Cult Med Psychiatry (2011) 35:209-235
DOI 10.1007/s11013-011-9212-4

ORIGINAL PAPER

From "Lists of Traits" to "Open-Mindedness": Emerging Issues in Cultural Competence Education

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Published online: 11 May 2011

Abstract The incorporation of "culture" into U.S. biomedicine has been increasing at a rapid pace over the last several decades. Advocates for "cultural competence" point to changing patient demographics and growing health disparities as they call for improved educational efforts that train health providers to care for patients from a variety of backgrounds. Medical anthropologists have long been critical of the approach to "culture" that emerges in cultural competence efforts, identifying an essentialized, static notion of culture that is conflated with racial and ethnic categories and seen to exist primarily among exotic "Others." With this approach, culture can become a "list of traits" associated with various racial and ethnic groups that must be mastered by health providers and applied to patients as necessary. This article uses an ethnographic examination of cultural competence training to highlight recent efforts to develop more nuanced approaches to teaching culture. I argue that much of contemporary cultural competence education has rejected the "list of traits" approach and instead aims to produce a new kind of health provider who is "open-minded," willing to learn about difference, and treats each patient as an individual. This shift, however, can ultimately reinforce behavioral understandings of culture and draw attention away from the social conditions and power differentials that underlie health inequalities.

Keywords Cultural competence · Medical education · Medical anthropology · Race/ethnicity · United States

> As long as someone is willing to change, and willing to be flexible among all cultures, and willing to give people within every cultural group the best quality of care that they possibly can, then at that point you can consider

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> yourself culturally competent…. As long as you try to do that, and you remain open-minded to change, then at that point you can say, "ok, I'm culturally competent."—Second-year medical student

Introduction

The importance of "culture" in U.S. biomedicine has received increased attention over the last several decades. Recent calls for the development of "cultural competence"[1] point to changing demographic patterns and significant health disparities among racial and ethnic groups, with advocates arguing that health care providers and institutions must address the cultural and linguistic barriers that prevent some patients from accessing good care (Brach and Fraserirector 2000; Betancourt et al. 2003, 2005). To this end, in 2001, the Office of Minority Health established national "CLAS" standards, a series of 14 requirements and recommendations for the development of Culturally and Linguistically Appropriate Services (see OMH 2001). Building on these standards, cultural competence efforts include a range of activities, from the use of interpreters and translated materials to communicate with limited English proficient (LEP) patients (Perkins and Youdelman 2008; Perez 2002) to the recruitment of providers from underrepresented racial or ethnic groups (Street et al. 2008; Cooper and Powe 2004) and the creation of ethnically specialized clinics (Santiago-Irizarry 2001).

A focus on the education and training of health providers, however, is one of the most prominent aspects of the cultural competence movement. In the last several years, professional organizations like the American Medical Association (AMA 2008) and Association of American Medical Colleges (AAMC 2009a, b) have issued statements in support of cultural competence training,[2] and an increasing number of states have started to mandate such training for health providers (Graves et al. 2007). Efforts to address the "softer" sides of health care in medical education are not new (Good and Good 1989, 1993; Good 1995), but legislative and regulatory

[1] The term "cultural competence" is only one phrase that has been used in this movement. Calls for "culturally appropriate care," "cultural sensitivity," "cultural humility," "multicultural health care," and "cross-cultural health care" are also common. This shifting language reflects in part an uncertainty over what exactly "culture" means, how it relates to medical care, and what the goals of increasing attention to culture in medical care should be. I have found, however, that references to "cultural competence" or "cultural competency" (the terms are often used interchangeably) are most common in recent educational efforts. The Office of Minority Health (OMH) uses one of the more widely accepted and cited definitions of cultural competence, stating that:

> Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. [OMH 2001, adapted from Cross et al. 1989]

[2] See Gilbert (2003) and Graves et al. (2007) for overviews of position statements from a variety of other health-related organizations.

efforts have accelerated their development. In 1991–1992, only 13 of 98 surveyed schools offered cultural sensitivity courses (and all but one of these courses was optional) (Lum and Korenman 1994). Nearly 10 years later, however, a survey of medical schools in California found that 100% of the schools included issues of cultural diversity as part of a required course (Wilson and Houghtaling 2001).

Training in cultural competence is not limited to undergraduate medical education; it has become common in educational programs for other health professionals and is regularly included in residency training and continuing medical education programs. Increasingly, all employees at hospitals and managed care organizations are also required to receive cultural competence education. Training methods vary from lectures and workshops (Deloney et al. 2000; Juarez et al. 2006) to small and large group discussion sessions (Satterfield et al. 2004), language training, online resources, and immersion programs designed to expose providers to various patient populations (Albritton and Wagner 2002; Takayama et al. 2001).[3]

Anthropologists have long been critical of the approach to "culture" that emerges in cultural competence efforts. Many critics have pointed to an essentialized, static notion of culture that is conflated with racial and ethnic categories, seen to exist only among exotic "Others," and ultimately places the blame for health disparities on the "difference" of culturally marked patients (Carpenter-Song et al. 2007; Kleinman and Benson 2006; Gregg and Saha 2006; Shaw 2005; Fox 2005; Lee and Farrell 2006; Taylor 2003a, b; Santiago-Irizarry 1996, 2001). These critiques are well founded—indeed, I have raised similar concerns myself (Jenks 2009, 2010)—but they do not address the internal complexities and contradictions of ongoing efforts to reform cultural competence education.

