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The Ethical Self-Fashioning of Physicians and Health Care Systems in Culturally Appropriate Health Care

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Abstract

Diverse advocacy groups have pushed for the recognition of cultural differences in health care as a means to redress inequalities in the U.S., elaborating a form of biocitizenship that draws on evidence of racial and ethnic health disparities to make claims on both the state and health care providers. These efforts led to federal regulations developed by the U.S. Office of Minority Health requiring health care organizations to provide Culturally and Linguistically Appropriate Services. Based on ethnographic research at workshops and conferences, in-depth interviews with cultural competence trainers, and an analysis of postings to a moderated listserv with 2,000 members, we explore cultural competence trainings as a new type of social technology in which health care providers and institutions are urged to engage in ethical self-fashioning to eliminate prejudice and embody the values of cultural relativism. Health care providers are called on to re-orient their practice (such as habits of gaze, touch, and decision-making) and to act on their own subjectivities to develop an orientation toward Others that is “culturally competent.” We explore the diverse methods that cultural competence trainings use to foster a health care provider’s ability to be self-reflexive, including face-to-face workshops and classes and self-guided on-line modules. We argue that the hybrid formation of culturally appropriate health care is becoming detached from its social justice origins as it becomes rationalized by and more firmly embedded in the operations of the health care marketplace.

Keywords

Health disparities; Cultural competence; Minority health; Physician training

Introduction

And finally, a history of the way in which individuals are urged to constitute themselves as subjects of moral conduct would be concerned with the models proposed for setting up and developing relationships with the self, for self-reflection, self-knowledge, self-examination, for the decipherment of the self by oneself, for the transformations that one seeks to accomplish with oneself as object.

This last is what might be called a history of “ethics” and “ascetics,” understood as a history of the forms of moral subjectivation and of the practices of the self that are meant to ensure it.

(Foucault 1990, p. 29)

At a September 2008 conference in Minneapolis, Minnesota, participants and attendees at a morning roundtable struggled to answer the questions: “What are the markers of an effective cultural competence program? Is it time for a national standard or other rating system?” The sixth national DiversityRx conference brought together hospital administrators, medical interpreters, anthropologists, and the occasional physician around themes of cultural competence and cultural difference in health care. During the roundtable’s Q&A, Margaret Donovan,¹ an audience member, described a Continuing Medical Education (CME) program that she had developed to train physicians to “incorporate cultural and linguistic competency into the diagnosis and treatment of depression.” The module that she described aptly illustrates the focus of this article: efforts to foster a kind of ethical self-fashioning for health care providers. Donovan’s online intervention begins with a self-assessment in which the user must first rate her own cultural competence. The physician-user then “self-selects” the items, that she might “want to promote in her learning” and chooses the medium she prefers as she proceeds (e.g., text, video, audio). At the end of each module, the “learner” is matched to a behavioral “action plan based on your individual responses to the subscales so that it should be self-motivating.”

Donovan described a typical cultural competence technology, one that is both modularized and measurable. Cultural competence interventions position physicians as “learners,” in contrast to their regular professional roles as experts, and deliver new forms of “cultural” expertise to these learners. While the understanding of culture invoked through such trainings is often likewise quantifiable (see Jenks, this issue), measurable improvement for learners is a primary goal. As minority advocacy groups and others seek to make health care more inclusive for diverse populations, new interventions are being developed to reform health care and expand the regimes of knowledge that are available to health care providers. An emerging cultural competence industry generates and distributes specialized social expertise to teach health care providers how best to respond to “cultural difference” in clinical encounters. Cultural competence (CC) interventions are designed to produce more equal health outcomes by eliminating prejudice among health care providers and reducing disparities in patient care across groups.² In so doing, these interventions work to govern the conduct of health care providers as they produce new kinds of ethical, self-reflexive medical professionals.³

¹A pseudonym, as are all the names of individuals presented herein.

²Another approach to eliminating disparities in quality of health care is through workforce diversity programs. These initiatives promote the recruitment of more minority health care providers to increase access to and quality of health care for medically underserved and minority patients (Shaw 2010). Yet the distribution of access to medical professions in the U.S. continues to ensure that health care providers are disproportionately white and economically privileged (Steinecke and Terrell 2010; Sullivan and Mittman 2010).

³In addition, cultural competence trainings are also rapidly becoming an important site for the construction of cultural difference in the clinic as ethnic categories are simultaneously being created, reified, and contested. In a related study, Epstein describes the ways in which new federal requirements to include racial and ethnic minority populations in medical research have produced new understandings of ethnicity through the emerging science he terms “recruitmentology,” the increasingly-researched effort to “enroll so-called hard-to-recruit populations for clinical studies” (2007, p. 15).

Calls for culturally appropriate health care (CAHC) have emerged in response to reports of ethnic disparities in health and quality of care which serve as critiques of social inequality in the U.S. (Epstein 2007; Institute of Medicine et al. 2003; Shaw 2005). Minority advocacy groups use health statistics revealing patterned inequalities among racial and ethnic groups to demand recognition and resources from the state (Santiago-Irizarry 2001; Wailoo 2001), to contest medical expertise (Hogle 2002), and to seek changes to make primary health care more “culturally appropriate” (Anderson et al. 2003). As a result of such activities, a new knowledge formation, “culturally appropriate health care,” is being advanced and disseminated by “cultural competence” experts through a variety of media.⁴

These interventions, trainings, regulations, and the like form an assemblage of knowledge and practices that we call, for lack of a better term, “technologies of culturally appropriate health care”.⁵ These technologies together work to address the problem of cultural difference in the clinic—indicative of larger structures of inequality—at the level of the health care provider and, perhaps less often, of health care organizations. We situate these technologies within the broader social transformations Rose (1998) terms the relocation of the state: “The state and the political are relocated as shifting zones for the coordination, codification, and legitimation of some of the complex and diverse array of practices for the government of conduct that exist at a particular time and place” (Rose 1998, p. 12). These changes produce distinctive ethical configurations of knowledge and practice, which Rose calls “ethico-politics” (1999, p. 188), carried out in part through the work of the self on the self. By fostering the self-reflexivity of health care providers, technologies of CAHC are designed to ethicalize medical practice to eliminate discrimination and ensure quality care for diverse groups.

CAHC is becoming increasingly tightly integrated in both public and private regulatory regimes. In a first step, in response to calls from minority groups for policy solutions to health disparities, the U.S. Office of Minority Health proposed regulations in 2001 requiring health care providers and organizations who receive federal funds to provide “Culturally and Linguistically Appropriate Services” (CLAS).⁶ More recently, elements of these regulations have been adopted by the Joint Commission, the hospital accreditation agency, in its annual survey.⁷ Yet, as hybrid formations (Epstein 2007), cultural competence programs sit uneasily among quality improvement (QI) efforts in health care organizations and anti-racist social

⁴For anthropological investigations of elements of this process, see Borovoy and Hine (2008), Jenks (2009), Ong (1995), Sargent and Larchanché (2009), Taylor (2003b), and Good et al.’s Shattering Culture project funded by the Russell Sage Foundation. Mattingly (2006) describes urban U.S. hospitals as “border zones” and identifies popular culture as a key resource mobilized by health care personnel seeking to practice medicine across ethnic and economic differences.

