

The interpretation of “culture”: Diverging perspectives on medical provision in rural Montana

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Abstract

Seeking to address evident disparities in health care delivery to minority populations, researchers have developed a framework generally referred to as “cultural competency.” This framework suggests that increasing providers’ knowledge about culturally specific beliefs and behaviors will both assist providers in caring for particular, traditionally underserved groups and enhance the quality of health care delivery for all patients. Meanwhile, a number of critics have challenged the presuppositions of the “culture” concept underlying cultural competency, arguing that such well-intended efforts may merely exacerbate received stereotypes. Despite such criticism, the influence of cultural competency, along with the related categories of cultural sensitivity, cultural humility, cultural proficiency, and cultural awareness, continues to grow in medical schools, governmental agencies, and health care organizations, particularly in the United States.

To better assess the varying theoretical and policy claims of proponents and opponents of the cultural competency framework, we undertook a modest qualitative, interview-based investigation. We explored how “culture” is being presented and enacted by Mexican agricultural workers and US health care providers in one rural Montana clinic. While the Mexican agricultural workers in the study emphasized structural dimensions of labor migration as the most relevant factors in shaping patient–provider interactions, the US health care providers tended to focus on the “cultural characteristics” peculiar to their patients. The discrepancy in these assessments serves to extend and complement existing criticism of cultural competency. While our study was limited to one locale with a limited number of participants, its findings highlight the paucity of empirical research in this area and suggest the need to examine the efficacy of cultural competency in settings outside conventional “needs assessment” or “outcome studies” models.

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Introduction

As part of an ongoing effort to address disparities in disease and morbidity among diverse popula-

tions, researchers and program developers have proposed various forms of increased *cultural competency* as a method for expanding health care access and improving health care provision. In most cases, cultural competency refers to a high degree of understanding and empathy between health care providers and patients of different ethnic, racial, or cultural backgrounds (Betancourt, Green, & Carrillo, 2002; Shapiro, Hollingshead, & Morrison,

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2002; Sherer, 2003). Advocates identify myriad “cultural” issues relevant to health care delivery, ranging from divergent understandings of personal and familial relationships to differing rates of drug metabolism (Betancourt et al., 2002; Hunsaker, 2001; Sherer, 2003; United States Department of Health and Human Services, 2001).

While the principles of understanding and empathy upholding cultural competency are hardly new, cultural competency as a tool is rapidly securing a place within formal education settings, governmental agencies, and health care organizations in the United States and elsewhere (Betancourt et al., 2002; Crandall, George, Marion, & Davis, 2003; Papadopoulos & Lees, 2002; Shapiro et al., 2002). In the US, some federal agencies now recommend increasing the cultural competency of health care workers through the recruitment and promotion of members of minority populations (Betancourt et al., 2002; Institute of Medicine, 2001); medical schools devise new programs and curricula specifically focused on the cultural and social context of patients’ lives (Betancourt et al., 2002; Crandall et al., 2003; Wear, 2003); and continuing medical education programs offer seminars pertaining to specific cultural groups (Crandall et al., 2003).

While increasing numbers of such programs continue to emerge, other researchers challenge the presuppositions of the concept of “culture” which give them shape. Many of these critics contend that using “culture” as a shorthand for how patients think, feel, and act may perpetuate rigid stereotypes (Guarnaccia & Rodriguez, 1996; Santiago-Irizarry, 1996; Taylor, 2003). Failure to appreciate culture as a dynamic, flexible system, they argue, may result in generalized, static descriptions, which obscure similarities between broadly defined cultural groups and differences within cultural groups (Geertz, 1973; Good, 1994; Guarnaccia & Rodriguez, 1996; Santiago-Irizarry, 1996; Taylor, 2003; Tervalon & Murray-Garcia, 1998; Wear, 2003). Other critics point out that disparities in disease and morbidity may be erroneously interpreted as stemming from beliefs, values, morals, and customs rather than sources such as economic inequity or racial discrimination (Goldberg, 1993; Kelleher, 1996; Lambert & Sevak, 1996; Wear, 2003). Some further argue that describing difference in terms of culture assumes the locus of normalcy to be white and Western while the “cultured patient” becomes the object of theorization and intervention (Wear, 2003).

Despite such critiques, which reflect long-standing debate about how to characterize human difference, initiatives to improve patient access and quality of care framed around the concept of culture are now firmly on the US health policy agenda. Although burgeoning literatures explore “racial” and “ethnic” variations in disease categories and health outcomes or assess educational needs with respect to cultural competency (Bamshad, 2005; Crandall et al., 2003; Oppenheimer, 2001; Osborne & Feit, 1992; Risch, Burchard, Ziv, & Tang, 2002; Shapiro et al., 2002), there remains a paucity of empirical research on just how “culture” becomes manifest in contemporary clinical encounters. This paper is a modest contribution to that nascent empirical project: an examination of how “culture” is being used in interactions between US health care providers and Mexican agricultural workers in rural Montana. We begin with a brief demographic history of these two groups, before moving to an overview of our research methods and key findings. We then discuss the divergent understandings of barriers to quality health care identified by US health care providers and Mexican agricultural workers, concluding with the implications for further research.

US health care providers

According to the 2002 US Economic Census, over fifteen million people are employed in health care and social service assistance industries in the United States. While most social scientific research focuses on the physicians and nurses within this group, over 90% of health care providers are outreach workers, secretaries, physician assistants, pharmacists, nurses’ aides, orderlies, social workers, hospital chaplains, and others (US Department of Labor, Bureau of Statistics, 2004–2005). Relatively little demographic information is available on these occupations. While studies show that 77% of medical physicians are male and 75% identify as white (Pasko, Seidman, & Birkhead, 2001), similar statistics for other health care providers are currently unavailable.¹ One may speculate that these allied health occupations include more women

¹The HRSA Bureau of Health Professions reports that accurate data on such providers are difficult to attain due to conflicting occupational categorization (e.g. orderly vs. attendant vs. nursing aide). <http://bhpr.hrsa.gov/healthworkforce/reports/facebook.htm>. Accessed July 2005.

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