



## Cultural health capital and the interactional dynamics of patient-centered care



Leslie A. Dubbin\*, Jamie Suki Chang, Janet K. Shim

University of California, San Francisco, USA

### ARTICLE INFO

#### Article history:

Available online 22 June 2013

#### Keywords:

United States  
Cultural health capital  
Patient-centered care  
Patient–provider interactions  
Health inequalities  
Bourdieu  
Habitus

### ABSTRACT

As intuitive and inviting as it may appear, the concept of patient-centered care has been difficult to conceptualize, institutionalize and operationalize. Informed by Bourdieu's concepts of cultural capital and habitus, we employ the framework of cultural health capital to uncover the ways in which both patients' and providers' cultural resources, assets, and interactional styles influence their abilities to mutually achieve patient-centered care. Cultural health capital is defined as a specialized collection of cultural skills, attitudes, behaviors and interactional styles that are valued, leveraged, and exchanged by both patients and providers during clinical interactions. In this paper, we report the findings of a qualitative study conducted from 2010 to 2011 in the Western United States. We investigated the various elements of cultural health capital, how patients and providers used cultural health capital to engage with each other, and how this process shaped the patient-centeredness of interactions. We find that the accomplishment of patient-centered care is highly dependent upon habitus and the cultural health capital that both patients and providers bring to health care interactions. Not only are some cultural resources more highly valued than others, their differential mobilization can facilitate or impede engagement and communication between patients and their providers. The focus of cultural health capital on the ways fundamental social inequalities are manifest in clinical interactions enables providers, patients, and health care organizations to consider how such inequalities can confound patient-centered care.

© 2013 Elsevier Ltd. All rights reserved.

### Introduction

Over the last 15 years, researchers, clinicians, governmental agencies and international health organizations have advocated for the adoption of a patient-centered approach in the delivery of health care (Institute for Patient and Family Centered Care, 2008, pp. 1–28; Institute of Medicine, 2001; International Alliance of Patients' Organizations, 2007; Kitson, Marshall, Bassett & Zeitz, 2012; National Health Service, 2005; Stewart, 1995, 2001; The Health Foundation, 2011; U.S. Department of Health and Human Services, 2008, pp. 1–302; World Health Organization, 2000). The goal of patient-centered care (PCC) is to provide medical care concordant with the patient's cultural values, needs, and preferences (Epstein et al., 2005). While PCC has been relatively under-

conceptualized in the literature, the construct seems to be captured by three broad domains: 1) a provider understanding the patient within his/her biopsychosocial context; 2) shared understanding of the clinical condition; and 3) sharing power and responsibility (Epstein et al., 2005; Mead & Bower 2000; Stewart et al., 2003; Wanzer, Booth-Butterfield & Gruber 2004). The notion of being patient centered is valued because it reflects a moral philosophy that patients are unique human entities, recognizes the multidimensionality of the human experience of health and illness, offers opportunities for patients to participate in their care, and enhances the patient–provider relationship through mutual understanding (Epstein, Fiscella, Lesser & Stange, 2010; Epstein et al. 2005; Institute of Medicine, 2001; Mead and Bower 2000).

However, a number of factors have hindered consensus on what elements comprise PCC. For example, Gillespie, Florin and Gillam (2004) observes that the varying agendas, interests and professional roles of different health care providers make it difficult to operationalize the concept at the patient level. In a recent review, Kitson et al. (2012) acknowledge that while there may be core features of PCC that transcend professional boundaries (e.g., patient

\* Corresponding author. University of California, San Francisco, Department of Social and Behavioral Sciences, Box 0602, 3333 California Street, Suite 455, San Francisco, CA 94143-0602, USA. Tel.: +1 415 271 0249; fax: +1 415 476 6552.

E-mail addresses: [Leslie.Dubbin@ucsf.edu](mailto:Leslie.Dubbin@ucsf.edu) (L.A. Dubbin), [Jamie.Chang@ucsf.edu](mailto:Jamie.Chang@ucsf.edu) (J.S. Chang), [Janet.Shim@ucsf.edu](mailto:Janet.Shim@ucsf.edu) (J.K. Shim).

participation, the patient–provider relationship, and the context of care delivery), the value and priority given to these elements may vary among different professions. Thus, there is little consensus on the elements of PCC, what they mean, how to measure them, and most importantly, how they can be enacted on the one hand or constrained on the other (Epstein et al., 2005; Swenson et al., 2004; Wanzer, Booth-Butterfield and Gruber 2004). Therefore, as intuitive and inviting as PCC may appear, it is difficult to conceptualize, institutionalize, and operationalize.