⁵Others have addressed this topic and related or narrower aspects of it using the terms cultural competence, cultural sensitivity, cultural awareness, and cultural humility. For reviews of this voluminous literature in medicine and public health, see Beach et al. (2005), Anderson et al. (2003); Kehoe et al. (2003), and Manson (2003). For anthropological treatments of themes of difference, liberalism, and multiculturalism in culturally appropriate health care, see Taylor (2003b), Borovoy and Hine (2008), Kowal (2008), Willen et al. (2010), Kleinman and Benson (2006), Dorazio-Migliore et al. (2005), Anderson et al. (2007), Benson and Thomas (2010), and Sargent and Larchanché (2009), among others.

⁶The full text of the CLAS regulations can be found at <http://www.omhrc.gov/templates/content.aspx?ID=87>.

⁷A private nonprofit organization, the Joint Commission is often known by its former name, the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO (pronounced “jay-co”). While accreditation is voluntary, it is linked to insurance reimbursement and thus its mandates and guidelines have the force of law (or, absent legal sanctions, even greater force). At the DiversityRx conference in Minneapolis in September 2008, Susan Shaw attended a workshop sponsored by the Joint Commission to gather attendees’ input on applying CLAS standards to Joint Commission accreditation standards. In one small group, a hospital employee encouraged the Joint Commission to develop strict standards for hospitals to demonstrate cultural competence. “You guys have a lot of

movements, bearing marks of a range of influences from anti-racist education to patient safety reforms and protocols. CAHC is composed of variable and at times contradictory practices, pushed forward by aims that include immigrants' rights efforts and patient-centered care initiatives.⁸

In this article, we draw on participant-observation research at conferences and workshops dedicated to promoting cultural competence, in-depth interviews with CC trainers, and over 5 years of posts to an email listserv on culture and health care. We analyze the ways in which cultural competence trainings seek to make health care providers ethical subjects who engage in constant self-reflection to eliminate prejudice and ensure equal treatment for their diverse patients. Reflecting expanding interest in "culture" across public health and the health professions, the number of subscribers to the Culture and Health listserv⁹ has grown steadily: when Susan Shaw subscribed in 2003, the list reached about 200 recipients, while in 2007, the moderator announced that she signed up the 1,000th list member, and in 2010, that number was nearing 2,000 subscribers around the world. Those who post to the list, whom we will call posters, are predominantly medical interpreters and health care administrators who have responsibility for handling issues related to "cultural diversity" or for assuring compliance with the CLAS regulations.¹⁰ Diversity trainers, anti-racism and social justice activists, medical anthropologists, and other professionals use the list to advertise and disseminate specialized forms of expertise designed to teach health care providers how best to address and respond to "difference" in clinical encounters.¹¹ Since these data are largely limited to discussions among cultural competence trainers and CC coordinators, we necessarily must restrict this discussion to representations of the goals for CC training from the perspectives of those who carry it out.¹²

This article focuses on approaches to cultural competence, which take as their aim the ethical awareness of physicians and other health care providers as they seek to re-fashion physicians' conduct and orientation toward others. We briefly explore the diverse methods cultural competence trainings use to foster a health care provider's ability to be self-reflexive. We outline the features of more and less ideal strategies (in the eyes of some CC trainers) for achieving this re-orientation, including face-to-face workshops and classes and self-guided online modules. We conclude with a brief reflection on the ways in which

power!" she said, emphasizing the force of Joint Commission standards for hospitals seeking accreditation. In 2010, when posters to the Culture and Health listserv applauded these efforts, one critic bemoaned the efficacy of these nongovernmental regulations over law and jurisprudence by commenting sardonically, "It is a pleasure to announce JCAHO's new standards since that somehow gets people's attention unlike federal law from 1964 which they find less compelling...go figure."

⁸For more information on QI in health care, see Jencks and Wilensky (1992), Scally and Donaldson (1998), and Shortell et al. (1998).

⁹A pseudonym.

¹⁰For convenience, we will refer to these administrators as "cultural competence coordinators," though as indicated in their email signature files, job titles range from "coordinator of cultural services" to "transcultural nurse specialist" to "advanced practice educator" to "language access coordinator," among many others.

¹¹While some might see text from the Internet as de-contextualized, we argue that the Internet is simply another frequently used context for communication. Lysloff argues that "on-line communities...are as 'real' (or imagined) as those off line" (2003, p. 236) in part because of the consequences that online interactions have for "lived worlds" (p. 234). The participants on the Culture and Health listserv are professionals who are deeply invested in the policies and practices of cultural competence and whose production of "online" selves is critically linked to their "real-world" selves. (For more about the production of self in online contexts, see Broad and Joos (2004).) As listserv participation does not afford the opportunity for "real-world" ethnographer-interviewee collaborative meaning creation, we have triangulated these data with other more traditional forms of ethnography such as in-person interviews and participant-observation (Robinson 2001).

¹²For more on health care providers' and medical students' responses to such trainings, see Willen et al. (2010), Jenks (2009), and contributors to Good et al. (forthcoming).

technologies of CAHC are becoming detached from their social justice origins as they become rationalized by and more firmly embedded in the operations of the health care marketplace.

Hybrid Formations of Cultural Expertise

New forms of cultural expertise are being produced and circulated in domains such as the Culture and Health listserv and in face-to-face cultural competence trainings, and these bodies of knowledge must be squeezed into existing conventions of instrumental rationality (e.g., Collier and Ong 2005). Because they stem from different intellectual lineages, CC frameworks represent both universalizing and particularizing tendencies (e.g., Dorazio-Migliore et al. 2005; Dysart-Gale 2006; Kowal 2008; Lo 2010). In their ethnography of mental health services for migrants in France, for example, Sargent and Larchanché (2009) outline three approaches to cultural competence in psychiatric care that are meant to address perceived cultural differences among West and North African migrants. While many state-run mental health clinics utilize the notion of cultural difference in developing effective therapies, they are governed by a French state deeply embedded in the ideals of equality and universalism. Hence, clinicians uncomfortably integrate “cultural” and “republican” ideas of the individual.

Jenks (this issue) usefully distinguishes between categorical approaches to cultural competence, which present a rational-technical solution to the problem of cultural difference in the clinic based on the application of empirical knowledge about particular groups to specific situations, and “cross-cultural” approaches, which seek to modify a doctor’s interactions with *all* patients rather than just with those who appear culturally “different” from the health care provider.¹³ Cross-cultural approaches to CC are analogous to “universal precautions” for infectious and blood-borne diseases insofar as reformers call for the incorporation of CC practice and measures into broader QI efforts across health care systems. Cross-cultural approaches often, but not always, emphasize transforming the subjectivity of health care providers so as to create the awareness in them of racist or prejudicial beliefs and practices, allowing them to control if not eliminate such beliefs. Health care providers are called on to re-orient their practice (such as habits of gaze, touch, and decision-making) and to act on their own subjectivities to develop an orientation toward Others that is “culturally competent.”

