intima a journal of narrative medicine

ACADEMIC | FALL 2011

Medicine and Cultural Competency: What Anthropology Can Teach Us

By Nita (Bhavnit) Bhatia

Over the twentieth century, the field of anthropology experienced a transformation with respect to both the definition and the centrality of the concept of culture within its ethnographic work. Straying from bound, static, and essentialist notions of culture that earlier anthropologists such as Bronislaw Malinowski had put forth, anthropologists such as William Roseberry, James Ferguson, and Sally Engle Merry offered notions of culture that were differentiated by time, space, context, and tradition. [1-4] In recent years "cultural competency" has emerged as a term in medicine, signifying the phenomenon that by understanding the background of patients, physicians will be better able to understand and treat them in healthcare settings. Hospitals in the United States have become increasingly aware of themselves as multicultural environments, in terms of both physician and patient backgrounds. While this biosocial approach seems to show great promise in creating an informed and cooperative healthcare system, professionals must be cautious not to reinforce essentialist and reductionist ideas about culture when attempting to demonstrate cultural competency.

There is an abundance of evidence on why healthcare providers and medical anthropologists alike have recently felt the need to incorporate cultural awareness into the American healthcare system. It is important to understand how patients from different ethnic groups experience and express symptoms, and how the relationship of culture to illness* can play a significant role in the creation of the theory and definition of a particular disease. For example, a recent study that compared African American, Latino, and Non-Hispanic White patients with Type II Diabetes revealed significant differences in beliefs about causes of self-identified depression symptoms and preferred treatment methods. [7] The greatest differences lay in whether patients believed a medical illness, other people, or they themselves caused their symptoms, and in whether they preferred medication or counseling for treatment. [7] Examining this situation through the lens of cultural competency can illuminate whether cross-cultural symptoms exist, and if these symptoms take on different meanings and warrant different actions in different contexts.

Beyond a purely biomedical concern, culture can have an effect on a range of healthcare experiences. Language and social roles can define the power differential at work in a patient-physician relationship and affect what and how symptoms of illness are communicated.

Reciprocally, a physician's familiarity with a disease and the local opinion of the disease can affect how the physician interprets the severity of that particular medical problem.
It is for reasons such as these that there is discourse concerning cultural competency in every corner of every major hospital, nursing program, and continuing medical education curriculum. Pertinently, the formal definitions of cultural competency seem to be very closely tied to common anthropological concepts such as positioning and participant observation, and to the viewing of culture through a refined anthropological lens. Professionals have claimed that cultural competency is more than just recognition on the physician's part that patients are cultural beings; it also involves the development of "connected knowledge" that allows one to see the world through another's eyes. [8] It includes the recognition that there can be multiple interpretations of the same situation, and it takes critical reflective thinking to potentially reconcile or choose between them in order to provide the most effective care. [8-9]

Given that physicians have such little time to spend with patients, how, then, are they supposed to adequately meet the demands of culturally competent care?

Ironically, the answer seems to have been the widespread acceptance of a reductionist approach to culture in medicine. Often, culture is reduced to language, nationality, or a checklist of essentialist cultural components. The fundamental problem with the idea of cultural competency as it is utilized in healthcare settings is its consideration as a technical skill that can simply be acquired, or an issue that can be handled by a translator. In actuality, what this approach does is equivocate the nuanced concept of culture with a set of ethnic "do's and don'ts" that can be learned and referred to when a physician encounters a patient who fits a given description. [6, 11]

Such attempts at cultural competency entertain the risk of over-attributing disease experiences to cultural differences, when there may actually be more basic socioeconomic factors at play. [5] In turn, there emerges a tendency to exoticize and stereotype members of ethnic groups, and in extreme cases to consider culture an obstacle to health. As Santiago-Irizarry so eloquently puts it, "medicalizing ethnicity as it happened at these [cultural competency] programs allowed it to be incorporated into medical discourses and practices as a pathologized element to be monitored and controlled." [9]

