earth. Would this make any sense to me, applying Martian logic to this problem? The
answer is no, it doesn’t make any sense. I don’t think if we were building a system we would build the one we have now. The strange thing is that as you go on you can be inured to these problems. You seem to somehow just accept them, probably as a coping mechanism. So it no longer seems so strange, but I know that it’s a very isolated culture in some ways. –interview 56

He then talked about the benefits of personal growth through struggling in such a bizarre system. Through that process, one eventually learns that it is very difficult to challenge ‘the system.’

And so I think that many of these things though they’re undesirable from a societal perspective, given that we’re sort of where we are, and conditional upon that—there are opportunities for personal growth through this strange process we go through. So I think it’s an attitude thing. If you get upset and you want to fight, ultimately it’s like breaking your head against a rock or something, because you’re not going to get anywhere at the level that you are at that point, at least that’s the feeling that one has. –interview 56

Then he spoke to how the system is ‘inefficient,’ as it relies on individuals’ abilities to work their hardest in the flawed system instead of supporting change towards a better structure.

The other thing is that the system sort of, I think generally favors personal commitment over structural change. So I think that whatever shortcomings there are, they’ve always been filled by excellent people trying to do their absolute best for someone else. They rely on altruism to fill the gap and the holes in this patchwork quilt of healthcare systems, and it’s really a plural thing. And for those who can rise to the occasion, that’s fine, but really the way to construct a system, and this is not my idea, but a lot of quality improvement theory, is to not say, oh, we need everyone to do their best all the time. We need to build a system where the average person provides good care, always. –interview 56

As the system wears out individuals, it takes away their energy to question or challenge the system. Thus, physicians start to realize that they do not have much power over the health outcomes of their patients; it is a larger structural issue.

Yeah, I think developing a sense of patience is very important. If you’re going to be a physician, you have to realize the limits of what you can do. Also realizing that you actually play a very small role of determining the health of your patients. I mean it’s sort of interesting when you look at the fact of medical care per se, I mean most of the big factors that determine health have to do with socio-economic status, education, those are the determinants of mortality for example. –interview 56
Then the question arises, why are these other issues not being talked about within cultural competence courses and within the discourse of efficiency? Why are systemic issues such as time constraints and reimbursement issues not receiving more attention within the discourse of decreasing health disparities?

The radical medical student pointed out how objectivity is validated and any variation or subjective experience is disregarded:

In terms of validating my own experience, okay a good example is when you meet a doctor and you’re a medical student, rather than saying hello, how are you, or try to get to know you, the only thing they say is: what do you want to be when you grow up, which means, which specialty are you going to choose within the profession of medicine? I think it’s classic. It’s the only thing that they say to you that has anything to do with who you are as a human being; other [than] that, it’s just focused on giving you critical feedback on your skills to improve your skills. This one thing is their attempt [at] validating your humanity. If you look at it at least in my opinion what’s implicit is: one, you’re not a doctor yet, so you’re not grown up and in fact, you’re not really anything yet until you become what you’re going to be. So not only are you not only grown up, but you don’t really exist. And two, you’re not really valid. Some of them say it without thinking about it. They have this tone in their voice when they ask this, it’s a condescending tone but it’s also a nurturing tone. I don’t know how to explain it.
–interview 68

When I asked her where she thought the idea of not validating others’ ‘subjective’ experiences came from, she answered:

One thing I’ve noticed is the kind of feedback one receives as a medical student. I remember the first week of medical school in anatomy they were citing one research and I asked this question where it was clear that I was thinking a little bit outside of the box. And I got really shot down. And there’s this culture where you’re not really supposed to think outside of the box. –interview 68

As she pointed out, the invalidation, or being ‘shot down,’ reflects how the ‘box’ can function as a means of control of ideas and silencing everything outside it. She continued to share throughout the interview about why she thinks the medical education system is so abusive towards anyone who does not fit the mold of the ‘ideal’ medical
student. She referred to medical education as a traumatic experience, and thought that physicians in a way suffer from post-traumatic stress disorder (PTSD).