A strong anti-racist and social justice orientation permeates many such cultural competence trainings (see also Jenks, this issue), an orientation which stands in contrast to the technical application of information and knowledge as a remedy to gaps in physician expertise. Yet, the incorporation of CC trainings into health care organizations necessarily involves their standardization and institutionalization. Not unlike what Epstein calls the “tacit coalition” that brought about reforms in the U.S. federal research infrastructure, the assemblage of

¹³See also the helpful discussion on the differences between these approaches in Anderson et al. (2007). Calls for patient-centered health care, for instance, are a frequently discussed cross-cultural approach; see, e.g., Din-Dzietham et al. (2004), Epstein and Street (2007) and Lo (2010). A small but growing literature on culturally “Other” health care *providers* poses interesting and related questions about difference in the clinical encounter, exploring the ways in which changed power relations (when the physician is Indian- American, for example) inflect discourses of culturally appropriate health care as they play out in practice in the clinic (e.g., Dorgan et al. 2009).

activists, advocates, and experts driving CAHC “spilled across the normally recognized divide between state and society, experts and the laity, science and politics, ‘insiders’ and ‘outsiders,’ and the powerful and the disenfranchised” (Epstein 2007, p. 87). Like those opposed to new requirements that clinical research must include women, minorities, and children discussed by Epstein, many both within and outside medicine are strongly opposed to the institutionalization of CC measures for a range of reasons, some of which are presented below. As cultural competence efforts become integrated into existing structures for medical education, reformers must balance goals as diverse as measurable achievement, self-transformation, patient safety, and social justice.

As government and regulatory mandates to provide “Culturally and Linguistically Appropriate Services” filter down from hospitals and health care providers to the level of community organizations, well-intentioned workers are tasked with the need to assess their own cultural competence and that of their organization, and then to locate a means to increase it. This was evident in a request for training resources posted to the Culture and Health listserv by a Catholic social service agency staff member, who outlined the features of CC interventions that administrators like her would find desirable:

Something web-based with modules for different levels of staff that is not expensive to use or purchase would be very helpful. And, if you were to expand it beyond the medical system to include mental health, for example, it would be even more helpful. [M]ost of the resources I have been able to find are targeted to health providers and health systems, and the need is much broader than that. My organization is expected to have a ‘cultural competence plan’ to improve our levels of cultural competence. In doing some research to determine what “cultural competence” looks like (in any sort of measurable fashion so that I can develop a plan and a training program to increase it, therefore) has been a challenge. Any assistance in that area would be welcome in my book, and the more concrete the assistance the better!

This administrator exemplifies the effects of new forms of governance on workers-on-the-ground. She is responding to a key premise of measurability that is at the heart of the logic of cultural competence as continuous improvement (Espeland and Stevens 2008; Porter 1995): the imperative for constant self-assessment and ongoing action on one’s own expertise to increase and expand it (Geary 2007).

The complex politics around the new forms of cultural expertise circulating in CC discourses can be glimpsed in a remark by Margaret Donovan, the speaker whose CME module we opened with. At the DiversityRx roundtable described above, she observed, “When we think about health care, we want our physicians, nurses, etc. to be competent. And we don’t have an issue with saying that. But somehow, if it’s preceded by the word ‘cultural,’ we got all kinds of issues!” We argue that it is the requirement of self-reflexivity for health care providers embedded in the concept of cultural competence—as well as collective struggles over the terms in which we are able to recognize inequality in the U.S. (see Epstein 2007)—that are at the root of the “issues” Donovan points out. Good et al. (2002) show how biomedicine has only recently been understood as located in and constituted by relations of power, since it was long constructed as a set of universally applicable knowledge and

practices (Rhodes 1996). In contrast, the concept of culture was entirely outside of biomedicine, constructed as specific, local, and ahistorical (Taylor 2003a)—a view which persists even in some CC trainings (see Jenks, this issue). Efforts to implement cultural competence trainings for health care providers, and CAHC programs more generally, have pushed together these two previously distinct concepts. In the process, culture is being re-constructed as both a barrier to good medical practice and as something to be measured, understood, and mastered—a new component of biomedical expertise (e.g., Andrulis and Brach 2007, see also Dorazio-Migliore et al. 2005, Grillo 2003) and a new form of instrumental rationality.

Many online CC curricula begin with cases that demonstrate the kinds of problems cultural difference may pose in clinical encounters.¹⁴ For example, a typical case study outlines the challenges for health care providers presented by a Mien patient who refused to have his blood drawn because of beliefs that “losing blood saps strength...and may result in the soul leaving the body”:

Saelee Mui Chua, a forty-two-year-old Mien gentleman, arrived at the clinic with his twelve-year-old son, who acted as interpreter. The son explained that his father had seen a traditional healer the previous week, but he had been unable to cure his father’s symptoms: weakness, fatigue, increased urination, and thirst. The symptoms suggested diabetes to the physician, and he ordered a blood glucose test. When Shawnee, the nurse, came to draw the blood, Mr. Saelee fearfully yelled, ‘No!’ His son told Shawnee that his father refused to have his blood drawn. When she asked for an explanation, all he would say is, ‘My father does not want the test.’¹⁵

A wide repertoire of similar vignettes can be found in cultural competence trainings and modules, especially those available online, representing the barriers to care that may result from cultural differences in clinical encounters. The logic of CC trainings leads “learners” to identify and then overcome the root causes of these barriers. Indeed, the very name of the *DiversityRx* conference illustrates how the problems posed by cultural difference (see also Borovoy and Hine 2008, Hester forthcoming) are being constructed by cultural competence discourses as treatable *by prescription*. DiversityRx, an international nonprofit organization which claims a central role in the development of the CLAS regulations, sponsors the biannual DiversityRx conference described above. In this term, “diversity” ambivalently represents both the problem and the remedy (cf. Santiago-Irizarry 1996). Workshops presented throughout the DiversityRx conference present both views: knowledge-based remedies to problems presented by diverse patients in the clinic, as well as the enthusiastic embrace of “diversity” as a social value and remedy to the ills of racism.¹⁶ The rationalization of cultural expertise and its implementation through practices of self-

¹⁴It is worth noting that oft-cited formulations of the “problem” of cultural difference, whether in the clinic, the school, or the ballot box, discursively locate the “problem” with those who are deemed “other” or different. In fact, as pointed out by many cultural competence educators who post to the Culture and Health listserv, the “problem” posed by the existence of cultural difference is frequently located with members of the so-called mainstream or majority populations who are unwilling or unable to accommodate language or other differences in the public sphere.

¹⁵http://www.gagalanti.com/case_studies/cases_by_topic.html, accessed 11 Nov 2010.

¹⁶On diversity as a social value, see Ahmed (2009), Hannah (2008), Mercer (1994), and Morgen (1988), among others. In a recent critique based on methodological insights from research with stigmatized populations, Benson and Thomas (2010) extend the concept

reflexivity and physician education provide a critical site for considering struggles over the management and governance of difference in health care. In the following section, we draw on comments from cultural competence program designers to further explore the process of ethical self-fashioning required of health care providers.

