

Decoding Underlying Meanings of Cultural Competency in Medical Institutions: a Qualitative
Case Study

By

Kristin Troutman

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Approved:

Dr. Dominique Béhague, Ph.D.

Dr. Juleigh Petty, Ph.D.

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Introduction

Cultural competency is a concept that has been a part of discussions about medical training and health care delivery since the 1990s. Cultural competency in medicine can be defined as “an open, accepting, and welcoming attitude toward other group cultures, defined broadly as other racial, ethnic, gender, and affinity groups’ normative, communicative, and behavior values. Openness is ideally coupled with understanding of the substance and nuances of specific cultural norms and practices” (Rivera, Johnson, & Ward, 2010, p. 2). For my research purposes, this definition of cultural competency includes understanding differences among cultures and how those differences affect health care, addressing and serving each patient as a unique individual, and encouraging open communication and active patient participation in the medical encounter. Because culture is something that shapes decision-making and decision-making is a crucial aspect of medical encounters, equipping clinicians to understand other cultures is essential to their ability to aid in their patients’ medical decision processes (Hendson, Reis, & Nicholas, 2015, p. 17). Cultural competency is a framework and a theory that can manifest in different ways depending on the context in which it is operating. One limit to cultural competency is its potential to trend towards essentialism, in which a patient of a certain culture is reduced to the traits that are associated with that culture, which often leads to stereotyping and false conclusions (Fuller, 2002, p. 199). Furthermore, cultural competency training is often difficult to implement in institutions of medical education as beliefs about its efficacy vary. All in all, cultural competency training implementation in medical institutions is complex, yet imperative; thus, it is important to study how it works itself out in specific medical contexts.

My research will focus on a case study of a private medical institution in the United States South. In order to anonymize the institution, I will call it Medical Center A (MCA). I am interested in the extent and implementation of the cultural competency training for physicians at MCA and physicians' personal perceptions of said training. Three of my main research aims were to study: 1) what cultural competency training looks like at MCA, 2) the efficacy of said program, and 3) perceptions of such training by the physicians employed there. Other research questions I have include: 1) should cultural competency training be standardized across medical education institutions, 2) how can cultural competency training be revamped to avert the potential development of essentialism, and 3) what suggestions do physicians have for improving cultural competency training implementation at MCA.

The topic of cultural competency in medicine is important because it affects virtually any patient that identifies with some aspect of a culture that is different from his or her provider. Because cross-cultural doctor-patient relationships occur widely in the medical field, it is important to observe the tactics by which these medical institutions are training their providers to navigate those interactions. It is also important to study the presence and implementation of cultural competency training programs because such programs have varied to such a large extent. Most importantly, the efficacy of cultural competency training is important because of how drastic the consequences can be for poorly-handled cross-cultural medical encounters. Because one's culture is so intimately woven into their identity, it affects medical decisions in a profound way. Without understanding a patient's culture and therefore understanding the factors that drive their medical decisions, behavior, and attitudes, it is nearly impossible to provide them with quality medical care. Studying various physicians' perceptions of cultural competency training will hopefully provide insight as to how

successful the programs actually are, as well as what sociodemographic or political factors may be at play in general attitudes towards cultural competency. Additionally, although there is much research done on the need for physicians to be culturally competent in their medical encounters, an assessment of their perceptions regarding how well their institution trains them in this area is lacking. In fact, according to Willen et al. (2010), “strikingly little is known about the on-the-ground challenges, problems, and pitfalls that arise when educators attempt to render issues of racial/ethnic and cultural difference ‘teachable’ and ‘learnable’” (p. 247).

In this paper, I will outline a series of positions based on an analysis of my interview data. First, I will show that cultural competency training at Medical Center A is discussed in a nuanced way which reveals a general understanding of intersectionality as it is embedded in cultural competency. Further, I will show that physicians have an underlying knowledge of the dangers of essentialization, even when it is not spoken explicitly as such. Next, I will suggest that at MCA, the word “culture” is sometimes used in a latent or coded way to refer to various forms of prejudice, including racism. Debates surrounding cultural competency, therefore, are used as a “safe” way to talk about such issues. Additionally, I will outline the construction of a social hierarchy among physicians revealing latent attitudes of responsibility and blame associated with a lack of cultural competency. Building on these insights, I will present the variety of suggestions that physicians offered and that these analyses point to for improving cultural competency training, and discuss the implications of such findings.

Literature Review

To begin, it is important to provide an explanation for the word “culture” as it will be understood in the context of this paper. Culture is defined as a set of values, beliefs, and norms that direct the thinking and decision-making of a group (Leininger & McFarland, 2006). Additionally, culture involves a variety of dimensions: “race/ethnicity, religious background, gender identity, sexual orientation, immigration status, socioeconomic class, etc. – all of which interact to shape individual and group experiences of identity and social interaction” (Willen, 2013, p. 266). With that definition in mind, we can proceed to build our understanding of what it means to be culturally competent. Most simply put, cultural competency is a framework used to interact appropriately in cross-cultural encounters in a way that promotes openness, understanding, and a willingness to learn the norms of others’ cultures. Put broadly, cultural competence is defined as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross, Bazron, Dennis, & Isaacs, 1989, p. iv). More specifically, cultural competency manifested in a cross-cultural interaction ideally centers on identifying the patient as unique (Hendson, Reis, & Nicholas, 2015, p. 26).

To understand the role of cultural competency in the medical realm today, it is imperative to understand the reasons behind its genesis. According to Betancourt and Cervantes (2009), cross-cultural medical education was first established for four distinct reasons. The first reason was the obvious need for providers to have the skills to care for diverse patient populations. To be sure, sociocultural background and all the individual factors that term encompasses affect health decisions and general wellbeing and for that

reason, understanding those factors is a necessary component to providing quality care. Bridging the gap of understanding between two different cultures is something that, albeit necessary, health care providers have identified as a difficult part of their day-to-day work (Hendson, Reis, & Nicholas, 2015, p. 20). The second reason for the development of the term “cultural competency” is the significant link between effective communication and general health outcomes. In other words, better communication leads to more mutual respect and higher patient satisfaction which therefore leads to greater adherence to treatment as instructed by physicians. In a similar vein is the third reason: that poor communication across cultures has the potential to contribute to racial and ethnic disparities. Cultural competence helps achieve equity in the sense that it eliminates at least some of the disadvantage that individuals face when they cannot communicate effectively with their provider. Finally, the last reason for the onset of cultural competency training in medical education is the fact that at least to some extent, it is required by medical school accreditation organizations. The Liaison Council on Medical Education states that “cultural sensitivity must be a part of the educational experiences of every student” (Betancourt & Cervantes, 2009, p. 472).

In addition to the four reasons of the creation of the term “cultural competency,” Betancourt & Cervantes (2009) discuss three approaches to cultural competency training as carried out across institutions. The first approach centers on cultural sensitivity and awareness, with the focus being examining and perhaps changing one’s attitudes in encounters with other cultures. Such attitudes include humility, empathy, curiosity, respect, sensitivity, and awareness. This approach encourages open communication about the effects of racism, sexism, classism, etc., with the hopes that confronting potential hidden biases will allow one to more readily dismantle them. The second approach to education of cultural

competence is the multicultural or categorical approach, which focuses on knowledge-making. This is the most common type of cross-cultural education, and it involves equipping trainees with a list of common beliefs, practices, and behaviors of a certain culture under the premise that the more one knows about a particular culture, the more able they are to understand it. However, the downside to this approach is that, “with the huge array of cultural, ethnic, national, and religious groups in the US... It is difficult to teach a set of unifying facts or cultural norms... about any particular group” (Betancourt & Cervantes, 2009, p. 473). This approach fails to consider the fact that cultures often influence each other, overlap, or even contain variability within themselves. The result is that, oftentimes, the knowledge-making strategy for cultural competency training can lead to stereotyping. The third approach discussed by Betancourt and Cervantes is coined the cross-cultural approach, and it focuses on the acquisition of soft skills in areas such as the medical interview, decision-making, awareness of prejudice, and more (Betancourt & Cervantes, 2009, p. 473).