It is at this nexus that we offer the concept of cultural health capital (CHC) to help to illuminate how PCC is accomplished through or confounded by the interactional work that patients and providers do in the clinical encounter. CHC is defined as a specialized set of cultural skills, behaviors and interactional styles that are valued and leveraged as assets by both patients and providers in clinical encounters (Shim, 2010). In the contemporary U.S., CHC may include: knowledge of medications and health conditions, the ability to communicate that knowledge efficiently, the ability to adjust one's interactional style, organizational skills, and cues of favorable social and economic status. These cultural skills and resources are critical to the ability of patients and providers to effectively engage and communicate with one another. In this paper, we employ CHC as a theoretical framework to analyze how patients' and providers' cultural resources, dispositions and interactional styles influence their abilities to achieve PCC.

The concept of CHC traces its intellectual roots to Pierre Bourdieu's (1977, 1980, 1986) notion of cultural capital, where cultural products and practices of all kinds—styles of dress, eating habits, verbal skills, scientific knowledge, educational credentials etc.—function as forms of capital. CHC also builds upon the work of other scholars who have noted the utility of using concepts of capital in understanding inequalities in health status and health care. Wall (1995) for example, defines cultural capital as the capacity to be and remain informed, thereby it disproportionately benefits those who are better educated, more financially secure and able to capitalize on public health prevention methods. Malat (2006) defines cultural capital as the “knowledge and behaviors that gain an individual advantage in a particular social environment” (p. 305). She suggests that patients' differential abilities to deploy particular strategies to improve physician perceptions and/or negate negative stereotypes in an attempt to reduce the perceived social distance between them and improve the care received may help explain racial disparities in health care. Abel (2008) also draws from Bourdieu to offer a theoretically derived definition of “health relevant cultural capital” as “culture-based resources that are available to people for maintaining and promoting their health” (p. 3). Such resources interact with social and economic capital in the structuring of people's health chances and choices.

What these concepts of cultural capital share in common is the sense that cultural skills and resources increasingly matter in contemporary health care in the West because of the intensified demands placed on providers and patients alike. Health care providers are being asked to do more with less, while patients are being asked to shift from being seekers of health care to informed consumers of medical services. Such consumerist logic requires patients and providers to have a broad set of skills and organizational savvy to navigate an increasingly complex health care environment (Clarke, Shim, Mamo, Fosket & Fishman, 2003).

CHC also has much in common with the concepts of health literacy and self-efficacy (Bandura, 1997; Schillinger, Bindman, Wang, Stewart & Piette, 2004, Schillinger et al. 2002). In fact, CHC often includes these very traits, in that health literacy and self-efficacy are cultural resources and skills that help patients interact with their providers. But the concept of CHC adds another dimension by

suggesting patients' mobilization of these resources not only directly facilitate communication, but also can lead to providers' more favorable estimations of their patients, and subsequently to additional attention and health care (Shim, 2010). The interactional focus and transactional, give-and-take nature of CHC add to our understanding of how these resources impact clinical encounters by underscoring not just the instrumental, but also the symbolic, ways in which CHC operates as a means of exchange.

While this article is based on an empirical study whose original intent was to identify elements of CHC and how they work, our data also enabled us to analyze when and how patient-centered efforts were made in interactions. Below, we illustrate how the differential mobilization of CHC facilitates or impedes the achievement of the three domains of PCC noted earlier: a provider's understanding of the patient's biopsychosocial context, shared understanding of the condition, and shared power and responsibility.

## Methods

The purpose of our study was to determine the types of CHC exchanged in patient–provider interactions and their inter-relationships; the processes by which CHC is acquired, developed and deployed; and the impact (or lack thereof) of CHC on the content, tone, and outcome of interactions. A total of 17 clinic interactions and 23 in-depth interviews comprise the data upon which this article is based. From 2010–2011, we recruited 6 physicians from 3 health care facilities in the Western United States. Two to three patients who had a diagnosis of coronary artery disease and/or Type 2 diabetes were recruited from each physician's outpatient clinic. We selected these particular diagnoses because they are common and chronic in nature, and require active disease management and ongoing contact with health care providers and institutions. Five providers specialized in cardiology; one in internal medicine. We intentionally elected to recruit physicians from different health facilities to give us a range of physician experiences; we also recruited several patients for each provider to give us a range of patient perspectives for each provider. Provider and patient characteristics are described in Table 1. The Committee on Human Research at the University of California, San Francisco approved this study.

One clinical interaction between each patient and her/his physician was digitally recorded in its entirety. The recorder was left in an unobtrusive place in the exam room just prior to the

**Table 1**  
Provider and patient sample characteristics.

Provider sample	N = 6
Race/ethnicity	
White	4
African American/Black	1
Asian American	1
Patient sample	N = 17
Race/ethnicity	
White	5 (29%)
African American/Black	6 (35%)
Latino/Hispanic	1 (6%)
Age	
31–40 years old	2 (12%)
41–50 years old	2 (12%)
51–60 years old	4 (24%)
More than 60 years old	9 (53%)
Annual household income	
\$15,000–\$25,000	5 (29%)
<\$15,000	11 (65%)
Refused	1 (6%)

Download English Version:

<https://daneshyari.com/en/article/7336963>

Download Persian Version:

<https://daneshyari.com/article/7336963>

[Daneshyari.com](https://daneshyari.com)