The Call for Ethical Self-Fashioning

Many “cross-cultural” CC programs aim to instill in health care providers the ability to recognize and identify one’s own social, cultural and racial positioning and its effects on clinical practice (see Jenks, this issue). For example, one “Training of Trainers” announcement posted on the Culture and Health list advertised that participants in this training will “develop and enhance...an increased ability to conduct honest self-assessments and acknowledgement of one’s own worldview and cultural identity, as well as the roles these play in understanding, interpreting and framing solutions to problems.” The ethical self presented in this and similar trainings is the one who recognizes racist or prejudicial thoughts in herself/himself and seeks to expunge or at least master them;¹⁷ who understands and accepts the impact of cultural differences on health; who is respectful of patient autonomy and practices patient-centered care; and one who is able to situate each patient in his or her social and cultural context. These ideals are part of the liberal society outlined by Rose (1999) and others who emphasize how the conduct of experts, in particular, must be continuously monitored and improved as part of the process of rationalizing governance. As the tenets of cultural competence are integrated into state and regulatory bodies of health care, physicians’ conduct becomes a problem of governance in new, specific ways following heightened public emphasis on problems of inequality in health care (Institute of Medicine et al. 2003).

The ethico-politics enacted through many CC trainings discussed on the listserv and at DiversityRx conferences relocates responsibility for cultural competence to the individual health care provider, while administrative staff are tasked with its monitoring and improvement. In many such trainings, new information and experiences combine to reveal to health care providers their own behavioral or attitudinal complicity in structures of prejudice, racism and discrimination, followed by programmatic recommendations for more culturally competent practice. Joan Morris, a nurse-practitioner, posted a comment on an online MedPage Today survey illustrating this call for the ethical self-fashioning of health care providers: “A long range plan to develop, maintain and continuously improve [physicians’] interpersonal skills that improve cultural competence as a lifetime and practice responsibility is the need in my professional opinion.”¹⁸

Though cultural competence trainings follow a similar Enlightenment teleology as the HIV trainings analyzed by Stacy Pigg (2001), here it is the biomedical practitioner who is being introduced to a set of broadly relativist ideas and practices, and the cultural competence

of cultural competence to include the ethical dimensions of relations between researchers and participants and between clinicians and providers. The authors call for greater attention to the “personal disposition” of the researcher/clinician in cross-cultural encounters and for the ongoing importance of situational ethics.

¹⁷This dynamic of self-control echoes the Christian pastoral emphasis on mastery of the self described by Foucault (Martin 1988).

¹⁸From: <http://www.medpagetoday.com/Surveys/>, Survey from Week of 16 Jun 2008: Should diversity training be a requirement for physician licensure and renewal? accessed 10 June 2010.

trainer who holds and seeks to convey contested and fragile cultural expertise.¹⁹ While some CC interventions echo consciousness-raising programs of the 1970s in their efforts to bring to awareness the systemic nature of discrimination, as well as health care providers' roles in unequal health care for minorities, CC trainings are distinctive insofar as their subjects are largely highly educated and privileged experts.²⁰ Many hope that what Fraser calls "intrusive forms of consciousness engineering" (Fraser 2001, p. 24) will result in greater self-reflexivity among health care providers (e.g., Lax et al. 2009).²¹ For instance, a couple of years ago, Shaw contributed a guest lecture on cultural competence to an online gerontology course. Students posted responses to this lecture, commenting on each others' responses as well. One pointed out the limitations of the "categorical" approach to CC as she commented on another student's essay:

In your essay, you state that it could be very difficult to avoid stereotyping after cultural competency training and that this habit of stereotyping can be overcome by spending more time with patients to get to know them as people rather than as another figure in a certain cultural group. In a sense, you logically cite a potential drawback to cultural competency training – the fear that "categorizing" people will cause professionals to expect a set of beliefs and behavior from an individual of a certain culture rather than respond knowledgeably to the set of beliefs and behaviors that are expressed. In class, we learned that cultural competency starts with an attitude rather than knowledge about another culture – the attitude being, 'I realize this person is from a different culture, I respect him/her as a person, and I want to better understand what difficulties they may be having or what contradicting beliefs may be present to best provide them fair services.' With a desire to understand others' perspectives and acknowledge that other cultures exist, perhaps even the tendency to stereotype can be eliminated from the get-go.

While this student ably articulates a critique similar to that found in Kleinman and Benson's (2006) article in PLoS, her final sentence hints at the scope and extent of ethical self-fashioning for physicians called for by the cross-cultural approach ("With a desire to understand others' perspectives...perhaps even the tendency to stereotype can be eliminated from the get-go"). Physicians and public health scholars Melanie Tervalon and Jann Murray-Garcia term this kind of self-understanding "cultural humility," which "incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (1998, p. 117).

¹⁹Pigg (2001) discusses the didactic nature of biomedical "trainings" for outreach workers in developing countries and their emplotment within broader contexts of language and modernity.

²⁰This is in contrast to, for example, the "empowerment" and consciousness-raising programs discussed by Cruikshank (1999), Sharma (2008), and others, which take as their target low-income, minority, and otherwise marginalized groups. Margaret McLaren describes feminist consciousness-raising groups of the 1970s as, in Foucauldian terms, both practices of the self and practices of freedom, insofar as they aim at "self-transformation" and "they create new nonnormalizing modes of existence and relationships. Practices of freedom are ethical practices requiring the work of oneself on self" (McLaren 2002, p. 159).

²¹Nancy Fraser observes that "identity politics" as a means of achieving equality "emphasizes psychic structure over social institutions and social interaction [in its explanations of inequality]. Thus, it risks substituting intrusive forms of consciousness engineering for social change" (Fraser 2001, p. 24).

The technologizing of conduct found in CC trainings has far-reaching and unanticipated effects. While many CC trainings can trace their genealogies back to anti-racist organizing efforts, as they become incorporated into the highly rationalized domain of health care where interventions are expected to demonstrate positive effects, broader social change often remains separate from the work they seek to accomplish. Tomas Matza makes an analogous argument about the unanticipated effects of “political technologies like [discourses of] self-esteem” in mediating social conflict in post-Soviet Russia. Matza observes that these discourses become “paradoxically antipolitical technologies because discontent is obscured by the endeavor of affective engagement, and the zone for political work remains at the level of the self” (2009, p. 513). The self-reflexive processes involved in both self-esteem discourses and in CC trainings diffuse group- or class-based conflict and grievances to the level of the individual, minimizing the possibility of collective remedy or response.

Emptied of the requirements for social action characteristic of feminist and other consciousness-raising approaches (e.g., McLaren 2002), cross-cultural approaches instead seek to level outcomes by eliminating individual subjective prejudice associated with disparities in health care quality (e.g., Like 2005; Tervalon and Murray-Garcia 1998) and by promoting patient-centered health care, which incorporates patients’ individual circumstances, needs, and desires.²² Categorical approaches to cultural competence, in contrast, may be more likely to preserve the concept of difference as locatable in the Other, similar to that traced by Kowal in her analysis of an antiracist health disparities institute in Australia. Kowal explores the “conflicting impulses of liberal multiculturalism to eliminate inequality and to maintain essential difference” (2008, p. 338) as a central feature of efforts to address Indigenous health disparities in Australia. We focus on efforts to promote health care provider self-reflexivity in this article in part because this approach may provide a way out of what Kowal posits as “the inevitability of a politics of difference when two groups are opposed to one another by definition (in this case, Indigenous and non-Indigenous)” (Kowal 2008, p. 343).