Similar to the aforementioned approaches to cultural competency training, Willen (2013) identifies two distinct approaches as well. The first approach is virtually equivalent to Betancourt and Cervantes’s multicultural or categorical approach: it seeks to fill in knowledge gaps that physicians may have by informing them of characteristics of different patient populations they might encounter, with the hope that more knowledge will lead to a higher quality of care given. This approach is generally regarded as having many weaknesses, including the dangers of reducing a culture or group of people to a specific knowledge set. On the other hand, the second approach is similar to Betancourt and Cervantes’s cultural sensitivity and awareness approach; it involves more of a self-awareness assessment on the part of the physician. The goal of this self-assessment is to identify one’s own personal blind

spots in sensitivities or awareness, and explore how those attitudes might affect one's relationship with the patient and, ultimately, the care they give. In addition to the sensitization of clinicians to the social determinants that affect the health of different cultural groups differently, another way that cultural competency is often practiced in medical institutions is through ethnic matching of patient and practitioner (Good, Willen, Hannah, Vickery, & Park, 2011).

Moving along, an issue that is central to this argument is the discussion regarding why exactly cultural competency is so vital in the medical encounter specifically. To start, cultural competency is important because without an understanding of how to properly engage with cross-cultural patients, a physician is not able to understand that patient's decision-making framework, and therefore he or she cannot aid the patient in making the best medical decision. Culture drives decision-making, ergo, without an understanding of a patient's culture, the physician will not be able to come alongside the patient in their medical decisions. Kirmayer (2012) emphasizes the interaction of culture in the doctor-patient relationship through discussing the role of power: "The clinical encounter is shaped by differences between patient and clinician in social position and power, which are associated with differences in cultural knowledge and identity, language, religion, and other aspects of cultural identity" (p. 149). Additionally, the traditional "universalizing biomedical gaze," which is the lens through which many physicians view their patients, oftentimes reduces the patient solely to their physiological symptoms, perhaps ignoring the cultural or social dimensions of their illness altogether (Willen, 2013, p. 275). It almost goes without saying that patients obviously detect the cultural competence of their physician, so when a physician displays a lack of cultural awareness or sensitivity, patient rapport and satisfaction are negatively impacted. In a 2009

study conducted by Michalopoulou et al. in Detroit, Michigan, African-Americans were surveyed about their satisfaction after an appointment with their doctor as well as their perceptions of their physician's cultural competency. Unsurprisingly, "the mean cultural competency score was higher in highly satisfactory visits than in those visits that were less satisfactory" (Michalopoulou et al., 2009, p. 897). Interestingly enough, perceived cultural competency scores of the physicians, as surveyed by patients, were higher when the patient-physician relationship was race-concordant (Michalopoulou et al., 2009, p. 898).

It should be noted that cultural competency training is not standardized across medical institutions: "Even though there is implementation of cultural competency training nationally, it is not uniform in medical education or PA education" (Kelly, 2011, p. 38). This lack of streamlined training contributes to the confusion regarding the extent to which medical institutions have a responsibility to equip their physicians for cross-cultural interactions. A few examples of different ways cultural competency is taught across different institutions are: knowledge-based lectures, journaling, student discussions, role-playing, simulations, and more (Kelly, 2011, p. 38). Clearly, physicians' perceptions of cultural competency training will be limited by the specific way they in which were taught. Because this education looks different everywhere, it is difficult to compare across different medical institutions. Despite the lack of standardization, there exists some accountability for medical schools to incorporate some form of cultural competency training into their curriculums. The Tool for Assessing Cultural Competence Training (TACCT) is a 67-item, self-administered assessment for medical schools to identify gaps in their training and work towards improvement of cultural competency training (Association of American Medical Colleges). However, this tool only

applies to medical schools instead of hospitals, residency programs, or other medical institutions.

Regardless of how exactly cultural competency is taught at a particular medical institution, in order for it to be effective, it must focus on ethnogenesis rather than essentialism. Essentialism occurs when training creates the tendency of physicians to oversimplify and reduce a patient to just their ethnic or cultural characteristics. As Fuller states, “such education cannot be simply a list of traits about other groups, as this may merely reinforce stereotypes” (2002, p. 198). Essentialization of cross-cultural patients through cultural competency efforts tends to reify cultures “as consisting of more or less fixed sets of characteristics that can be described independently of any individual’s life history or social context” (Kirmayer, 2012, p. 155). One additional downside to essentialism is the fact that teaching about one’s differences automatically otherizes cultures different from one’s own. Instead, physicians should hold a mentality of ethnogenesis, which acknowledges and honors the inherent complexity in every individual and recognizes that a particular individual may not always subscribe to a streamlined list of traits assigned to their culture (Fuller, 2002, p. 199). This is important in larger sociological and anthropological scholarship, as the view of contemporary anthropology is that culture is not fixed, homogenous, or intrinsic at either the individual- or group-level (Guarnaccia & Rodriguez, 1996). This line of thinking will ideally lead to more collaborative decision-making, and more understanding between the physician and the patient. In summary, “the essence of cultural competence is not mastery of the “facts” about different ethnic groups, but rather a patient-centered approach that incorporates fundamental skills and attitudes that may be applicable across ethnic boundaries” (Michalopoulou et al., 2009, p. 898). The line between essentialism and ethnogenesis is very

blurred, and thus extra care is necessary in achieving a healthy mode of education about cultural competency without alienating the ones we are trying to be culturally competent with.

In this same realm, it is important to consider Didier Fassin's sociological and anthropological framework for understanding how public health and medicine culturalize their subjects by "produc[ing] statements and act[ing] on the culture of those for whom it is intended and whose representations and practices it is designed to change so that they may have a better or longer life" (Fassin, 2004, p. 173). Consequently, he points out the way that public health sometimes reductively attributes health inequalities to matters of culture, when in reality those inequalities are a product of sociopolitical or structural forces. He cites several scenarios in which this mechanism played out, concluding that there is "a permanence of a form of practical culturalism that essentializes culture and makes it a last resort to interpretation of these inequalities" (Fassin, 2004, p. 175). Ultimately, when discussing matters of cultural competency training, it is important to remember that a reductive discourse of "culture" is not always enough to explain health-related issues.

It is important to bear in mind that cultural competency means something different to everybody. Medical institutions should take caution when rolling out new training models because what may be an effective theoretical framework to train physicians with, may not actually be helpful in practice. One example that highlights this disconnect is a year-long ethnographic study done by Willen (2013), where it was found that "classroom-based engagement with the clinical implications of culture and difference can run awry when the emotional potency of these issues is not adequately taken into account" (p. 253). In this discussion, Willen (2013) points out an important factor to consider, and that is the fact that race, ethnicity, and culture invoke inherently personal emotions in us because of how closely

we identify with our own backgrounds and contexts (p. 258). Thus, to try to teach on such matters without acknowledging the emotional aspect of it, is to fail to teach it to its fullest extent. Willen also raises the additional issue of generational gaps in teaching cultural competency. The medical residents in this particular ethnographic study reacted negatively to the fact that their instructors were teaching them as if they were “blank slates,” or had never heard this material before, even though they had been exposed to it all throughout medical school (2013, p. 265). All in all, cultural competency training is not a simple, one-size-fits-all scenario; instead, it is a sensitive, potentially volatile (and therefore all the more important) arena that requires a tremendous amount of maturity and sensitivity to be able to teach.

