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Resisting the colonization of the lifeworld? Immigrant patients' experiences with co-ethnic healthcare workers

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ABSTRACT

This article analyzes how "ethnic concordance" (i.e., matching the ethnicity of patients and healthcare workers) shapes patients' experiences of clinical interaction. Adopting the Habermasian framework of lifeworld-medicine contention, we inductively analyze 60 in-depth interviews with low-income LEP (limited English proficiency) Vietnamese and Mexican immigrants, which were conducted in a metropolitan area in Northern California between January 2006 and April 2007. Our findings indicate that, net of linguistic concordance, ethnic concordance appeared to exacerbate rather than alleviate the problem of "the colonization of the lifeworld." Patients often felt that co-ethnic healthcare workers introduced additional power struggles from other systems, such as boundary work among co-ethnic immigrants, into the institution of healthcare. Likewise, immigrant patients sometimes racialized the professional competence and virtues of healthcare providers, ranking co-ethnic doctors below white doctors. While these two general themes characterize the experiences of ethnic concordance among both Mexican and Vietnamese patients, the comparison between the two groups also highlights some differences. Existing research has documented the impacts of ethnic concordance, but little is known about patients' subjective experiences of these interactions. Our findings address this empirical gap. Drawing heavily on the Habermasian theoretical framework, our research in turn broadens this framework by showing how *both* lifeworld and medicine can become distorted by strategic actions in other systems, such as class and immigration, in which the American healthcare system has become deeply imbedded.

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Introduction

In recent years, matching the ethnicity of doctors or staff and patients has been promoted as an important measure for achieving "patient-centered care" for minority patients in the US. However, empirical studies report mixed findings about the impact of ethnic concordance. Researchers have speculated on why ethnic concordance generates different outcomes, but little has been done on patients' subjective experiences with ethnic concordance in healthcare. Our study inductively addresses this question, in particular by exploring why immigrant patients sometimes feel that working with co-ethnic healthcare workers hinders clinical communication. We interpret our findings through a Habermasian perspective; our findings, conversely, broaden this theoretical framework.

We start by offering a concise discussion of the Habermasian framework of lifeworld-medicine contention and a review of the ethnic concordance literature. We then describe our Data and method. We proceed to present our key findings about the negative impact, as perceived by patients, of ethnic concordance on clinical encounters. The Discussion section addresses how our findings, in turn, move beyond the lifeworld-medicine divide, specifically by theorizing how class- and immigration- related issues can distort *both* voices of lifeworld and medicine. We also document patterns of group differences, cautioning against homogenizing the experiences of immigrant patients.

Struggles between voices of lifeworld and medicine: a Habermasian perspective

Habermas' theory of communicative action theorizes the tension between human communications in the "lifeworld" and the "system." The lifeworld refers to everyday experiences and interactions guided by "value rationality" (Habermas, 1984). In the lifeworld, communications constitute true "communicative actions" which are sensitive to context, oriented toward mutual understanding, and result in planned actions through consensus and coordination. In contrast, the system comprises of modern social institutions organized and operating with "purposive

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rationality." In the system, communications amount to "strategic actions," which are governed by abstract, decontextualized rules, pursue goals that are defined in technical and instrumental terms, and are oriented toward producing one's desired outcome instead of achieving mutual consensus. Communicative and strategic actions are ideal typical concepts; in reality, any communication is a mixture of the two. In several of his major works, Habermas theorizes the colonization of the lifeworld by the system, namely the complex and multifaceted process in which the power of the system becomes excessive and aggressively intrusive, distorting lifeworldly communications (Habermas, 1971, 1979, 1984).

Conceptualizing the institution of modern medicine as one aspect of the system, scholars in medical sociology have used Habermas's framework to theorize how clinical interactions often distort and fragment patients' lifeworld voices (Barry, Stevenson, Britten, Barber, & Bradley, 2001; Greenhalgh, Robb, & Scrambler, 2006; Leanza, Boivin, & Rosenberg, 2010; Mishler, 1984; Porter, 1998; Stevenson & Scambler, 2005). Mishler (1984) criticizes typical clinical communications in terms of the distortion of the "voice of lifeworld" (which is inclusive of patients' preferences and experiences and oriented toward doctor–patient consensus through negotiation) by the "voice of medicine" (which is dominated by doctors' biomedical framework and oriented toward the goal of patient compliance). Barry et al. (2001) note that the voice of medicine is not inherently imperialistic when used in a purely scientific context; for example, two scientists can engage in purely technical discussions with the end result of achieving greater intellectual understanding. But "when dealing with patients, science-based medicine operates on a number of hidden assumptions which could be seen as distortions of the lifeworld" (489). Such "hidden assumptions" largely entail an over-reach and uncritical acceptance of the authority of medicine, as in the medicalization of everyday life (Conrad, 1992; Illich, 1976) and the norm of physician-dominance in clinical narratives (Brody, 1994; Good & Good, 2000). The distortion of the lifeworld does not necessarily imply any ill intention on the part of the doctor; rather, a physician can sincerely believe that a particular biomedical framework prescribes the best approach of healing for her patient, without recognizing the relevance of the patient's lifeworld context or the limitations of biomedical approaches (Barry et al., 2001; Stevenson & Scambler, 2005).