…It’s like isolation or denial of the abuse or normalization of abuse, like that’s just how it is in this culture, or punishing people if they don’t stay silent about the abuse. I think that doctors are still doing it, [they] were almost parented by the culture of medicine. … There’s this fear that they had never met someone who would actually question or someone who would actually think outside the box. It’s very threatening to them. … I think it’s fear of the unknown. If you’ve only done something one way, if you’ve been beaten into submission that that’s the only right way to do it, then even if in the beginning it’s uncomfortable at least it’s familiar. –interview 68

This analysis may initially seem a bit extreme, but her stories of emotional, mental, and physical abuse towards those who choose to challenge their instructors shed light on how important it is to the individual instructors to maintain ‘tradition’\textsuperscript{15}. Her experiences also reflect how the biomedical establishment controls the voices and ideas that are passed around within the biomedical sphere. Expanding on her ideas, she stated:

And I think in a way, that doctors think that the only way to do medical education is to invalidate people. Even I learned. I used to have a lot of facial expression and this light in my eyes. And I learned right away that in medicine you’re supposed to have your eyes look sort of dead and when someone’s talking to you you’re supposed to keep your face really flat so they can’t see your expression or see what you’re thinking about them. The idea is e=mc\textsuperscript{2}, if they see a reaction in you then they’ll change what they’re bringing to you. So you’re supposed to be as unreactive as possible. You learn quickly from the doctors, that people treat you like you’re bad and wrong and crazy if you have a certain amount of expression or light in your eyes. It’s not because they hate you, it’s because anyone who has facial expression, there’s something wrong with them—they don’t fit in the culture. And they’re trying to help you by squashing any sort of humanity you have in you because that means you’re having feelings and to be a doctor, you’re not supposed to have feelings, because it will blind you from your objectivity. I think it’s trauma. –interview 68

The interviewee’s comment speaks to how emotional distancing is part of the process of being objective, but in a very deep and personal way in her case. She also provides insight into how any hint of emotion, whether positive or negative, gets pathologized by

\textsuperscript{15} See appendix for her stories.
biomedical standards. Yet all of this ‘shooting down’ of anyone who steps out of the designated box, as she points out, is just the instructors’ efforts to help the student become a ‘productive,’ ‘efficient’ and therefore ‘objective’ physician.

The medical student then elaborated on the contradictory messages sent out by instructors:

They say they want your opinion, but they really, I mean sometimes they really do, but you have to be really careful, because the ideal medical student has no self, and no opinions, and no boundaries. You’re supposed to let them touch you and ask you all sorts of personal questions. But you’re not allowed to touch them and you’re not allowed to ask them any personal questions. And they can challenge you if you share [your] opinion or [your] values. They’ll challenge you in a kind of attacking way, if you stick up for yourself. But if they share their opinion, you’re not supposed to say anything. –interview 68

According to this interviewee and another medical student (interview 84), there are constantly these types of mixed messages of saying one thing, then expecting another. The ‘box’ that one is supposed to fit into as a good medical student thus becomes a very fragile space that creates a lot of silence as communication is on the superior’s (biomedical) terms.

So you can’t acknowledge any sort of behavior that is off in any way. … To actually set the boundary is wrong, because that brings up the fact that there are boundary issues and there are barriers, there are cultural differences. –interview 68

Thus to acknowledge that there is a biomedical ‘box’ or expectation for the ideal medical student, or physician problematizes the tension that exists between those on ‘opposite’ sides of the boundary. This links back to questions of cultural competence education and how culture can end up being blamed for health disparities and barriers to ‘appropriate’ care instead of looking at problems within the biomedical system and social injustice that exists in American society. Culture lies on the other side of the boundary, on the subjective experience side, where things that inhibit ‘efficient’ care exist.
When I commented on how it seemed contradictory to expect medical students to set strict emotional and professional boundaries with patients (interview 68), but then to be completely vulnerable to their attendings in a uni-directional way, she quickly responded:

It’s more subtle that way. If it’s just something, just keeping silent about certain taboo things, it’s all under the surface, and it’s more powerful that way. – interview 68

Her comment speaks directly to how power is maintained and perpetuated through breeding silence. That silence leads to apathy towards changing the system by creating the image that there is ‘too much’ structural change that needs to occur. As she noted, the biomedical/structural power is upheld by remaining under the surface where one cannot directly point to the problems and source of power and therefore cannot challenge them or the authority behind them. If the problem can never be isolated and continually evade being ‘spoken into existence,’ it allows the structure to persist and thus the problems of inequality that occur within it to also live on.