One additional critique of cultural competency is the idea of structural competency, a relatively uncharted topic in the medical field. Structural competency challenges the fact that a physician’s cultural competency is enough to adequately address the multitude of barriers to care that a patient may face. Ultimately, the need for structural competency is based on the premise that having cultural sensitivity in the medical encounter does not sufficiently reduce health-related stigma and improve overall health outcomes. The central dogma of structural competency is that “clinical training must shift its gaze from an exclusive focus on the individual encounter to include the organization of institutions and policies, as well as of neighborhoods and cities” (Metzl & Hansen, 2014, p. 3). The argument here is that if a physician is focused too much on the individual patient’s narrative, he or she will miss the systematic, structural factors that played a role in the production of the patient’s condition. According to Metzl & Hansen (2014), in practice, structural competency in the healthcare field manifests in five specific skill sets: 1) a “recognition of how economic, physical, and socio-political forces impact medical decision,” 2) learning the structural components of

health apart from clinically-related factors, 3) being able to differentiate between “cultural” clinical presentations and structural ones, 4) efforts towards structural intervention, and 5) the “trained ability to recognize the limitations of structural competency” (p. 6, 12). Ultimately, the critique of cultural competency is that it does not include structural factors in its discussion of influencers of health. In many ways, structural competency fills in the gaps that cultural competency leaves behind, and for that reason it is an important concept to consider in observing ways to improve the pedagogy of cultural competency in medical institutions.

Methods

My research focuses on physicians' perceptions of the cultural competency training programs administered at Medical Center A.

The design of this study is a qualitative case study of one private medical institution in the United States South, Medical Center A, assessed via one-on-one interviews with physicians that are employed there. During the months of February and March 2018, I interviewed a total of eight MCA physicians for about 20 to 30 minutes each. Additionally, in the months of November and December 2017, I interviewed two students – one in medical school and one obtaining her Master's degree in Public Health, and neither affiliated with MCA – as part of my pilot research to gauge general attitudes towards cultural competency training in the medical field. The style of the interviews was semi-structured, open-ended, and mostly informal, although I prepared a few central questions ahead of time to guide the discussion. I asked open-ended questions about each participant's role at MCA, their role in training of medical students or residents (if any), their experiences with patients in which there was some kind of barrier to understanding (cultural beliefs, language, etc.), their opinions on the cultural competency training at MCA and the extent to which it equips them as physicians, and any suggestions they may have for improving such training. I was interested in gaining insight into each of the physicians' own experiences and personal opinions, so I chose to leave the interview mostly open-ended as to give them space to process their thoughts. I asked follow-up questions that were relevant to each of their individual statements. For the two student interviews, I applied these questions to their respective institutions. Their responses will not inform my questions about perceptions of cultural

competency at MCA specifically, but they can add to the larger discussion of cultural competency's application in the medical field.

At one point in my preliminary brainstorming, I considered conducting a quantitative study by creating a numerical survey to assess physician satisfaction with the cultural competency training they receive at MCA, but ultimately I decided against that because of how important it is for me to gain experiential evidence from the physicians I will interview. I am less interested in satisfaction ratings and more interested in the story behind them, and my hope was that if I was able to dig deeper into the day-to-day experiences these physicians have with exercising their cultural competency, I would be able to glean information useful to an eventual revamping of the training program at MCA. In this way, the qualitative interview approach is strong, because it allows for story-telling and the sharing of experiences, so that I can see the bigger picture at play. Some of the weaknesses of this approach, however, are the obvious presence of various biases as well as the limitation of only being able to interview a handful of physicians, who certainly cannot be representative of the population of providers at MCA. These limitations are further discussed in their own section further below in this report.

My sample of physicians was hand-selected for me by Dr. X [redacted for anonymity], a key informant at Medical Center A. Dr. X connected me with six physicians that have recently been exposed to the same training seminar surrounding unconscious bias, who she saw as willing to meet with me and speak with me about their experiences. Because of the sensitivity surrounding cultural competency training, Dr. X decided it would be in the best interest of all parties if she chose the interviewees based on personal relationships she has with them, knowing those of them that are open, honest, and willing to talk about such issues. For each physician, Dr. X sent a short recruitment email drafted by the researcher (me),

giving a brief description of my research and asking whether or not they would have about 20 minutes free to speak with me. From there, whenever a physician responded to Dr. X and said that they were willing to meet with me, I then followed up with that individual to set up an appointment. Additionally, I was able to meet with two other physicians that were not hand-selected by Dr. X. I was referred to one of these physicians by an unbiased, third-party faculty member of graduate school associated with MCA, who is not involved in my research. I was referred to the other physician by one of the interviewees that Dr. X connected me with, in a snowball sampling scenario. The two student interviewees were individuals that I have had previous relationships with, so I contacted them personally and asked if they would be willing to answer a few of my questions about cultural competency.

All of the interviews were held at Medical Center A, a private medical institution. More specifically, each interview was held in a private setting, usually in the participant's personal office. Additionally, it was interesting to study perceptions of cultural competency training there, as it is an esteemed medical institution often at the forefront of cutting-edge technology and research.

To ensure ethics clearance, my research study was approved by MCA's Institutional Review Board (IRB #172175). Ethics risks are minimized in this study, as it consists solely of interviews in which participants are welcome to refrain from answering any question as well as have the ability to end the discussion at any point. I transcribed the recorded interviews and grouped quotes and paraphrased ideas after identifying dominant themes using deductive and inductive coding. The audio recordings, transcriptions, and other notes taken from the interviews are kept on a password-protected computer.

Confidentiality was maintained throughout the entirety of the research process because the researcher (myself) was the only person collecting data. No other person had access to the audio recordings or transcriptions of any of the interviews. No identifying information was collected or recorded during the interviews. In my report, I detached each physician's name and other identifying features from their responses by coding the data with names such as "Dr. A," "Dr. B," etc. as alternative identities. Once the entirety of the research process concluded, I disposed of the audio recordings of the interviews as to protect participants' anonymity.

A few limitations to my study revolve around the nature of how the sample was collected. First, six out of the eight interviews I conducted at MCA were with physicians that were personally chosen by Dr. X, who had previous relationships with these individuals. Therefore, the sampling bias introduced to my research by this selection method requires acknowledgment that I cannot extrapolate my results to fit other populations. Further, because each of my interviewees has a personal relationship with Dr. X, there existed an incentive for them to speak highly of her training seminar and to not necessarily reveal to me their negative thoughts about it, if they had any. Therefore, some of their responses must be interpreted under the assumption that they were connected with me via Dr. X and consequently may have interpreted the interview as a collection of responses for her.

One additional limitation is that the physicians that will be interviewed have all come from different medical schools and residency programs, and thus will have all received different variations of cultural competency training at their respective institutions before coming to MCA. Thus, it will be impossible to control for their previous training, so I will

attempt to narrow the scope of each interview to refer solely to the training they have completed at MCA.

Limitations to my pilot research with the two students are similar. Primarily present is a sampling bias, as I chose these two students to interview based on the fact that I already had relationships with them. It should be noted that because I know these two students personally, their responses may have been influenced. Further, their responses cannot be generalized or compared to those of the physicians that I interviewed because 1) the students are not physicians, and 2) the students are at two different institutions, neither of which is MCA.