Mishler (1984) argues that fragmenting and stifling patients' lifeworld voice renders medical encounters inhumane and ineffective. Studies of patient narratives seem to lend support to this view. Similar to Mishler, narrative studies find that doctors' biomedical framework reduces patient narratives to a set of abstract symptom presentations, which are in turn treated as the scientific basis of diagnosis and treatment options. This may lead to miscommunication, inappropriate treatment, or generally dysfunctional consultations (Good & Good, 2000; Hunter, 1991). Furthermore, it can prevent patients from making sense of their own illnesses, which is arguably an integral part of the healing process (Kleinman, 1988; Mattingly, 1998).

Barry et al. (2001) have nuanced Mishler's argument both empirically and theoretically. Going beyond the dichotomy of doctor-medicine versus patient-lifeworld, the authors observe that *both* doctors and patients may adopt either the voices of medicine or lifeworld. When both parties adopt the voice of lifeworld ("Mutual Lifeworld"), patients are respected as unique human beings and their psychological needs and lifeworld contexts are addressed. As expected, the pattern of "Mutual Lifeworld" leads to a satisfying experience. Surprisingly, they find that patients are also highly satisfied when both parties use the voice of medicine ("Strictly Medicine"), usually for acute conditions and when patients themselves are concentrating on achieving certain health outcomes instead of establishing in-depth understandings of their illness experience. Patient satisfaction notwithstanding, this pattern of clinical communication usually remains superficial, failing to constitute a true communicative action. The most challenging problem is when patients try to introduce lifeworld concerns unsuccessfully, and are dismissed or blocked by doctors' dominant voice of medicine ("Lifeworld Ignored" and "Lifeworld Blocked," which we refer to jointly as "Lifeworld Suppressed"). Finally, it is theoretically possible that a doctor may adopt the lifeworld voice while the patient prefers to engage in purely technical discussions – a pattern that is empirically rare and indeed not reported by Barry et al. (2001). Among other things, Barry and coauthors' research reinforces the importance of the lifeworld voice while documenting its suppression as a persistent challenge for patients. At the same time, their research complicates the theorization of clinical communication – patients, not just doctors, may sometimes embrace the voice of medicine, either as a sign of their internalization of distorted norms of communication (Stevenson & Scambler, 2005), a learned behavior of self-censorship from past experiences, or a survival strategy to prioritize their basic healthcare needs over the need for meaningful communication (Barry et al., 2001). We summarize this conceptual framework in Table 1.

Achieving "Mutual Lifeworld" for ethnic minorities? Ethnic concordance policies in the US

Moving from theory to practice, scholars and policy makers observe that the "patient-centered care" model is a concrete step toward achieving the most desired pattern of "Mutual Lifeworld" (Brown, Ueno, Smith, Austin, & Leonard, 2007; Cooper, Roter, & Johnson, 2003; Institute of Medicine, 2001). The core of patient-centered care focuses on increasing patients' own participation in their healthcare and encouraging greater therapeutic alliance, or partnership between patients and healthcare workers (Epstein et al., 2005; See Mead & Bower, 2000 for an extensive literature review). Proponents for patient-centered care advocate a style of medical interviewing "in which physicians ascertain and incorporate patients' expectations, feelings, and illness beliefs" (Swenson et al., 2004: 1069). Indeed, Barry and coauthors point out that "the focus on 'understanding the whole person' is one of the stages of the patient-centeredness model and could also be interpreted as listening to the patient's lifeworld" (503). In Habermasian terms, the model of patient-centered care attempts to reintroduce into healthcare settings a form of communicative action – context-sensitive, meaning-oriented, consensus-building – that expresses the voice of the lifeworld.

Targeting ethnic minorities, increasing the ethnic concordance between patients and healthcare workers has been promoted as a measure to achieve greater patient-centeredness in the US (Brown et al., 2007; Cooper et al., 2003; Institute of Medicine 2001). Proponents of ethnic concordance argue that co-ethnics, i.e., members of the same ethnic group, are likely to share similar cultural beliefs

Table 1
Patterns of clinical communication (adapted from Barry et al. (2001)).

Doctor	Patient	
	Medicine	Lifeworld
Medicine	**Strictly Medicine** Patient and doctor both focus on biomedical goals. Superficial communication. *Patient satisfaction*	**Lifeworld Suppressed (Ignored or Blocked)** Patient desires to discuss lifeworld concerns, but is suppressed. *Patient frustration*
Lifeworld	Theoretically possible but empirically rare	**Mutual Lifeworld** Patient treated as unique human being; lifeworld concerns addressed. *Patient satisfaction*