Towards the end of the interview with the radical medical student, I asked her about the silence surrounding problems in the system and if cultural competence courses addressed what is going on within biomedical culture. Then I asked about the fear that may surround loss of authority in addressing power dynamics. In response she discussed two types of people who create change, one being the person who goes into the system and “is not afraid and they make change,” the other being individuals who,

feel like change has to come from within first and what they do is…they just get really centered and they learn how to do that within themselves. And they go into the system quietly. –interview 68

Then reflecting on her reply, she placed herself within that spectrum, saying:
But I think what I decided for myself is that after talking to the dean about acupuncture and my comment in oncology class and setting that boundary with the mental patient, I’m going to keep my mouth shut until I have my MD. And I’m going to have no opinion whatsoever and if a doctor touches me, I’m going to ask him very politely to please not touch me. And if they ask me really personal questions, I’m going to try very daintily to skirt the question. But other than that, I’m not going to express my opinion or ideas. I’m going to really take care of myself and really love myself and really focus on self-awareness. And maybe by keeping my mouth completely shut, in that silence, I can notice more about what’s going on in those dynamics and learn from it and grow from it. After I’ve mastered it, but I guess it takes a lifetime to master. But after I have basic competency of knowledge and skill bases, then I’ll start to bring more of myself, and more of my creativity. As of now, I leave myself at home when I go to the hospital. I try to just leave myself at home and I go as an empty shell. I try to sort of soak up the knowledge and skills because I think there’s something to be said for mastery of any form. –interview 68

Her raw response evoked a lot of personal sadness as she seemed very invested in change and critical of the biomedical system in a discerning way, yet in the end decided to opt for ‘keeping her mouth shut.’ Her self-defense mechanism speaks to how the most radical and well-intentioned individuals can enter the system and end up coming out silenced to a certain degree as a means of survival.

A recurring subtext in interviewees’ comments was the sense of urgency to survive. Those who have been in the biomedical system for over a decade now seem to be leaning back in their chairs, acknowledging problems and willing to talk about the taboos to a certain extent, but also seem very aware of just how difficult it is to change the system. Other newer physicians expressed that they were conscious of how it is hard to change one thing without changing the entire system, and were bitter as a result.

In the end, the interviewees all had at least some interest in improving care for patients whether through structural change, policy work, health disparities research, HIV education, or health finance work. Yet they all seemed comfortable or trained to accept that change is gradual and that they are contributing in what they may call ‘small’ ways. The question remains whether their contributions help to break the silence, and whether
cultural competence can constructively finds ways to decrease health disparities and create a space for dialogue and self-reflection.

Conclusion

This chapter looked at how the discourse of efficiency is supported through certain patterns of time constraints, reimbursement mechanisms, and expectations to assert and emotionally distance oneself in the culture of biomedicine. This in turn breeds a kind of apathy that creates silence surrounding the problems of the biomedical system and the impact of larger social issues created by structural inequality of power. The questions and concerns about the structural inequality of biomedicine get either crushed or forgotten amidst the need to constantly increase efficiency on the individual level. Yet pausing to question why they are so overworked, the interviewees looked around only to realize how limited they are by how ‘inefficient’ the system is. Their commitment to biomedicine has become more about the individual physician’s survival in the system and less about addressing the actual problems in the system, as one is not allowed to challenge the deeply-rooted structure maintained by silence.

Though the intentions of cultural competence may be good, it gets ‘bent’ in the process of being applied within medical education so as not to disturb the structure of biomedicine. Cultural competence education has thus, through biomedical discourse, turned discussions regarding culture into a ‘problem’ that is ‘subjective’ and not as ‘real’ as biomedicine. Until the structural inequality of biomedicine and US society that perpetuate discrimination are addressed, cultural competence programs are in danger of maintaining the silence about institutional racism, classism, sexism, and issues of reimbursement and lack of time in biomedical practice.
Conclusion

Cultural competence education has a lot to offer to biomedicine. As a concept, it acknowledges the importance of cultural differences and diverse explanatory models, and it provides an opportunity for physicians to reflect upon and improve their communication with patients. It also acknowledges the biomedical establishment’s desire to decrease racial and ethnic health disparities. Yet, while the concept is well-intentioned, its application is complicated by the nature of structural inequality in biomedical culture and U.S. society. Inequality and the uneven distribution of power are historically deeply rooted within biomedical and U.S. social structures. Thus, cultural competence education can act as a subtle way of maintaining biomedical authority and institutional forms of discrimination.

As demonstrated in this thesis, biomedical power is maintained in part through the process of silencing those who question the system or culture of biomedicine. Biomedical culture seems to breed apathy or hopelessness towards changing the system through by equating competent care with efficiency. The culture and power structure of the biomedical system, through a complex array of interactions, subtly mutes the voices of those who stop to question and take the time to reflect on the system in place. As Chapter Four points out, the expectation of assertiveness, constantly moving forward at a fast pace due to the lack of appropriate reimbursement policies, and emotional distancing, ultimately function to create an environment that leaves little space to reflect or voice one’s self.