Results

In order to better understand the underlying issues at play regarding the way that physicians perceive cultural competency training at Medical Center A, I have grouped together quotes and ideas from each physician according to the themes that emerged from the various conversations. After analyzing the eight physician interviews and two student interviews, the following themes appear to be most dominant: 1) cultural competency training at Medical Center A is discussed in a nuanced way which reveals a general understanding of intersectionality as it is embedded in cultural competency, 2) physicians have an underlying knowledge of the dangers of essentialization, even when it is not spoken explicitly as such, 3) at MCA, the word “culture” is sometimes used in a latent or coded way to refer to various forms of prejudice, including racism; therefore, debates surrounding cultural competency are used as a “safe” way to talk about such issues, 4) the construction of a social hierarchy among physicians revealing latent attitudes of responsibility and blame associated with a lack of cultural competency, and 5) the variety of suggestions that physicians offered which may imply that the cultural competency training at MCA only partially addresses physicians’ needs, reflecting the complexity inherent in addressing broad-scale sociocultural systems.

Intersectionality in Cultural Competency

As aforementioned in the literature review, one critique of cultural competency is that it excludes structural factors, such as socioeconomic status, environmental context, and the neighborhood and city in which the patient is living. Further, the critique argues that oftentimes physicians exclusively pay attention to cultural factors influencing health, without

incorporating consideration of structural factors. Fortunately, I found this to not be the case for the physicians I interviewed at MCA. Throughout my conversations, I found that many physicians spoke about cultural competency with an underlying understanding of intersectionality, as they mentioned influencers of health beyond just culture. This finding reveals that physicians at MCA may have an understanding of the complexities embedded in cultural competency, regardless of what their training explicitly mentions.

When asked about the cultural competency she has received at MCA, Dr. A mentioned that the training covers several different types of biases, such as “gender, and all that stuff.” Part of the seminar includes showing pictures of certain individuals from different races, ethnicities, genders, classes, etc., and urging the audience to consider what types of biases they have towards the person showed in each image. One example Dr. A gave me of such images about which physicians self-reflect about their biases was a “biker from Harvard.” This description of the training was an encouraging reminder that physicians are trained to examine their biases related to more than just culture. When asked to identify gaps and/or limitations to the existing cultural competency training at MCA, Dr. A mentioned the need for a more developed curriculum on patients with physical disabilities: “It’s not just racial biases that we normally think of, it’s biases to the disabled that we have to think about and understand. What do the kids face when they go to school, what do newly injured people face when they return to work, it’s all those biases that you have to be cognizant of too.” Dr. A gave the example: “Sometimes a patient can’t pay the \$2000 to get the treatment and I get that because that’s real for some people.” She went on to explain that in that situation, it’s a “systems-based issue” so as a physician, she would try to code things a certain way or write something different in a chart in order to get that patient treatment in a different way. This

revealed more understanding of intersectionality in cultural competency training, as Dr. A mentioned bias against patients with physical disabilities and structural factors such as socioeconomic status as a barrier to care. Dr. D also spoke about structural issues when she told me about how many patients at MCA are from low socioeconomic categories and the barriers that come with that. She also mentioned how many patients do not show up to appointments on time because they do not have a ride, all of which points to a deeper understanding of cultural competency as needing to incorporate competency in more than just the area of culture.

Finally, Dr. A mentioned that she feels equipped to serve patients different from her, because: “I’m fortunate; I worked in a ton of underserved and metropolitan areas, so I have met with many, many patients that are different than I. If you’re not used to working with those patients in those cultural situations, you may not understand why the wife doesn’t speak or things like that.” The fact that Dr. A mentioned that she worked in underserved and metropolitan areas implies issues surrounding socioeconomic and political factors, not so much (or potentially in addition to) cultural factors. Her discussion of these things in response to a question about cultural competency reflects her nuanced understanding that in order to effectively communicate with a patient, physicians must be competent in many different areas, not just in cultural factors. Dr. E revealed a similar train of thought. When asked about his training in cultural competency, Dr. E talked about his experiences in different cities besides the city in which MCA is located, and how being in those places has taught him how to interact with different patient populations. He described his “open attitude” as being a result of his extended time in Cleveland, Ohio. This, too, implies an understanding of structural influencers of health as products of living in a city, rather than just cultural issues.

Dr. C also revealed an understanding of intersectionality in cultural competency in his discussion of the “many gaps” that he sees in MCA’s training. He pointed out that the existing cultural competency training does not include LGBT health, which sometimes necessitates different clinical training than is required for non-LGBT patients. Dr. C stressed that there are entire generations of clinicians who do not have these skills, which urges inclusion of such matters in cultural competency training as soon as possible. Dr. C also mentioned that there is no training for patients with physical disabilities, which corroborates what Dr. A expressed. These thoughts incorporate non-cultural factors that influence health, such as sexual identity/orientation and physical disability, which shows that Dr. C also understands cultural competency to be intersectional.

Dr. F expressed his knowledge of intersectional factors when he explained that ideally, there would be a “menu of trainings” that a healthcare worker at MCA could choose from based on his or her specific needs. He gave the example of providing a specific cultural competency training for the obstetrics department that teaches different cultural beliefs surrounding pregnancy. This statement implies an understanding that not only do cultural beliefs affect the health experience, but also that a pregnant patient would have a different patient experience than a non-pregnant patient, and that pregnancy is an influencing factor that requires additional understanding on the part of the physician. Dr. F, as a medical educator, also told me that he teaches structural competency in his classes despite having never been trained on it himself. He went on to say that he sees no evidence of knowledge of structural competency in the clinic among his colleagues, and that this is indeed a big gap in the training administered at MCA. He provided his personal insight as to why there is a lack of training on structural competency, explaining that it risks being irrelevant or impractical as

compared to the vast amount of other topics that physicians need to learn about. Dr. F explained, “There’s so much that students have to learn that they can do to directly influence a patient, that learning something over which they have little control seems impractical.” He suggested a possible solution to this problem being teaching structural competency later in medical education, such as in the last years of medical school or in residency, when students already have a framework built. He also suggested partnering with other professions to address structural issues in a collaborative way, because structural issues cannot be solved using solely medical resources.

When asked about cultural competency training, Dr. G placed an emphasis on language as it relates to the patient experience. He explained that he organizes several seminars per year where the language interpreters that work at MCA speak with faculty about the cultures that they represent; Dr. G maintained that this is the most accessible and understandable training material that his team gets. He gave the example of the Arabic interpreters teaching the faculty about how many Arabic-speaking populations come from a background of persecution and thus bring a certain level of distrust and suspicion into the medical encounter. By knowing this, said Dr. G, he can better navigate those interactions and build trust with his patients in a meaningful way. He also explained that his clinic is intentional in pursuing different training opportunities: they bring in speakers from different cultures to teach, they specifically hire residents, nurses, and even front desk staff that are bilingual and of a diversity of cultures, and they even organize outreach events to connect with their patients in their communities. These examples reveal Dr. G’s understanding of several factors that influence the health experience of his patients: their culture, the language they speak, and their previous institutional relationships which has led to their mistrust and

suspicion of physicians. Altogether, Dr. G shows an understanding of the complexities that shape each patient's experience in healthcare, including more than just their culture.