At the same time, the call for self-reflexivity and the continuous monitoring of a physician’s internal attitudes and habits of thought reflects broader transformations in the U.S. economy. In his discussion of the effects of neoliberal developments on labor formations, Nikolas Rose shows how the solution to the need for permanent re-skilling is “the transformation of the subjectivity of the worker” through, for example, retraining for those “downsized” by corporations seeking to streamline and minimize labor costs (Rose 1999, p. 162). Further, the re-skilling of physicians through the layering of additional “cultural” skills and responsibilities onto traditional biomedical competencies is a process carrying specifically ethical valences, since discourses of cultural competence are deployed within larger frameworks of equality and, increasingly, patient safety.²³

²²This individualized understanding of ethical care is counter-balanced by other elements of CC, however, such as language access policies and procedures that are more systems-oriented. For example, see related efforts around health literacy (e.g., *Health Literacy Universal Precautions Toolkit*. AHRQ Publication No. 10-0046-EF, April 2010. Rockville, MD: Agency for Healthcare Research and Quality. <http://www.ahrq.gov/qual/literacy/index.html>).

²³In her 2003 article in *Academic Medicine*, Janelle Taylor cautions that, “medical students as a group may be forgiven for failing to take [their cultural competence courses] very seriously as long as they perceive that they are quite distinct from the real ‘competence’ that they need to acquire. To change this situation will require challenging the tendency to assume that ‘real’ and ‘cultural’ [competence] must be mutually exclusive terms” (Taylor 2003a, p. 559). Situating CC within the frameworks of QI and patient safety

Technologies of Culturally Appropriate Health Care

While some quantitative research shows that physicians' attitudes toward the medically indigent (who are disproportionately minority) are influenced by circumstantial and social factors such as relationships with mentors (Chirayath 2006), a variety of programs with different strengths and limitations have been developed to inculcate health care providers with new information and attitudes toward diverse groups. The enterprising cultural competence coordinator or health care provider can quickly locate myriad curricula, tools, videos, bibliographies, vignettes, and other resources online. Linking those cultural competence coordinators who have been assigned responsibility for meeting new federal requirements for culturally appropriate services with these resources is one of the major functions of the Culture and Health listserv. Online curricula and training activities make it possible for health care providers to engage in training outside the boundaries of the reimbursable workday, and offer easily quantifiable results. Many CC trainers, however, endorse face-to-face trainings in large or small groups as more likely to effect the sought-after transformations of consciousness. For example, Manny Ortiz, an instructor whom we interviewed, and who taught a cultural competence seminar to medical students, suggested,

Well you know, I've used different venues, I mean I've done it in a small group. 'Done it' meaning lectured on cultural competency. I've done it online where I'm videotaped and I'm looking at a screen and there's people out, you know, at different satellite places, you know, there's a monitor. That doesn't work that well, I don't think.

Armin: Is that because you don't have the kind of give and take?

Ortiz: Don't have that pers—Yeah, that interpersonal interaction there, those warm bodies right there in front of you. Umm, plus [it's] more sterile. I think the ideal way is a small group discussion that, that, that people are free to talk about their own experiences and then reframe those experiences in terms of what goes on, the reality of the patient-provider interaction. So at one level, one can talk about the patient-provider interaction which is primarily the case [at the medical school]. And on another level you can talk about it as a general approach to community health.

Ortiz points to the face-to-face experiences in a small group setting as the most effective technology for promoting self-examination through encouraging medical students to "re-frame [their clinical] experiences." As in the feminist consciousness-raising groups analyzed by McLaren (2002) and others, "reframing" one's experiences is a key element of the process of the transformation of consciousness as participants place their experiences within a critical theoretical framework offered by CC trainers. Ortiz rejects CC training via videolink as "more sterile" in favor of the "warm bodies right there in front of you," acknowledging the contribution that those warm bodies make in the chemistry of the transformations he seeks.

could be read as an attempt to equalize medical and cultural competence by linking CC with other technical and ethical concerns such as patient safety.

For some cultural competence trainers, face-to-face workshops may offer greater credibility compared to online trainings. While hospital administrators responsible for ensuring and “increasing” cultural competence necessarily value “tools” that demonstrate change in both knowledge and attitudes as a result of their completion (and, ideally, changes in patient health outcomes as a result of this new knowledge and attitudes²⁴), those who actually run such trainings are more apt to value the evidence of personal transformation that is observable in a face-to-face setting. (Tears, for example, are highly esteemed by trainers as evidence of the emotional import for participants of new insights achieved through the training.) Such scenes also create the possibility for the displacement of authority from trainer to peers, and many trainers particularly appreciate the opportunity for that “peer-to-peer” interaction.

In May 2008, Shaw attended another breakfast roundtable on cultural competence, this one at the Cancer, Culture and Literacy conference sponsored by the Moffitt Cancer Center in Florida. Tables seating 10–12 people were scattered around a hotel ballroom holding perhaps 400 participants, who gravitated toward round tables bearing placards displaying topics such as “cultural competence” or “literacy” or “prevention.” Andrew Jordan, the facilitator of the cultural competence roundtable, introduced himself as a public health researcher and someone who regularly conducts trainings for health care providers and medical faculty. Like Ortiz, Jordan described his preference for small group work over online trainings, commenting that a one-time workshop is often not as effective as small groups that meet regularly over time. He explained, “We run 12-week sessions for those health care organizations that will pay for it. And we dread the first of these meetings. There are two common responses among health care providers on the first meeting: (1) ‘I’m already culturally competent,’ and (2) ‘Well, it’s the patient’s fault.’²⁵ But what you ultimately want to achieve, and you know you have been successful, when you see peers correcting peers.” Jordan emphasized the relocation of pedagogical responsibility from trainer to participants—“when you see peers correcting peers”—as an index of the successful inculcation of ethical self-fashioning among participants. The small group environment, as described by Jordan, becomes a kind of laboratory in which work on the self can be taken up by individuals who then, as “learners,” enact “forms of moral subjectivation” (Foucault 1990, p. 29) with and for each other.

Jordan said that stereotypes such as “All Mexican immigrants are maids” are among his biggest talking points. “We all do it,” he continued, “and if you say you don’t I know you’re lying. The point is to have discussions about these prejudicial ideas and it’s ok.” A woman sitting next to me interjected here, “I disagree, I don’t think it’s ok for people to hold

²⁴But, as Hester (forthcoming) and others point out, evidence showing improved health outcomes for those patients whose physicians receive CC training is hard to come by. The strong push for CAHC, in the absence of such evidence, illustrates how arguments for CC training rest as much on beliefs about what should constitute ethical social relations (beliefs which are shaped in part by the political claims of minority health and other advocacy groups) as on the demonstrated effectiveness of such approaches.