Those who choose to question the system and challenge it are usually dismissed as illegitimate voices because they are experiencing biomedicine ‘subjectively’ while
biomedical practice is meant to be ‘objective.’ In order to be an ‘efficient’ physician one must be objective. It is this discourse of biomedical efficiency into which discussion of culture and cultural competence are thrown and thus cultural competence education achieves different goals from those originally set forth.

The discourse of cultural competence programs in the context of biomedical emphasis on efficiency can lead to unintended adverse side effects such as ‘Othering,’ distancing the patient, and pathologizing race. This leads to blaming culture for biological phenomena and for creating communication barriers. The result of these processes is that institutional racism, classism, and sexism that exist in biomedical culture are perpetuated. Through maintaining the power dynamics that exist and reinforcing biomedical authority, the ‘side effects’ then actually become the underlying outcome of cultural competence education. The power in biomedical authority is not created or belonging to one individual, rather it is institutional in nature and cannot be pinned on the physician, the policy maker, or the politician. One can use Ferguson’s analysis of development projects in Africa as a parallel to the results of cultural competence education:

One must entertain the possibility that the ‘development’ apparatus in Lesotho may be what it does, not at the bidding of some knowing and powerful subject who is making it all happen, but behind the backs of or against the wills of even the more powerful actors. But this is not to say that such institutions do not represent an exercise of power; only that power is not to be embodied in the person of a ‘powerful’ subject. A ‘development’ project may very well serve power, but in a different way than any of the ‘powerful’ actors imagined; it may only wind up, in the end, ‘turning out’ to serve power. (pg 18)

Drawing from Ferguson’s statement, those who created cultural competence education did not plan for biomedical authority to be sustained through the programs. Yet it is
through the nature of biomedical notions of culture that cultural competence programs end up ‘serving power.’

Biomedical ideology is instilled in and helps shape the discourse of culture and thus cultural competence education. If biomedicine is seen as the objective ‘truth’ and ‘reality,’ then those who carry ‘subjective’ experience into a biomedical interaction are digressing from what is seen as valuable within the biomedical scope of practice. As demonstrated through the interviews in Chapter Three and Four, and through Taylor’s argument introduced in Chapter Two, if biomedicine is understood as having no culture, then culture belongs to ‘others.’ In order to fit into the biomedical paradigm, culture then needs to be isolated and is prone to being pathologized through cultural competence education.

It is not merely the culture of biomedicine that influences the ‘unintentional’ effects of cultural competence, but the systemic structure of biomedicine itself. Ferguson articulates splendidly how,

intentional plans are always important, but never in quite the way the planners imagined. …intentional plans interacted with unacknowledged structures and chance events to produce unintended outcomes which turn out to be intelligible not only as the unforeseen effects of an intended intervention, but also as the unlikely instruments of an unplotted strategy. …the…outcomes that at first appear as mere ‘side effects’ of an unsuccessful attempt to engineer an economic transformation become legible in another perspective as unintended yet instrumental elements in a resultant constellation that has the effect of expanding the exercise of a particular sort of state power while simultaneously exerting a powerful depoliticizing effect. (pg 21)

Ferguson’s reference to structure is complicated, but can nevertheless be applied to my analysis of biomedical structure. Cultural competence education can be bent into the shape of the structurally unequal system that it is being implemented in (i.e.: biomedical system), ultimately contributing to an ‘unplotted strategy.’
When cultural competence education is brought into biomedicine within the discourse of increasing ‘efficiency,’ it leads to programs that can essentialize culture. In doing so, and associating specific cultural beliefs and behaviors with communication barriers and negative health outcomes, culture becomes the explanation for social phenomena created by the structural inequalities of biomedical culture and U.S. society. Thus the biomedical establishment can evade responsibility for social inequality and injustices and place blame on the ‘other’s’ culture. As Charles Briggs points out in *Stories in the Time of Cholera* (2003),

Culture is widely used to create and control these fragmentations of social relations. … Programs promoting “cultural sensitivity” can cloak assertions of the superiority of biomedical interpretations and denigrations of alternative and resistant views as backward and pathological in the guise of a celebration of ethnic diversity. (pg 313)

As a result, the larger social issues of institutional forms of discrimination, reimbursement, and government health policy are left unaddressed as cultural competence education directs attention away from questioning the power structures involved in those issues.

The question remains: what does the future of cultural competence education look like and where can potential change occur in order to address the larger social issues affecting the health of all populations in the U.S.? Change could start on the micro-level with individual awareness, challenge, and reflection through anti-racism work provided through revamped cultural competence courses. Henry Giroux provides a useful model of,

Multiculturalism as a radical, cultural politics should attempt to provide white students (and others) with the self-definitions upon which they can recognize their own complicity with or resistance to how power works within and across differences to legitimate some voices and dismantle others. Of course, more is at stake here than having whites reflect critically on the construction of their own
racial formation and their complicity in promoting racism. Equally important is
the issue of making all students responsible for their practices, particularly as
they serve either to undermine or expand the possibility for democratic public
life. (pg 339)

Questioning the power structures and the roles individuals play in them that can form a
launching point for self-reflection, learning to fight apathy towards the system, breaking
the silence, and recognizing personal and biomedical privilege.