Professionals, be they physicians, anthropologists, or anything in between, seem to struggle with the existence of culture as an elusive, obscure concept that they cannot hold neatly in their hands. So much of culture is about experience, solidarity, and history, rendering it difficult to confine the transformation of physicians into culturally competent professionals to a mere few training sessions. Culture cannot be separated from the social process that creates it, and thus it must be regarded as a material process so that professionals can properly understand it both as a product and an ongoing production. If culture were merely a static product, perhaps translators would suffice in bridging the culture gap between physicians and patients. Yet, since culture is a continuously evolving process, a successful patient-physician relationship requires a much deeper consideration of how social, political, and economic factors might account for the prevalence and understanding of disease.

If we were to place improved cultural competency training within a larger anthropological framework, perhaps it would be worthwhile to incorporate dialogue at the level of individuals, as Sally Engle Merry and Uni Wikan suggest. [4,12] It is, after all, individuals who create and enact culture, who experience illness and disease, and who can illuminate the variation that exists both within and among what we understand as cultures. [5, 12] Such an approach recognizes that culture is not simply language, common tradition, and ethnicity as current discourse suggests, but that these elements converge with socioeconomic and political stratifications to affect a person's life experience. While there tend to be commonalities among people who identify with the same culture, there is always diversity in individual experience. Ultimately, culture should be used as one of many tools to determine how best to treat every individual, not just those from non-Western backgrounds or non-English-speaking worlds. Simultaneously, we must not assume that culture defines the entirety of a person's experience of illness. Medical anthropology continues to show us just us how vital the tool of cultural competency is in providing the most comprehensive and effective medical care for any patient.

** In this piece I use the term "illness" as Dr. Arthur Kleinman defines it in The Illness Narratives (1988). Illness is "how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability." [5]*

References

1. Malinowski, Bronislaw. Argonauts of the Western Pacific: An Account of Native Enterprise and Adventure in the Archipelagoes of Melanesian New Guinea. London, G. Routledge& Sons, Ltd, 1932.

2. Roseberry, William. Anthropologies and Histories: Essays in Culture, History, and Political Economy. New Brunswick: Rutgers University Press, 1989.

3. Ferguson, James. Global Shadows. Durham: Duke University Press, 2006.

4. Merry, Sally Engle. "Human Rights Law and the Demonization of Culture (And Anthropology Along the Way)." Political and Legal Anthropology Review 26(1):55-76, 2003.

5. Kleinman, Arthur. The Illness Narratives: Suffering, Healing, and the Human Condition. New York: Basic Books, 1988,

6. Kleinman, Arthur and Pete Benson. "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix it." PLoS Medicine 10(3):1673-1676, 2006.

7. Noël, La Tonya. "An Ethnic/Racial Comparison of Causal Beliefs and Treatment Preferences for the Symptoms of Depression Among Patients with Diabetes." The Diabetes Educator 36(5):816-827, 2010.

8. Skultans, Vieda and John Cox. Anthropological Approaches to Psychological Medicine: Crossing Bridges. London: Jessica Kingsley Publishers, 2000.

9. Lavizzo-Mourey and E.R. Machenzie. "Cultural Competence: Essential Measurements of Quality for Managed Care Organizations." Annals of Internal Medicine 124:919-921, 1996.

10. Santiago-Irizarry, Vilma. Medicalizing Ethnicity: The Construction of Latino Identity in Psychiatric Settings. New York: Cornell University Press, 2001.

11. Betancourt, Joseph. "Cultural Competence--Marginal or Mainstream Movement?" New England Journal of Medicine 351(10): 953-954, 2004.

Bhatia attended Harvard College where she studied Social/Medical Anthropology and wrote her senior honors thesis on the lived experience of Indian women with vitiligo. She is interested in the social impact of skin disease, as well as the overarching role cultural context plays in how patients and their social networks experience illness. Bhatia is currently completing her MD at Rush University in Chicago, IL., and will begin her internship in Internal Medicine in Oakland, CA in June 2015, followed by her Dermatology residency at Henry Ford.