²⁵An example of the displacement of responsibility for refusal onto patients, coded as “noncompliance,” can be seen in Borovoy and Hine’s thoughtful ethnographic case study of diabetic Russian émigrés (2008). The ethnographers conclude that physicians’ judgments regarding these “non-compliant” patients are shaped in part by their unreflexive application of the U.S. consumer model of care, coupled with an ideology of personal responsibility. Borovoy and Hine argue that the American consumer model of health care conflicts with émigrés’ understandings of state-run health care and personal autonomy, leading to uncontrolled blood sugar among these patients and physician frustration with their lack of adherence to a “highly rigid approach to diabetes care” (Borovoy and Hine 2008, p. 19).

prejudicial ideas.” She mentioned an employee lawsuit against an academic medical center for racism, concluding, “We really need to work on getting rid of prejudice.” Jordan agreed, and clarified that the idea is to get people to discuss *changing* their normative beliefs. He closed with a summary of an individualized notion of culture, similar to that outlined by Angela Jenks in her participant-observation study of cultural competence trainings in California (Jenks 2009), emphasizing, “The aim is to teach physicians that everyone is different, everyone has a unique culture.”²⁶

Another participant at this roundtable said that she felt fortunate to have strong leadership support for CC training at her hospital, and she asked Jordan for guidance as she chose among the various modules available online for CC training. Jordan repeated that he preferred face-to-face trainings that allow interaction and discussion among participants. A woman sitting across the table from her made disparaging noises about trainings that “you click through,” making the hand motion of clicking a mouse in the air. Others at the table agreed. Jordan said that if online training were the only option, he would recommend modules offering testimonials that encourage participants to “stop and think.” Emphasizing the ways in which health care providers are impelled to act on themselves using these technologies, he said, “You want to look for opportunities for self-reflection in the module you choose” and suggested that “poignant stories” allow the participant to do a “double-check.”²⁷

Another participant asked, “How do you get providers to show up?” for in-person trainings. Heads nodded around the table; clearly others had encountered this issue as well. Jordan replied that Florida requires three CME credits in cultural competence for state licensure, and recommended that all states should require this. Further, he said, accreditation agencies must step in and enforce the requirements. In their study of CC efforts in Canadian hospitals, Anderson et al. emphasize the importance of the broader economic context within which CC is implemented: “Policies are implemented within complex organizational structures, and the knowledge of health professionals and the availability of resources influence how a policy can be implemented, and how ‘culture is written into’ the health care system” (2007, p. 315). Difficulty in motivating and achieving attendance could thus be related to the widespread understaffing of hospital and health care organizations that makes reimbursable hours a priority and restricts health care providers’ ability to attend outside meetings or trainings. Making cultural competence mandatory, either on the organizational or the state levels, Jordan argued, is the best (and perhaps the only) way to get buy-in among health care providers and organizations.

Even where CC training for health care providers is mandated, cultural competence technologies often shift the onus onto the “learner” herself. The CME course outlined by Margaret Donovan at the opening, for example, is “learner-driven,” reflecting larger trends

²⁶Another approach to cultural competence that follows from this individualized understanding of culture does not, in contrast, rely on a physician’s self-reflexivity but rather positions the physician as “cultural broker.” Based on in-depth interviews with 24 California physicians (15 of whom identified as members of a racial or ethnic minority group), Ming-Cheng Miriam Lo emphasizes the importance of negotiating different “sense-making schemas” between patient and provider (Lo 2010, p. 485). She outlines four elements of cultural brokerage, each of which requires the health care provider to at least recognize his or her worldview as culturally situated, and provides examples of physician stories about how this recognition can be followed by action (Lo 2010).

²⁷On self-reflection as a strategy for “scaffolding knowledge building,” see Lax et al. (2009).

in contemporary adult education. Rather than positioning the physician as the passive recipient of information, which is often less than successful, Donovan's CME program makes the physician responsible for "choosing" not only the content of the training but even the medium in which it is delivered. Health care providers' ethical subjectivities are thus actively enrolled in this technology in which no longer does the external ethical authority didactically present information, but the self is acting on the self (Matza 2009) by choosing both topics and media for education. Creating a choice is key part of active engagement for the "learner." The link with behavior is accomplished by the individualized "action plan" generated by Donovan's program in response to these selections.

While many trainers express a preference for face-to-face trainings, this particular method for achieving ethical self-fashioning seems to carry the risk of possible emotional costs, warned Heather McKinlay, a medical anthropologist who is the head of the Cultural and Linguistic Services Department for a California managed care organization. At the DiversityRx roundtable where Donovan outlined her CME program, McKinlay hinted at the occasionally profound emotional consequences of these forms of self-examination, especially those produced in face-to-face trainings. She said that often in the trainings she facilitates, "there's an 'ah-ha!' moment where somebody realizes why some life event took place. That can be very, very traumatic for that person. ... You've brought up a bunch of emotional issues that can range from outrage to anger to emotional trauma and victimization," and she cautioned listeners against "cutting them loose after the 50 minutes to go back to work" without offering any resources or support to deal with those emotions. McKinlay argued that trainers need to advise participants that this kind of reflective process may produce difficult-to-handle emotions and that trainers should mitigate those responses where possible with additional information. In this critique, technologies of CAHC, particularly multi-occasion, face-to-face workshops, seem to possess a peculiar efficaciousness allowing them to cause such effects. Individual psychological responses to structures of discrimination may rest just below the surface of awareness, triggering responses such as those McKinlay describes.

The Problem of Refusal

Health care providers of various stripes often resist the call for ethical self-fashioning enacted in these programs, however.²⁸ This resistance itself is a frequent topic of discussion on the Culture and Health listserv and in gatherings of CC promoters (where, like the DiversityRx conference, physicians are usually in the distinct minority). For example, an audience member at the DiversityRx roundtable described above asked the panelists, "I appreciate your comments about [the importance of] teaching cultural competence with medical students, but what do you do with residents and that wonderful group of faculty [this phrase provoked chuckles around the room] that aren't 'on-board'? What do you do with them?" Panelist Paul Armstrong, a physician, researcher and CC advocate, agreed, "Yeah, I think it's always a challenge to figure out, how do you reach everyone. One of the

²⁸Willen et al. (2010), and contributors to the Good et al. forthcoming collection *Shattering Culture*, describe reasons for psychiatric residents' resistance to cultural sensitivity training, including prior experiences with cultural sensitivity trainings, personal experiences of racism, and ethnic and cultural diversity among mental health professionals that potentially limit the relevance of trainings oriented toward majority-culture health professionals treating culturally "Other" patients.

approaches we've taken is to figure what the leverage points are for those individuals to be interested in this. What would make them interested in a training around something that we might call 'cultural competency'?" For example, Armstrong named informed consent as a topic sure to pique the interest of surgeons. In his explanation, Armstrong characterized surgeons' views of cultural competence training this way: "you have to be very nice to people, you have to think about what their expectations are and their values and things like that." Armstrong imagined that surgeons who held such views "might turn off" in response to such excessive displays of sensitivity. But, Armstrong continued, a CC trainer might have more success "if you say... [we understand that] it might be challenging to have good informed consent discussions around surgery with patients from different backgrounds, [and] we're going to help you figure out how to do that well." In contrast to the didactic moralizing he gently mocks above ("you have to be very nice to people"), Armstrong situates the approach in the online CC trainings he developed firmly in the biomedical case method (Good and Good 1993):

So we've tried to...build in very interactive cases where you'd be challenged to actually think, 'what's going on with this patient? I just don't understand it.' Clinicians specifically, but everyone really tends to have a drive to solve the problem. That's what we try to build in there. Let's make a problem, and then let's generate their creative, and get their competitive juices flowing, almost, about, 'all right, can I figure it out what's going on with this person?' Then they go through it and in the end wind up hopefully being able to crack the case, solve the problem. And, of course it's not so easy, there's no *one* answer, but they feel as they're going through it that they're trying to get somewhere, and as they go through the process they learn pieces of information along the way.