The existing biomedical establishment and medical school system have the
authority to define what is acceptable and thereby mold competent physicians. Since the
medical school curricula is based on the model of biomedical discourse that prioritizes
hard sciences and efficiency, cultural competence is, first of all, a comparatively low
priority, as was confirmed by the interviewees in Chapter three. Cultural competence
then becomes something separate, often a catchall category, and somewhat expendable.
Secondly, up to this point in history, designers of cultural competence curricula have had
to legitimate the curricula itself within the framework of biomedicine. Consequently,
medical schools’ cultural competence education programs have designated themselves as
the authority on defining culture and what is worth learning about cultural issues. They
then create and regulate identities as part of that system.

Giroux (1994) emphasizes the need for a shift in the discourse of multicultural
education, or cultural competence education, towards what he calls insurgent
multiculturalism. Through this notion of insurgent multiculturalism, Giroux examines
how power lies in the ability to define. Therefore individuals need to question what
knowledge is produced and the function it serves in normalizing certain information as
‘truth’ or valid and others as false or invalid.

In this view, multiculturalism becomes more than a critical referent for
interrogating the racist representations and practices of the dominant culture, it
also provides a space in which the criticism of cultural practices is inextricably linked to the production of cultural spaces marked by the formation of new identities and pedagogical practices that offers a powerful challenge to the racist, patriarchal, and sexist principles embedded in American society and schooling. Within this discourse, curriculum is viewed as a hierarchical and representational system that selectively produces knowledge, identities, desires, and values. The notion that curriculum represents knowledge that is objective, value free, and beneficial to all students is challenged forcefully as… Moreover, an insurgent multiculturalism performs a theoretical service by addressing curriculum as a form of cultural politics which demands linking the production and legitimation of classroom knowledge, social identities, and values to the institutional environments in which they are produced. (Giroux, 1994: pg 337)

Similarly, the discourse of cultural competence and of efficiency need to be examined to understand what purpose specific narratives serve in reproducing biomedical values and knowledge in a way that determine them as ‘truth.’ If producing biomedical knowledge as ‘objective’ information and attitude necessary for competent care is legitimated, then what are considered more ‘subjective’ experiences are illegitimated.

Multiculturalism…should attempt to provide white students (and others) with the self-definitions upon which they can recognize their own complicity with or resistance to how power works within and across differences to legitimate some voices and dismantle others. (Giroux, 1994: pg 339)

Within the framework of biomedicine, this would lead to the physician locating herself within a power-matrix of biomedicine and U.S. society. Ultimately this approach can empower the physician to learn about the political economy of the system and how it works so that she can locate agency within it.

On the larger level, there is a need for major re-organization of the biomedical establishment including education, training, and clinical practice. Every interviewee brought up time constraints as a major factor affecting patient care. Falling considerably short of the utopian ideal of physicians having all the time they want with patients, the biomedical system needs to be re-examined on multiple levels to look at issues of ‘efficiency’ and how the system is organized.
Starting with pre-medical undergraduate training, one is expected to emphasize and prioritize the sciences and the MCAT as they are used as the primary factors for selection. This process alone helps set the mentality that pre-medical students are learning the ‘objective’ sciences and preparing to align themselves with the ‘objectivity’ of biomedicine. I would recommend requiring more social science and community health courses as part of the pre-medical requirements. Experience abroad would also greatly contribute to helping individuals step out of their comfort zones to recognize their cultural biases and learn how to utilize different cultural spaces.

There is even more need for transformation of medical education on the graduate school level as well as residency programs. Some interviewees spoke to this necessity and recommended acknowledging the history behind biomedicine in order to recognize failure as part of the process. As one interviewee points out, biomedicine “has this sort of a-historical religious quality” in which,

it’s revealed truth. And revealed truth by its very nature is eternal, and doesn’t change. Science…sometimes takes on…that character as well. Essentially what you see chronicled are things that have persisted in being true. …you have no idea about all the rejected therapies, all the misplaced theories that turned out to be wrong, you don’t really have a sense of failure and sort of circuitous roads. There’s this linear progression and we’re at the acme of that progression, and we’re at the best there is. And what was before is irrelevant. –interview 56

Recognizing science and biomedicine progression as non-linear can establish the space for self-reflection for medical students. The emphasis to always get everything right, and asserting oneself, could possibly be changed by acknowledging failure as part of the training process. This could happen through contextualizing how biomedicine historically and currently can be used to politicize or de-politicize bodies and voices. Part of recognizing the authority that biomedicine has could also help physicians reflect on the privilege they carry in belonging to the biomedical establishment. Naming
biomedical authority could shed light on the ‘Othering’ process that can occur in the patient-physician interaction. It is important for physicians to recognize biomedicine as one definition of health and just one of the many subjective world views that reflect power structures in American society.