Dr. B gave an example of one Burmese-speaking patient from Southeast Asia whose family lived in a trailer in a city about an hour away from MCA that did not have the technological resources that the patient needed for his life-dependent treatment. Dr. B revealed that in this scenario, some MCA employees suggested that they find another family to take care of the kid, but Dr. B did not think this was a good idea. Eventually, the MCA Chaplain got involved in order to help the family make the decisions about how to best care for the patient. This example clearly contains several layers: cultural, structural, environmental, social, etc., and Dr. B's recognition of those factors in addition to culture shows that he also understands the need for cultural competency to include training on more than just a limited notion of "culture."

Essentialization in Cultural Competency

Moreover, I found that many physicians were able to identify the tension between being informed about a specific culture while simultaneously trying to avoid stereotyping. This tendency for cultural competency training to lead to reducing patients down to the essential characteristics of their culture is referred to as essentialization. Many interviewees acknowledged the fact that all patients do not fit perfectly into a certain cultural mode, which addresses the dangers of essentialization. Dr. D processed her thoughts about how to best teach the balance between being informed but being careful not to stereotype. She explained how it is possible to be of a certain culture and not fit those characteristics, and that this

concept needs to be emphasized when teaching cultural competency. Likewise, Dr. F suggested that in order to address the essentialization piece of cultural competency training, training should explicitly say (when teaching about a certain culture): “‘These are things that characterize a certain culture,’ instead of framing it as something that all people within a culture do.” Further, he asserted that training needs to explicitly acknowledge the inherent variability within a culture as well as the need to view each patient as an individual. Dr. H also identified the tension between informing and stereotyping, understanding that in some cases it would be helpful for a physician to know the cultural norms of their patients but that in some cases, acting based on stereotypes could lead to acts of offense towards the patient. She suggested that physicians be equipped with the knowledge of the cultural norms that may be present in a certain patient, but maintained that ultimately the physician has a responsibility to ask the patient how they want to be treated and what makes them the most comfortable.

The danger of essentialization was also pointed out by Dr. C, who described how hard it is to find the balance between informing and stereotyping. He explained that the most effective physicians see situations from a big-picture perspective, while being able to simultaneously see the patient as individual. It was also mentioned by Dr. D, who further explained that in her experience, “60% of patients [of a specific culture] fall into the stereotype of that culture,” and that therefore sometimes it is helpful for the physician to remember the traits of that culture, however when caring for the other 40%, issues with stereotyping arise. Dr. D shared that one of the ways she tries to find that balance is by remembering the traits that characterize a certain culture to guide her interaction, but by prioritizing the fact that every family is individual and unique. Dr. G spoke about the difficulty of not stereotyping patients while still remaining knowledgeable about certain

tendencies that different cultures may have. He said, “You want to know how to approach [the cross-cultural patient encounter], but you also have to know that every patient is different.”

He also followed up with saying that, “‘Stereotype’ is such a charged word... I wish we could say something like ‘typical pattern.’” He gave the example of how 90% of Egyptian mothers that he sees will insist on feeding their babies formula in addition to breastfeeding, even though Dr. G and other faculty always explain that if they are breastfeeding, there is no need to also feed the baby formula. He gathered that because this is a trend that rings true more often than not in Egyptian populations, it has become necessary for the efficiency of his practice to skip the back-and-forth conversation about this matter than he would typically have with other patients. This concept was intriguing to me as it reveals that while physicians may be aware that they operate under a certain set of stereotypes regarding their patients, these stereotypes may act as a tool with which to save time in daily practice. However, the dangers with such thinking, such as not fully explaining something to a patient that may not fall into the stereotype or potentially missing something important, persist despite its perceived efficiency.

Additionally, Dr. F expressed the importance of having a person of that specific culture, language, group, etc. to provide input in developing the curriculum of training; the training cannot be developed by someone that is not a part of the group that is being taught about. This revealed a deeper understanding of culture and the need to avoid stereotyping, as Dr. F acknowledged that culture is not something that can be taught easily, it must be communicated by someone that falls into that category to ensure a true representation of its values.

Coded Meaning of “Culture” and Narratives of Blame

In addition to revealing an understanding of intersectional factors embedded in cultural competency, my interviews with physicians also brought to light many hidden or coded narratives that exist within the physician culture of MCA.

First, it appears that the word “culture” is sometimes used to mean more than just the reductive meaning of culture as it is typically defined. Throughout my interviews, at times, references to a lack of “cultural” competency was used to refer to forms of prejudice, including racism, not just discrimination based on culture. This points to the potential use of “culture” as a “safer” word for discussing sensitive issues.

Upon asking Dr. G what he remembers from his own cultural competency training, he exclaimed, “Oh my gosh it’s been... Years ago we had a half-day seminar,” and explained that the seminar was not about cultural differences specifically, but rather difference in general. The fact that this was his response to me asking about cultural competency training specifically reveals the way that “culture” has become coded to mean any kind of difference.

Dr. A explained that the cultural competency training seminar that she has received at MCA is important because “it’s not accusatory, it just puts it out there for you to think about... [this] training brings [our biases] to the forefront of your mind.” Similarly, Dr. D described that this lecture about biases “opens up our eyes to how this cultural insensitivity goes on and how you’re a part of it.” These descriptions given when asked about cultural competency training at MCA reveal the lumping together of any range of prejudices under the umbrella term of “cultural,” even when some prejudice may exist in realms other than cultural. Further, Dr. A’s emphasis on the non-accusatory fashion of the training seminar reveals that there exists a fear of accusation in this realm; the sensitivities surrounding

prejudice, including racism, have led physicians at MCA to use the word “culture” to distance themselves from speaking explicitly about potentially volatile topics. This concept is also addressed by Dr. G, who says that “‘Stereotype’ is such a charged word... I wish we could say something like ‘typical pattern.’” This statement reflects the sensitivity surrounding topics of stereotyping and prejudice as well as the desire for a different language to speak about such topics, therefore supporting the idea that “culture” has become that safe word to refer to prejudice in place of more “charged” words such as “stereotype” and presumably other words such as “racism.”

Dr. A also shared that “[the training] makes me realize how to speak to people better.” Similarly, Dr. B explained that after being trained in cultural competency, he now asks patients of a different culture or language more open-ended questions instead of yes-or-no questions to make sure that there is full understanding between them about whatever treatment, condition, or process that they are talking about. He also stated that he has learned the importance of maintaining the same behavior in every patient encounter, no matter who the patient is, suggesting that it is important to not make assumptions or stereotype patients. Both of these points refer to guarding against prejudice in general, not necessarily cultural prejudice, which further shows how the term “culture” has become code for broad-scope prejudice.

Second, after having several conversations with physicians, I began to see language pointing to narratives of blame and responsibility emerge regarding cultural competency skills. Further, it became clear through this language that there exists some form of social hierarchy among physicians at MCA according to perceived level of cultural competency.

This discussion suggests the presence of latent social values connected to being culturally competent, which contributes to the construction of such a hierarchy.