This technical approach to increasing cultural expertise is aimed at providing quality care to all patients, but does *not* depend on providers working to identify and remove their own prejudices. Rather, these online, case-oriented modules *are* self-reflexive in making physicians responsible for reasoning through the cases to arrive at the desired "lessons" independent of other cultural experts. Cultural differences enter these cases as variables or factors akin to age, employment, or medical history that must be recognized to understand their biomedical or social effects.

Anderson et al. (2007) argue that this articulation of "culture" may be an effect of hegemonic discourses of efficiency in health care, as well as often-overwhelming burdens of patient care: "We recognize that, as a way of managing the practicalities of heavy workloads in clinical settings, health care providers fall back on categories they believe will allow them to provide efficient care to patients and, at the same time, display cultural sensitivity. For most [this] seems to mean being knowledgeable about specific beliefs and predictable practices of different ethnic groups," a "fact"-based approach to culture that the authors suggest is "in keeping with the epistemological underpinnings of biomedical science" (Anderson et al. 2007, pp. 304, 294). This "fact-based" approach to CC is akin to Epstein's concept of *niche standardization*: "the biopolitical management (and redefinition) of population subgroups via a specification of standards at the 'intermediate' level of the categorical group" (Epstein 2007, p. 136). Niche standardization—lumping all "Hispanics"

into a single demographic category, for instance—avoids the “polar opposition between... universalism and particularism” (Epstein 2007, p. 136) and may offer a helpful way to think about what Jenks terms “categorical approaches” to cultural competence, which similarly generalize across groups at a meso-level between individuals and entire populations.²⁹

John Hendrick, another family physician and cultural competence advocate, also responded to the question of how to get participation and support from medical school faculty. He said that his organization occasionally received evaluations after cultural competence trainings in which people said that cultural competence is just “PC run amok,” or a waste of time because “we should be addressing real issues like racism,” or else “it’s a generally uncomfortable topic.” Hendrick paradoxically cited such sentiments as evidence of the degree of transformation that may be experienced by these very resisters, observing that “the people who are most challenged by [cultural competence training] can become the biggest champions later.” Others have a less optimistic view of the possibilities offered by CC training in medical schools. For example, Manny Ortiz, introduced above, felt that while

...there was buy-in from the administration and the College of Medicine at that time, there wasn’t a whole lot of buy-in from the departmental heads and regular faculty. Basically if you wanted to include anything on culture and linguistic competency they wanted you to come in and do it yourself and have it stand alone and they didn’t necessarily wanna take up their time in doing that. ...

Armin: ...Could you talk a little bit more about that?

Ortiz: Um, basically they felt that... they had already had a short amount of time to present the information necessary in the basic science courses. So I tried to facilitate the development of vignettes that we could share to highlight examples of issues that could confront folks. For example in genetic counseling, umm, and those courses that are more amenable to those kinds of vignettes. But there was resistance, again, primarily time management and ...the lack of expertise on cultural competency among the professors themselves, and them wanting someone else to do it rather than themselves.

While Ortiz made a similar effort to offer CC training using “vignettes” tailored to those fields like genetic counseling that he saw as “more amenable” to such interventions, other medical school faculty viewed the whole endeavor as so marginal as to be unworthy of their own time (and barely worthy of that of their students), and as something to be delegated to others. This could be due to the fact that they see few institutional rewards for including cultural competency trainings in their curriculum.

Academic and professional debates about the value of cultural competence trainings and the transformations they produce are occasionally extended into the public sphere. For example, online comments on a *New York Times* health column reveal disagreement among physicians about CC programs’ chances for effectiveness, especially when they depend on

²⁹Epstein continues, “This slippage between referencing individuals and groups is a common feature of discourse surrounding the inclusion-and-difference paradigm; it endows the paradigm with legitimacy by associating it with individualism, one of the cherished values of U.S. political culture” (Epstein 2007, p. 139). We would suggest that the appeal of individualistic notions of culture is related to this tendency as well.

physician self-reflexivity. In her 14 November 2008, article “Confronting Racial Barriers between Doctors and Patients,” Pauline Chen, MD, reported on her reflections on her own practice that followed a conversation she had with Dr. Somnath Saha, a health disparities researcher at the Oregon Health and Science University:

“I think the first step in addressing [health] disparities,” Dr. Saha continued [in a phone interview with Chen], “is really acknowledging that certain things affect the way we deliver care – our own stereotypes, our own cultural upbringing, our own ‘anxiety meters’ when we are interacting with people who aren’t like the people we grew up with.” [Chen continues,] I have prided myself on being as fair and as compassionate a doctor as I could be. But I am also very much the daughter of Taiwanese immigrants; and when, for example, I see patients or colleagues who come from a similar background, empathy comes almost automatically. However, when I meet individuals whose race or ethnicity differs from mine – individuals who, for instance, are black, white, Hispanic or American Indian – there are fewer shared experiences. So I, like others, unconsciously tap into past experiences to bolster the connection and bring a greater sense of familiarity to the interaction. And it’s difficult to acknowledge that what I have tapped into may not always be fair.³⁰

Among the generally critical online comments posted in response to this article, the following, from a physician, was more sympathetic to Chen’s (and Saha’s) arguments. Davis Liu, MD, begins, “As the son of Taiwanese immigrants who grew up in the prairies of Saskatchewan, I was more familiar with Ukrainians and ice hockey because of the lack of Asians in that part of Canada. Yet when I moved to California, where there is no majority of any ethnic group, I had more empathy automatically for Asians I interacted with. As doctors, it is our job to overcome these natural tendencies and make patients from all backgrounds comfortable. As members of the public, however, we must continue to be dissatisfied with the disparity in medical outcomes among different racial groups.” CAHC builds on and strives toward ideals established by patient-centered health care (Miller et al. 2010; Nutting et al. 2010) in which the physician’s “co-presence” with the patient is highly valued. Racism and prejudice are problematic, in this view, not because they produce poor health outcomes (though this is not contested) but because they impede possibilities for establishing co-presence.

Most of those commenting on the Chen article, who identified themselves as health care providers, argued that doctors are not intentionally prejudiced and therefore have nothing to gain from such self-examinations. This view, especially common among health care providers who work in settings such as community clinics or academic medical centers dedicated to serving low-income and minority populations, can also be seen in responses to a poll offered on the website www.MedPageToday.com on 16 June 2008.³¹ The poll question asked, “Should diversity training be a requirement for physician licensure and

³⁰Available online at www.nytimes.com/2008/11/14/health/chen11-13.html?_r=1, accessed 9 April 2011.