Based on the data collected and my focus on the larger structural issues that affect cultural competence education and clinical interactions, government health policies also need change. If healthcare is a ‘free’ market-based business, it conflicts with the proposition that healthcare is a universal human right. While my knowledge is limited in the political arena, it seems as if there needs to be more checks and balances of imposed insurance and pharmaceutical companies which to a large extent set the terms for healthcare staff reimbursement and biomedical research. Until government officials are prepared to question lobbyists and hold companies accountable for how their investments reflect special interests, the system will only continue to weave itself into a further knot. If government policies do not provide a safety net for citizens, then even healthcare, a basic need, revolves around profit and becomes less and less accessible to those who need it most. Though the single payer plan would help in terms of access to healthcare, even in the United Kingdom, where there is universal healthcare coverage, there is still a health gradient (Kawachi & Kennedy, 2002). Those at a higher social status enjoy higher levels of health compared to those at lower social status. This points to how social issue of how prejudice and the political economy involved in access to resources sustains inequality in healthcare, which is deserving of its own separate thesis. Until the social inequalities are addressed within U.S. society and biomedical education, cultural
competence education will continue to be the ‘bandaid’ solution to the power differentials that create unequal treatment.

In the end it is breaking the silence about the power dynamics that exist within biomedicine and American society that can provide a foundation for productive self-reflection. The process of reflecting on one’s role in the larger power structures can help individuals simultaneously recognize their own biases and challenge the institutions in which they live and work.

Cultural competence has the opportunity to be one tool to engage in the process of questioning authority and challenging discrimination not only within biomedicine, but also in American society.
Appendix 1

Basic Format of Interview Questions:

There were slight variations in the questions asked and order depending on how the participant was responding and the questions often shifted to go more in-depth with the topics the individual was addressing. Some questions were omitted completely if they were already answered indirectly. Many questions are not listed that were sparked by the participants’ responses. For that reasons, those questions tended to be participant dependent and allowed them to talk about the issues that they found pertinent to my research topic of the culture of medicine.

Age:
Race:
Medical School attended:

1.) How did you like your medical school? Where was the emphasis in the curriculum?

2.) Did you have your Cultural Competence classes? What was the curriculum like?

3.) Did you and your peers find it useful?

4.) What was the general feeling your peers had towards the class?

5.) Have you ever had communication barriers with patients? Examples?

6.) How do attendings address communication barriers if at all?

7.) Do you think it is easier to communicate with patients from a similar racial/ethnic or socio-economic background?

8.) How has your identity changed upon entering and graduating medical school?

9.) How have you changed through the process of residency (if applicable)?
10.) What are the expectations/traits of a good student, resident?

11.) What was the style of communication with the attendings while you were a resident?

12.) When strapped for time, what do you end up emphasizing and what gets de-prioritized?
Appendix 2

Politics Involved with Reimbursement and Related Government Policy (Chapter 4)

And you know, the other thing is this is a matter of political will. I mean I think that one of the things that I used to think while I was in public health school and medical school is that people just weren’t rational and if they could just realize that they were being irrational then they would change. But, it’s really not about reason. I mean reason is kind a superficial faculty in some ways, feeling runs a lot deeper. And collectively our willingness to allocate resources to healthcare is already being strained.

You know, Medicaid budgets are continuing to rise, they’re being driven by pharmaceutical expenditures, long term care expenditures, medical costs have been escalating. And it’s not just a US problem. The costs levels have been rising similarly in all countries. We have a higher base level so our total expenditure is higher, but our percent increase over time has been relatively similar across many industrialized countries and they’re all struggling with the same thing of how to allocate resources. So you take that backdrop of strained resources and a body politic that really isn’t interested in spending any more money on it, even though we are. They’re not aware of the fact that Medicare expenditures are rising and a lot of that is coming out of general revenues. So Medicare part A is the hospital benefit, comes out of your paycheck. So whenever you look on your check it says Medicare. –interview 56

And that money goes to the hospitals for the most part, but the other half, when someone goes to see a doctor, that comes out of your income tax. There is a co-pay that Medicare beneficiaries have to pay but the other part, 75% is being covered by general revenues. So people don’t see to what degree we’ve been spending more money on healthcare. The thought of spending more money, even more, to make some of these VERY expensive changes, is not something that a politician probably wants to bring up with their electorate.