Many physicians expressed how competent they felt to handle cross-cultural patients, but how they felt that cultural competency training could be improved for others. This notion revealed an interesting distinction between taking personal responsibility for self-perceived proficiency in cultural competency while assigning blame to others for their lack of such proficiency. Dr. E mentioned that he feels as though MCA physicians are confident in their skills, but that in reality, people need more training than they think. A similar sentiment was expressed by Dr. B, when he explained that in the aforementioned scenario with the Burmese-speaking patient, some MCA employees suggested that they find another family to take care of the kid, but Dr. B did not think this was a good idea. In this example, Dr. B accepts his own cultural competence as more correct, and holds the other employees accountable for not being culturally competent enough to understand that family's particular views on end-of-life care. Further, Dr. D explained her perspective that "The more people know, the less they think they need to learn." Thus emerges an interesting gap between how MCA physicians perceive their cultural competency skills and how their skills are actually perceived by others. This insight also supports the idea that physicians may be confident in their personal skills, but simultaneously make judgments about others needing further training. Moreover, there may exist an underlying narrative of self-pride that becomes attached to cultural competence: over time, some physicians may develop an attitude that they have "learned it all" so to speak, and have subsequently mastered the art of cultural competence. Similarly, Dr. C explained his perspective that over time, doctors develop a "practicing persona," where they get into a routine of how they interact with patients. Dr. C framed this is a potentially dangerous

concept, especially when doctors “become less interested in changing how they practice,” especially when it comes to being trained in things like cultural competency. This reveals underlying projections of blame onto the physicians who allow themselves to fall victim to this “routine” without continuing to grow their cultural competency skills. The expression of these judgments about responsibility and accountability thus reveals the construction of a social hierarchy within MCA related to how culturally competent each physician is.

An important point to note is that all but one physician that I interviewed (seven out of the eight of them) explicitly mentioned a specific training lecture surrounding the identification of unconscious biases given to some (but not all) physicians at MCA. All seven of these physicians praised this specific training, and Dr. A expressed that “It should be standardized in every single department – students, faculty, everyone.” She went on to suggest that the seminar be something that physicians have to listen to every year or so, suggesting institutional responsibility for mandated, timely trainings. The fact that this lecture on unconscious bias is the only specific mention of cultural competency training implement at MCA suggests that either this is the only semblance of cultural competency training that exists, or it is the only training that has stood out to physicians. Knowing that physicians at MCA do indeed undergo other forms of cultural competency training upon being hired at this institution, this finding carries interesting implications. The reason that physicians attach themselves to this specific lecture above other trainings could reveal a potential affinity for cultural competency framed within the language of insensitivity and bias being “unconscious,” thus removing responsibility from the physician and subsequently mitigating the blame away from them. This embrace of cultural incompetence as “unconscious” further rejects accountability on the part of the physician, which implies that there is high value

placed in having cultural competence. If latent social values of respect and authority were not embedded in having cultural competency, then there would be no reason for physicians to hide their cultural competency blind spots under the blame-free guise of “unconscious bias.”

Many physicians explained that life experience was a central influencer for cultural competency skills rather than formal training, which reveals a social value of being able to attribute one’s cultural sensitivity to their own efforts, rather than to institutional efforts. Either unprompted or in response to one of my questions about how equipped they feel in cultural competence, almost every interviewee mentioned their past experiences as a physician as being integral to their current knowledge and practice. As previously mentioned, Dr. A shared with me that, “I’m fortunate; I worked in a ton of underserved and metropolitan areas, so I have met with many, many patients that are different than I. If you’re not used to working with those patients in those cultural situations, you may not understand why the wife doesn’t speak or things like that.” This quote expresses the latent social hierarchy that exists among physicians at MCA, as Dr. A describes the difference between her own knowledge in cultural competency, as opposed to those physicians that are “less fortunate.” When asked how she has seen herself grow as a physician, Dr. A talked solely of her life experiences and not did mention any formal training at all. Similarly, Dr. B shared many realizations and epiphanies he has had throughout his medical career that have become more apparent to him “the older [he] get[s].” This statement implies that, in the same vein, his growth and equipping as a physician has come from his own efforts as a physician, revealing a self-esteem associated with having cultural competence. Also like Dr. A, Dr. B made no mention of formal training during this question. Dr. D described the symbiotic relationship between formal training and life experience, stating that institutional training serves to open up

physicians' eyes to the cultural insensitivities that they are a part of, while being in the clinic helps to "build your muscle around what to do about it."

When asked about the extent of institutional responsibility as opposed to individual responsibility in developing cultural competence, the majority of interviewees pointed to the individual as having more responsibility for acquisition of these skills. Dr. C discussed his perspective that physicians are not engaged enough in training because there are too many demands on their time, which implies that there is some level of individual responsibility on each physician to engage him or herself in the learning process. Further, Dr. C's statement implies blame on the physicians that do not engage themselves enough in training. In a broader sense, Dr. C suggested that it was most important to promote self-reflection first, so that physicians can identify their own weaknesses in caring for people different than themselves. Additionally, he said that it is each physician's responsibility to identify the gaps in his or her own knowledge, while it is the institution's responsibility to provide the tools needed to fill in those gaps. Dr. F's first response was that "The most important person in your learning is you." He then went on to express views similar to Dr. C, that there is an institutional responsibility to provide the framework, space, and tools, but that it is the individual's responsibility to take advantage of those tools and acknowledge the areas in which they need to learn. He summed up his opinion by saying that "The institution is 100% responsible, and so is the individual." This statement was unique in its implication that regardless of the institution, the individual is still 100% responsible for their own cultural competency. On the other hand, Dr. G expressed blame towards MCA as an institution for not providing MCA faculty with the resources they need to excel in cultural competence. He told me that because 40% of their patient visits require an interpreter, it is "out of necessity" that

his clinic push for more effective training and resources, even when MCA does not provide these tools on an institutional level. He gave me the example of how the well-child visit handouts that they give out to patients are only available in English and in Spanish, even though many of his patients are Arabic-speakers. Thus, his clinic requested that MCA provide this resource in Arabic and after a while of no progress being made, one of his residents who speaks Arabic ended up producing the translated handout herself. This example provides a ground-level view into some of the challenges physicians face when not being provided with adequate resources by MCA at the institutional level. Further, this example provides a position of blame towards MCA as an institution for not providing those resources, along with an esteem associated with the way Dr. G took matters into his own hands to obtain the resources his department needed to improve its cultural competence. Along these same lines, Dr. H pointed out that it is largely the responsibility of the medical school or medical institution to teach the tools of cultural competency to students and faculty because “You don’t know what you don’t know”; in other words, if someone has never been confronted with the fact that they operate with a set of biases, they can never make steps towards improvement. Therefore, Dr. H, too, believes that it is the institution’s responsibility to make physicians aware of their biases and provide them with the tools to mitigate them.

Overall, by having these conversations with physicians, I was able to identify coded language and underlying discourses in the culture of physicians at MCA. One meaning that I uncovered was the way that the word “culture” is sometimes used to refer to different forms of prejudice that may or may not actually have to do with culture. The other hidden discourse that became clear through my conversations was the way that responsibility and blame are assigned to either proficiency in, or lack of, cultural competency skills. Many of the

statements reveal that individual physicians may feel confident in their skills, while judging others as in need of further training. This suggests that it is important for physicians to take the credit for their skills, especially in cultural competency. The narrative of individual responsibility also implies blame for those who do not take that responsibility, thus constructing a social hierarchy embedded at MCA in which physicians place more respect and authority in themselves or others when they are seen as more culturally competent. There was also some discussion of institutional accountability for providing resources in cultural competence, although by and large, more importance was placed on the responsibility of the individual. The discussion of life experiences as the most important influencer for cultural competency skills also reveals the way that esteem is embedded in a personal acquisition of skills, as opposed to acquisition from formal training.