³¹The webpage carries the disclaimer, “Medpage Today surveys are polls of those who choose to participate and are, therefore, not valid statistical samples, but rather a snapshot of what your colleagues are thinking.” (www.medpagetoday.com/Surveys/, viewed 16 June 2008).

renewal?” Fifty-eight percent of a total of 430 respondents felt that diversity training *should* be a requirement, though most comments on the page, especially from those who identified themselves as physicians, were not in support of the idea. One poster responded, “While diversity training in general is a good idea, it will not make a significant difference in disease outcomes. I have not met anyone who will not do his/her best simply because the patient is from a different cultural background.” Views that cultural competence trainings are unnecessary because health care providers are already free of prejudice are another frequently encountered obstacle to cultural competence training for health care professionals.

In contrast, Tanya Wright, a quality assurance coordinator at a community health center in New England, described another set of negative reactions to her efforts to organize a cultural competence training for the clinic’s health care providers, based on their beliefs that immigrants should acculturate to American lifestyles and health care as rapidly as possible. In an in-depth interview with Shaw, she said,

I really believe in everybody being treated for who they are and try to understand their cultures, their ethnicities. And, a lot of times they [health care providers and other staff] think it’s a big joke. You know, like, it’s not necessary. Like, you’re here in the United States, so you do what we say. And I feel like, not everybody has to mold to the Western culture.

Wright waged an uphill battle at this safety-net clinic that serves predominantly minority and low-income patients, an irony since the organization was founded by community health activists and others emphasizing the importance of culturally appropriate health care for these populations (Shaw 2005). Equally important, limitations in provider availability due to the clinic’s financial difficulties also restricted Wright’s ability to schedule a face-to-face training, which would have required “closing clinic” to take providers away from seeing patients.

In online discussions and at face-to-face meetings, cultural competence trainers report encountering significant resistance among many of the health care providers they target for training. Doctors’ prejudicial attitudes, which presumably lead to unequal health care for minority patients, are identified as both the source of the problem and the site of transformation. Yet according to Jordan and other cultural competence advocates, accreditation, and licensing organizations such as the Joint Commission must mandate cultural competence for health care organizations to force past on-the-ground resistance and reaffirm cultural competence as a key tenet of quality assurance with all that entails, including measurement and continuous improvement.

Conclusion

Like the forms of pharmaceutical governance outlined by Biehl (2007), cultural competence efforts are imbricated in the technologies and relations of the marketplace, even as they draw on the language of social justice. In his analysis of access to AIDS therapies in Brazil, Biehl shows how “Patienthood and civic participation thus conflate in an emerging market [for pharmaceuticals]. ... Magic bullet approaches (i.e., delivery of technology regardless of

health care infrastructure) are increasingly the norm, and [pharmaceutical] companies are themselves using the activist discourse that access to ARVs [anti-retrovirals] is a matter of human rights” (Biehl 2007, pp. 83–84). In *Will to Live*, Biehl outlines the at times paradoxical effects of state and NGO interventions to protect and promote health. He tracks the construction and actions of a hybrid formation that includes AIDS activists, government health reformers, and pharmaceutical companies (among others) to account for the emergence of Brazil’s universal access policy. Many of these actors, in interviews with Biehl, show an impressive degree of awareness of the ways in which possibilities for action are both enabled and constrained by the political-economic setting of reform (see also Anderson et al. 2007). Within cultural competence fields, as well, educators and advocates operate in a field composed of diverse interests, where actions bring wide-ranging and perhaps unintended effects for the claims of marginalized groups for recognition by both the state and health care institutions.

As a hybrid formation bringing together QI, language access, refugee health, and anti-racism advocates (cf. Epstein 2007), cultural competence trainings enact a new ethico-politics of health care that depends on and constructs new forms of learning, self-reflexivity and practice for health care providers. Along with anti-racism advocates within health care organizations, private consulting firms provide and promote a range of educational interventions at the level of the individual health care provider as well as health care organizations. These assemblages together make up technologies of CAHC which, when applied to health care providers in both online and face-to-face media, are remaking physician’s ethical subjectivities and medical expertise.

Technologies of CAHC emerged in response to activist efforts that frame health disparities as indicators of broader patterns of inequality as well as of discriminatory health practices. Cultural competence trainings direct responses to these structures of inequality to individual health care providers and, to a lesser extent, to health care organizations as a whole. Locating the source of health disparities in “cultural differences” rather than structural factors shifts our perceptions of broader social and economic inequalities at the root of health disparities to individual patients and physicians. Steven Epstein makes a related observation in his book *Inclusion*, a social history of federal policies mandating the inclusion of women, children and minority populations in the U.S. health research. Epstein argues that these policies, which were justified in part using the evidence of racial and ethnic health disparities, may wind up “preclud[ing] direct attention to reducing inequalities in the domain of health, while encouraging the misleading notion that better health for all can best be pursued through the study of the biology of race and sex” (Epstein 2007, p. 4). Many technologies of CAHC implement a vision of social justice that becomes technical in its application of principles of equality to clinical encounters between doctors and physicians.³² In this case, it is the individualizing focus on physician self-reflexivity that has the potential to divert attention from the organizational and structural factors that play important roles in

³²In her article, “The Politics of the Gap,” Emma Kowal distinguishes between “the two pillars of postcolonial logic, remedialism and Orientalism,” which govern liberal efforts to remedy Indigenous health disparities in Australia. She writes, “Remediable difference is a difference amenable to normalization. It promises that what makes Indigenous people culturally distinctive is neither an obstacle to achieving statistical equality nor threatened by this quest. When remediable difference is enacted at the institute, remedialism and Orientalism meet in a happy, if awkward, embrace” (Kowal 2008, p. 343).

health inequalities. Margaret Donovan, the speaker whose CME module we opened with, observed as much at the end of the DiversityRx roundtable on evaluating CC trainings. She encouraged the audience to “not to get stuck on the individual level” when thinking about how to define cultural competence. “I suggest to you that it’s very difficult to be a culturally competent physician, nurse, in an organization that does not support it with policies, procedures and resources. We really need to look at training as an aspect, and not the primary aspect, for helping people to move along the continuum of cultural competence.” Donovan’s comments emphasize the importance of organizational change as even more critical to reducing disparities in quality of care than the ethical self-fashioning of health care providers (see also Anderson et al. 2007, p. 315).

While many cultural competence advocates see themselves at the forefront of an antiracist movement and seek to extend this awareness to others, they simultaneously acknowledge their limited ability to address the structural factors that determine the health disparities that opened this movement (e.g., Chapman and Berggren 2005; Krieger et al. 2005; Sargent and Larchanché 2009). Another speaker at the same roundtable observed that most “awareness tools” focus on being comfortable with and knowledgeable about different cultural groups, which she worried “might take attention away from what we really need to do to address the underlying factors” in health disparities. While a vast array of technologies of CAHC seek to promote the ethical self-fashioning of both physicians and health care systems, few of these transformations hold potential for transforming the larger structures of inequality underlying health disparities.

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