No politician gets re-elected by saying we’re going to spend more money on something. The way you get re-elected is you say I’m going to give you lots of benefits now and defer the costs till later, so you don’t have to think about it. Unfortunately that’s not a very responsible way and these things always come back to get you eventually. But how that’s going to play out I don’t know. Unless we think that we ourselves have chosen, and we have as voters, we collectively have chosen it. We may not agree with our fellow citizens, but when there is a sufficient will I think to make a reform in healthcare it will happen. And it won’t happen before then. It’s not going to be something that, it may require crisis too. –interview 56

…My share of the costs of my own health benefits is small enough that I’m not going to be picky. Am I personally affected by the fact that costs are going out of control- no. And that the quality is lousy- not really. Maybe through family members. And then extrapolate that to most people. Most people are healthy most of the time. And those are the people who vote, so they’re not necessarily going to worry about it. So until a sense of discipline and sort of a sense of trying to invest now to make the future better for our
children and grandchildren, until that sense of looking beyond the present and beyond immediate benefits develops.

I mean is there any evidence in our society that that’s the way people think? I mean, you just have to look around you. Well, that doesn’t seem to be the case. Look at how people spend money on their homes and capital on their homes using home equity loans. Those things keep more voters. And they have feelings. And their feelings aren’t going to suddenly change when it comes to voting versus when it comes to how they make their personal consumption decisions. These things, you can’t force them to happen.

You can’t force healthcare reform to happen. When the time is right though, you have to be ready for when that happens, and you have to have a plan in place. And there are plans in place. –interview 56

Stories of Abuse in Medical School (Chapter 4)

Acupuncture Story:

Another example is, I have an interest in acupuncture. I’m actually also in acupuncture school. When I told the dean of my school that I wanted to switch my form so I was going to go to another school for public health but decided I wanted to go to acupuncture school instead. I went in and said, I need your signature so I can get this year of leave of absence so I can go do this other thing. He said well, students from medical school, especially [medical school] students don’t study things like that. I was like what do you mean? … He’s like well, it’s not real. I said, but for 30 years, it’s been my primary world view. I come from a community that believes strongly in energy medicine. And yeah, I’m here in medical school because I believe that too. That doesn’t mean that this thing that I believed in for 30 years, but I’m needing your signature for this paper. He basically told me that anyone who believes in energy is actually psychotic. And in order for him to have the paper signed I would need to go to a psychiatrist and be mentally evaluated. And that I would have to put that I had psychiatric reasons down on the paper before he signed it to allow me to take an academic leave of absence from [medical school] to study acupuncture. And what I sensed from him in that moment was…[it] was an incredibly frightening experience for me, because he was the dean of my medical school. And I actually told him that what he was doing was illegal and then he blew up at me, and I mean blew up. And it just really scared me. And what I felt from him was he had fear, he had tremendous fear of the unknown. –interview 68

Oncology Class Story:

Another example, there was this one time where I was in oncology class. The teacher was giving us hypothetical cases, like he’ll describe a certain patient and we’d raise our hands say what we think they should do. The hypothetical patient had stomach cancer and on average the kind they had the person was predicted to die in 6 months. If they had this one treatment of chemo they could live for 12 months. It only had a 50
percent chance of working. But it had this huge chance of making them feel really sick and shitty forever, like the whole time the treatment is extending their life. Everyone in class was saying, well, based on the scientific literature, I would do this, blah blah blah. Have chemo or not have chemo. And I raised my hand and said I think he should take the money he would spend on treatment and go to Hawaii on a nice vacation. … Maybe I could have phrased it a little more academically but the teacher all of a sudden, his eyes got really hard, and almost glazed over, and his breathing changed and his shoulders went up a little bit and he glared straight at me and said “You are the doctor and you are paid to tell this patient what to do,” in that tone.

Then he said something about, “Some times when I have difficulty feeling any compassion at all for a patient I think how my grandmother would feel in that situation and what would I do for my grandmother.” So he was implying that I had no compassion.

Then afterwards he came up to me and squatted down next to my desk after most of the people had left. He squats down next to me in this non-confrontational way and puts his hand on my chair. And he said, “I hope you didn’t feel singled out by the way I talked to you.” And I say, “Oh, I didn’t feel singled out,” and he’s like, “you didn’t?” And I was like, “No, I have a strong opinion and we have very different opinions about this.”