Additional Opinions and Suggestions

All in all, the physicians interviewed expressed varied attitudes about the cultural competency at MCA and most offered suggestions for how it can be improved. Overall, all interviewees expressed that cultural competency training is important in medical education, but most offered ambiguous or uncertain information relating to the actual training that they and their students undergo. Dr. A., involved in residency training for her department, quoted that she “[doesn’t] know what the students undergo.” Similarly, Dr. E, who is also involved in residency training for a different department, said that he does not do cultural competency training with residents currently, but he plans to “roll it out soon.” Dr. G, who regularly oversees residents in his clinic, offered: “I believe there is a lecture or seminar...” when asked

about the cultural competency training his residents undergo. If the individuals involved in the training of residents in different departments do not know anything about the residents' cultural competency training, this could suggest that the cultural competency training at MCA is very minimal. Regarding medical students, Dr. H informed me that they go through a week of training at the very beginning of medical school, during which one hour is devoted to an interactive presentation about unconscious bias. Beyond that, Dr. H was not sure of what other training the students go through about cultural competency and asserted that there is no consistency in this training process. Apart from the residents' and students' training, I further inquired about the cultural competency training that the physicians themselves undergo. Dr. D told me that she does not remember her cultural competency training, and Dr. F mentioned that he recalls some type of online module training but that he is not sure how effective it was because the online format is not very engaging. The overall ambiguity surrounding cultural competency training at MCA is important to note, as it implies that whatever training does exist may not be enough to cement cultural competency skills in the physicians.

Dr. D maintained that "People [at MCA] are overdone with cultural competency," suggesting that the concept of cultural competency has become less meaningful over time due to its transformation into a medical buzzword. Conversely, Dr. E told me that he is encouraged here at MCA about how important cultural competency training is, providing a more positive outlook. Dr. G lamented that he could not remember his cultural competency training and expressed frustration with the fact that there are "no ongoing opportunities" offered at MCA to refresh one's knowledge.

As far as suggestions, Dr. C reported that the language services at MCA are not that great. Dr. C also suggested that MCA needs to frame cultural competency training as the

development of tools that will make them better physicians in order to pique their interest in engaging with the training. From a medical education perspective, Dr. F reported that he does not believe that there is a very thorough assessment of cultural competency needs at MCA. Dr. A felt that it would be good to teach residents about certain aspects of specific cultures, for example, “_____ culture is male-dominated.” She went on to explain that in some cultures that she serves at MCA, male residents are not allowed into the room with a female patient, and that knowing this cultural belief ahead of time is necessary. She then identified the difficulty with that approach; namely, that there is a wide spectrum of cultures with much variation within and between each culture, making it a large task to teach the characteristics of each one: “I mean how many people can you talk about, right?” She then settled on suggesting that MCA should research which major cultures come into MCA and then focus on training physicians on those “main players.” More specifically, Dr. B discussed his experience working with end-of-life scenarios, stressing the importance of equipping physicians with the knowledge of how different cultures view death and dying. However, he also expressed that big-picture training, such as a focus on overarching biases, is more important than teaching specific cultural characteristics, even though sometimes a physician needs to understand that culture’s specific beliefs. Regarding general training format, Dr. B suggested that cultural competency training should incorporate story-telling, because patient stories and examples are always the most effective in engraining themes into physicians’ heads regarding the importance of cultural competence.

Dr. D suggested that MCA, when developing cultural competency training curriculum, liken this concept to something relatable for physicians. An example she gave was that it is possible to be from the American Northeast and not be aggressive, talk fast, etc. Further, Dr.

D supposed that the training approach should be layered, with first teaching about cultural competency as a framework (allowing for the teaching about certain cultures), but then later acknowledging the dangers of essentialization and training on viewing the patient as individual. Dr. D compared cultural competency training to a menu, where physicians will pick from the training what they think applies to them, without ever being able to fully soak up 100% of any given training. Even more interestingly, Dr. G suggested a similar concept, stating that it would be helpful for physicians to have access to a “tool kit” or “arsenal” of one-pagers giving quick, necessary information about certain cultures such as “Do I shake hands in this culture, do I not.” His reasoning was that it is extremely important for physicians to be able to refresh themselves on cultural norms in an efficient and easy way before entering the patient visit. Another concept that Dr. F pointed out was something called “just-in-time learning,” where physicians are taught something right before they are supposed to use it in practice, so that it is fresh in their minds. Along these lines, Dr. F suggested that it would be a good idea for there to be some kind of archive that exists of short video clips each providing quick training on a wide array of cultures and processes, so that a physician could access any video from the list at any time, preferably right before they would interact with a patient that fits that category. The fact that three of the physicians I interviewed spoke about a similar potential structure for providing cultural competency (through a menu of sorts) is significant, as it reveals a somewhat consistent need that does not seem to be addressed by the institution. Dr. F said that he “doesn’t want to learn about something in a conference and then have to use it six months later.” This notion brings up the concept of what is the purpose of cultural competency training: is it to quickly train a physician to interact with a specific patient and

then forget the information later on? Or is it to enable long-term transformation and growth in the way that a physician interacts with different cultures in the context of his or her practice?

Although the two students I interviewed offer a different perspective and do not relate to my research questions about physicians at MCA specifically, their insight is intriguing to include. An MPH student at another local institution explained that one negative aspect of cultural competency is the damage that comes when individuals being trained in cultural competency respond with indifference or even destructiveness towards the training. She explained that she has seen incredibly damaging situations where someone is being trained in cultural competency and responds with contempt or indifference to the training, both of which injure the people around who feel as though cultural competence is necessary for others to understand them. The MPH student also offered some insight as to why gaps in cultural competency knowledge exist in the medical field: that oftentimes, a failure on the part of the physician to be culturally competent in a patient encounter can be attributed to being “out of the loop in terms of the demographic shifts and evolution of some racial or ethnic group within the U.S.” She then went on to give an example of how many providers do not know the extent to which complementary and alternative medicine is used by African-American women in this current time and space, and that lack of that specific knowledge often creates barriers of understanding in the patient-provider relationship. On the other hand, the MD student expressed views related to the dangers of essentialization: she stated that although she has seen apparent trends among certain cultures, she has also seen such a wide variety of patients that any training that attempts to reduce a group to their core qualities would be unhelpful to her and her fellow medical students.

All in all, it was clear that physicians at MCA all have their own individual suggestions for improving cultural competency at MCA, thus implying that it does not sufficiently cover what it needs to cover, or perhaps that it does not succeed in training what it is meant to train on. Furthermore, this confusion, ambiguity, and/or lack of satisfaction with cultural competency at MCA may reflect the broad-scope complexities inherent in not just the training of cultural competency, but in society at large.

Discussion

Based on my analysis of the interviews, there are several important takeaways that can hopefully guide institutional cultural competency training implementation in the future. In order to provide training that will make MCA employees better physicians, it is necessary to first gauge general perceptions of those physicians and conduct a needs assessment that can inform cultural competency training curriculum. Additionally, determination of some of the underlying attitudes towards the self and others surrounding cultural competency training will be helpful in providing a more comprehensive understanding of the processes at play.

First, it became evident that even though the cultural competency training at MCA may not explicitly include intersectional factors, physicians seem to have a nuanced understanding of the way that cultural competency training must include factors aside from just a limited notion of culture. Particularly, analysis of the interviews showed that physicians understand structural factors despite not being trained on it explicitly. When asked about cultural competency training, many of them mentioned structural variables such as gender, socioeconomic status, the environment in which they live, and other factors that do not directly fall under “culture.” The mention of these concepts suggests that physicians understand, and operate under, the complexities of intersectional cultural competency.