And he’s like, “Well you’re a student, you don’t know anything.” He’s like, “I AM THE DOCTOR, I have been doing this for 20 years, you know nothing.” He’s like, “I AM THE DOCTOR!” and he was raising his voice at me. I was like, yeah , but I’m a human being and I have a right to be respected. And he’s like, “I AM THE DOCTOR and you will find out how it really is and he stomped away and he wrote a letter to the dean about me being disrespectful.”

-Interview 68

Psychiatric Patient Story:

Another time at [medical school] we had these preceptors, which is like a mentor, and once a week you’d go to a family doctor into their office and see patients with them all afternoon. And so my preceptor was a family doctor and most of the time I’d just listen, but there was this one patient who had these emotional problems who was on psych drugs who had inner personal difficulties and lived in the woods. A little bit slightly unusual thing. I would always just listen. He shook my hand and wouldn’t let go and told me I’d become a really good doctor. Five days later I got an e-mail from him. He must have gotten my last name from my name tag or something, but somehow he got my e-mail. And it’s clear from his e-mail that he’s thinking about our future life together and he’s asking me out to dinner and wants to take me to a movie and I’m so special and all this stuff in the e-mail. And I wrote back hello so and so, I received your e-mail, however I prefer that our relationship remain one of a strictly provider and client and in such a context I feel it would be inappropriate to make any suggestion of intimacy and I hope that you respect my request that I not be contacted in this way in the future. It was very professional and very nice but very clear. Then I carbon copied a copy to my preceptor and the end of my next time there after everyone left, and he closed his door.
He’s like, “I read that e-mail. I’ve spent years counseling this patient, he’s so anxious. You’re a good looking young woman, the least you could’ve said to him was that you were flattered. He had to work up a lot of nerve to ask you out. You’re a good looking young woman, you should’ve been more receptive.”

I was like, “That was an invasion of my privacy. I have certain boundaries. It’s weird when a pt who has all these problems, in general the picture the patient had trouble understanding boundaries.”

And the doctor was like, “You’ve ruined all the counseling I’ve ever done with this patient.”

[I said], “Maybe it’s because you’re male and I’m female and maybe it’s because you’re married and I’m single or maybe we’re just from different generations but I really feel that I have the right in that case to set a boundary.”

He’s like, “You are just a medical student you have no right to do anything like that, I’m the doctor,” and he was screaming at me. I tried to counsel him for a while and finally I was just like, “I think we’re just going to have to agree to disagree.”

And every time after that any time there was a male patient he would be like, “Well, do you have an issue with that patient, do you have to set a boundary with this pt and harass.”

The interface of Non-Biomedical, Traditional, or Complementary Methods of Healing and Biomedicine (Chapter 4)

…I mean people vote with their feet. People going to all sorts of therapies, some of which have an evidence-based component like chiropractic works for certain things, acupuncture works for certain things, but if people want therapeutic relationships they often have not been coming to western medicine for that. But they vote with their feet, so something good must be going on, you know. It may not be the actual therapy that’s delivered, it’s maybe the interface between the clinician and the patient. So it’s hard to disentangle that. But policy-wise, we can’t for example start recommending homeopathy on a large scale if we can’t find evidence that homeopathy works better than not using it…[it needs to be backed up by] a randomized trial. So I distinguish between the ability to have a therapeutic relationship or a therapeutic treatment on an individual level, and the fact that a lot of complementary therapies may provide that for people, but it’s very operator dependent versus something that we want to be able to recommend to the population as a whole as a safe and effective therapy. –interview 56

I’m this type of practitioner. It’s not like, I am the world. This is my school of training. [She is] a Chinese doctor, and I’m an allopathic doctor. These are the therapies that I offer. And I’m really not properly trained to offer you the other ones. If [this is] not good for you, that’s fine, you can go see so and so who does that sort of thing and that’s fine. So that helped because instead of being the culture, I was a culture, amongst cultures and she could choose which culture she wanted to be in. –interview 56

Recommendations
I remember we had a short little economics, allocation of resources type course, but I think there’s nothing like going out and actually having to do it. Or pushing someone and sending them to another country and having to interact with another culture and not having it be something you sort of talk about abstractly. I think as much as you can just put people in a position where they’re forced to do something different than they normally do, that’s a much more effective way than just sitting around and talking about it as a group. I would say one big thing was realizing that some things just aren’t an option somewhere and that’s kind of eye-opening especially coming from the U.S. where we’re sort of, this pit that doesn’t really have a bottom. You just go do whatever you want and you don’t have to think about it. –interview 21
References

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