Next, it was also clear that physicians at MCA understand the tension between being informed about certain cultures and the dangers of essentialization, or stereotyping. Many mentioned the need to avoid stereotyping while serving patients of a different culture than themselves, which further reveals the nuanced way that physicians understand cultural competency, despite not being explicitly trained on the dangers of essentialization. Several of the interviewees also addressed the need to teach medical workers about different cultures but

also to emphasize that each patient and each family is individual, which reveals the underlying understanding that physicians have of needing to avoid essentialization.

Subsequently, in discussing the term “culture” with the physician interviewees, it became clear that at MCA, the word “culture” is sometimes used in a latent or coded way to refer to various forms of prejudice, including racism. Several times, physicians used the word “culture” or “cultural competency” to refer to issues surrounding other variables besides culture, whether it be structural forces, race, etc. One possible explanation for this miscoding could be due to the fact that physicians have a strong self-defense mechanism in wanting to distance themselves from being labeled as prejudiced, therefore leading them to tread lightly around these topics by renaming them “cultural” issues. It is almost as if “culture” becomes a safe word for prejudice that does not carry the blame-based, emotionally-charged connotation of “racism.” This concept suggests that more open debate around sensitive issues such as racism could be helpful to deconstruct previously-built walls and allow for more conversation about these issues among physicians.

Next, there emerged a social hierarchy among physicians related to attitudes of responsibility and blame surrounding cultural competency. One theme throughout my interviews was that many physicians expressed pride in their own cultural competency skills, but placed judgment on the lack of skills in others. Thus, blame and accountability is embedded in viewing someone as lacking cultural competency. There also may be a political layer at play, with possible stigmatization and negative judgments of physicians who are viewed as being “in need” of more training in cultural competency, which would explain why there is such a wide difference between opinions of the level of need; some may speak defensively of their skills so as not to come across as prejudiced. Furthermore, all participants

expressed that life experience was a more important influencer of their cultural competence than formal training, which suggests the underlying value of being able to attribute their cultural competence to their own efforts. However, some physicians expressed the view that the medical institution has some responsibility for providing resources and tools for training their faculty in cultural competence. Additionally, all but one physicians mentioned the efficacy of a specific lecture that is centered on unconscious bias. The prevalence of such a positive view on this specific lecture could imply that physicians (either consciously or subconsciously) attach to this one lecture because of the way its approach mitigates the responsibility; it positions bias as not a reflection of the physician's explicit ideals or intentions, but rather an unconscious and therefore unintentional byproduct of other forces.

Finally, the range opinions and suggestions of physicians regarding cultural competency training at MCA reveals that perhaps the presently established training does not necessarily succeed in doing what it is supposed to do. Attitudes towards the training at MCA were mixed, which raises questions about whether or not this formal training meets the needs of all physicians in all departments. Most common was the expression of a need for having access to a "menu" or "tool kit" that could offer short trainings on very specific things (cultures, populations, medical beliefs, etc.) that physicians could take advantage of immediately before meeting with a patient. This suggestion, along with the collection of other ones, reveals the lack of satisfaction that physicians have with the way cultural competency is taught at MCA as well as potentially unaddressed needs. Furthermore, the range of opinions and suggestions may reflect uncertainty regarding how to approach understanding the sociocultural intricacies of society at large.

Conclusions

Altogether, this qualitative case study comprised of eight interviews with physicians at Medical Center A shed light on both explicit and latent attitudes and beliefs surrounding cultural competency that are important in our understanding of how to go about teaching such a topic. Not only does the cultural competency training at MCA not seem to be all that prevalent, but its existing forms do not seem to address the needs that physicians have.

Furthermore, this research serves as a charge for medical educators to reassess how their employees are trained in cultural competency, as well as to have an awareness of the underlying social hierarchy that is being constructed. Understanding the connection between a physician's ability to be culturally sensitive and his or her self-image as compared to other physicians is crucial to demystifying the motives and agendas of learning to be culturally competent. Additionally, even though MCA physicians already seem to grasp the nuances and complexities of cultural competency, medical institutions have the responsibility of explicitly addressing their employees' understanding of not only cultural, but also racial, structural, and social barriers to health.

There are many directions I would be interested in going with future research based off of this initial investigation. Although my specific research was not meant for comparison across physicians but rather for learning the current perceptions of physicians at MCA surrounding cultural competency training, it would be interesting to study the perspectives of an entire graduating class of medical students at the end of their four years of medical school. This method would better control for the cultural competency training they receive, as they will have all been at only one medical education institution at that point, and it would allow for comparison of perceptions across different racial, cultural, and social categories.

Furthermore, it would be advantageous to study the experiences of physicians across all medical specialties (for example, by comparing across residency programs within a specific institution) to gain ideas about how perceptions of cultural competency training differ across different areas of care. Additionally, it could be beneficial to further explore the relationship between the skill of cultural sensitivity and a physician's perceived level of respect, to hopefully realign motives of being culturally competent with patient-centered ideals. Due to the way that physicians at MCA favored the training focused on unconscious bias, this could suggest a need for cultural competency training in general to directly address blame and accountability in its curriculum. Addressing the difference between operating under unconscious bias and blatantly rejecting personal accountability for cultural sensitivity is important in empowering physicians to take responsibility for sharpening their cultural competency skills.

All in all, this dialogue about the nature of cultural competency training across medical institutions carries many implications. As the literature review has outlined, the need for physicians to be culturally competent is high, especially when they are serving diverse patient populations. The implementation of cultural competency training is necessary in counteracting the evidence-based biomedical approach to care that operates under the "one-size-fits-all" mentality (Whitley, 2007). It is imperative that medical institutions are checking in to get a pulse on how their providers view their cultural competency training; if the physicians do not feel as though the training they receive is effectively equipping them to appropriately engage in cross-cultural patient interactions, then it is the responsibility of the medical institution to revamp its approach. Furthermore, although there is individual responsibility to treat others with respect and sensitivity despite difference, it is the

institution's task to provide the tools and the framework for physicians to properly communicate that respect and sensitivity on the ground. Ultimately, without understanding the belief systems and attitudes of physicians surrounding cultural competency training, it will be impossible to equip them to serve others well.

Appendix

The list of questions I used to guide my semi-structured interview with each physician lies below.

1. Please briefly describe your role at MCA (i.e. how long you've been here, what your day-to-day schedule looks like, etc.).
2. What are some of the challenges or perks of working in this specific institutional context, here at MCA? In other words, what do you like or dislike about working at MCA, in general?
3. From your experience, what has been some of the benefits and challenges of working with patients and families from different backgrounds (cultural, gender, socioeconomic status, etc.) than yourself?
4. Can you think of any particular examples of a cross-cultural patient interaction that you had recently? Can you tell me as much detail that you can remember about it? What obstacles, if any, arose in your communication or understanding with that patient?
5. What are some of the common trends, patterns, or experiences that you notice when serving a patient of a different culture?
6. What do you think should be an institutional responsibility for training faculty and staff on cultural competency and awareness?
7. Please describe a time when you were able to use the knowledge obtained through the online cultural competency training to inform your interactions with patients and families from diverse backgrounds.

8. In your opinion, what can we do at MCA to reinforce cultural competency knowledge over time to help make diversity and inclusion intentional every day at our institution?

In most cases, after asking one of the above questions, I asked a follow-up question related to the physician's response. Some follow-up questions were very specific to the participant's response; however, most follow-up questions can be categorized as one of the following:

1. Could you tell me a little bit more about that?
2. Would you provide me with an example of that?
3. Could you please explain that a bit further?
4. Would you guess that this thought is a general consensus among the physicians at MCA, or would you guess that this is a personal opinion that you hold?
5. Do you have evidence to believe that others here at MCA also feel this way?

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