This article uses an ethnographic examination of cultural competence training to highlight recent efforts to develop more nuanced approaches to teaching culture. I argue that much of contemporary cultural competence education has rejected the notion of culture as a "technical skill for which clinicians can…develop expertise" (Kleinman and Benson 2006, p. 1673), striving instead to produce a new kind of health provider. This new culturally competent provider doesn't, as one second-year medical student explained, "need to be aware of every single culture out there, and what each culture believes, and what little rules and regulations you need to follow." Rather, the culturally competent provider should

> be aware that there are differences and that you should try to be respectful of all these different issues. … Try to be exposed to as many different situations as you can, and be open-minded. … Each patient has their own beliefs, and you can't jump to any conclusions about what you think that patient will or will not believe just because they're from a certain background.

The goal of "open-minded" cultural competence was repeated by many of the students, providers, and educators I interviewed. Such an approach, I was told, means recognizing that "every single person's situation is different."

[3] See Elliott (2006), Hobgood et al. (2006), and Beach et al. (2005) for overviews of the variety of instructional methodologies used; see Gilbert (2003) for an extensive collection of guidebooks, manuals, videos, websites, and other resources that have been developed for use in cultural competence training.

This new clinical subjectivity challenges notions of cultural competence that rely on stereotypical knowledge about behavioral traits or the "dos and don'ts" of working with patients from various racial and ethnic groups. At the same time, however, the focus on open-mindedness and the need to treat each patient as an individual reflects increased attention to what I have elsewhere called decontextualized difference (Jenks 2010). Providers learn to recognize—and to some extent uncritically accept—individual differences without developing an understanding of the social and historical conditions in which these differences have been produced or currently operate. As a result, cultural competence education, while designed to address socially produced health disparities, can ultimately reinforce a depoliticized understanding of cultural difference (see Jenks 2010).

This article examines the way efforts to improve cultural competence education have both failed to fully address many prevalent critiques and resulted in an ambiguous approach to culture that emphasizes the need for open-mindedness but avoids more in depth examinations of inequality. In what follows, I describe my research methods and then place this study within the context of anthropological concerns with biomedicine, medical training, and the culture concept. I then draw on specific ethnographic examples to examine the way a depoliticized, individual notion of culture and the need for open-mindedness emerge from responses to two particular critiques of cultural competence: (1) the need to move away from an essentialized, static notion of culture that is linked to race or ethnicity and (2) the need to move away from a focus on the culture of "Other" patients and to encourage providers to reflect on their own cultural positions and biases. I conclude by drawing attention to the potential stakes of this discussion for understandings of health disparities and by suggesting future directions for anthropological research on cultural competence.

Methods

This article is based on research conducted in 2005 and 2006 in Southern California. As a "majority minority" state where over a quarter of the population is foreign born (U.S. Census Bureau 2007), California was cited by many of my informants as a forerunner in the development of cultural competence education and of CLAS more generally. The policy letters developed by the California Department of Health Services' Cultural and Linguistic Task Force in 1999 were a main force behind the adoption of the national OMH CLAS standards a little over a year later. Most California health plans have developed Cultural and Linguistic (C&L) Services departments, and nearly all of the state's medical schools include some form of specialized cultural competence training (see Brach et al. 2006).

The arguments and conclusions presented in this article are drawn from several sources, including published educational materials, unpublished materials shared by the developers of training programs, and participation in a CLAS listserv, an electronic forum that allows researchers, providers, institutional managers, and others interested in the development of cultural competence to share information. I conducted semi-structured interviews with eight cultural and linguistic specialists at

managed care organizations who were responsible for the development of cultural competence training programs, nine second-year medical students with a self-identified interest in cultural competence, two medical anthropology professors who develop and deliver cultural competence trainings locally and around the nation, one medical school administrator and cultural competence program developer, and seven additional cultural competence promoters working with patient advocacy groups. Most of these formal interviews were approximately 1–2 h in length, though I also had informal conversations with many of these individuals at other events. Formal written consent was obtained in-person from interview subjects and the interviews were audio-recorded and later transcribed. All names have been changed in this article. Finally, the specific vignettes included in this article are drawn from participant observation at eight cultural competence workshops, training sessions, and conferences designed for medical students, nurses, hospital and managed care organization employees, and medical interpreters. Most of these were between 1 and 3 h in length, although a few were full-day sessions. I obtained prior consent from the directors and organizers of non-public events and oral consent from participants through a brief introduction of myself and the research project. Rather than focusing on an in-depth reading of one particular training session in this article, I draw from these multiple sites and varied informant perspectives to identify general trends and patterns in the changing approach to cultural competence education.

Anthropology in/of Biomedicine

This examination of cultural competence education is not only an anthropological analysis of one aspect of biomedicine but also reflects the important relationship *between* anthropology and biomedicine. The cultural competence movement developed in response to critiques that have been made by medical anthropologists since the 1980s. As anthropologists examined biomedicine as a cultural system, they drew attention to its basis in Western philosophical traditions emphasizing naturalism and individualism (Gordon 1988); in biomedicine, the realm of "nature" is separated from the supernatural, from culture and morality, and disease becomes an individual problem unrelated to social context (Gordon 1988; Lupton 1994; see also Hahn and Kleinman 1983). Anthropologists and other social scientists argued that this legacy has resulted in a split between the biological and the psychosocial (Scheper-Hughes and Lock 1987, p. 10), as biomedicine separates signs from symptoms (Gordon 1988, p. 25), disease from illness (Kleinman 1980; Gordon 1988, p. 25), and removes the social person from the physical body (Conrad 1988, p. 325; Hirschauer 1991, p. 287). These taken-for-granted assumptions are taught alongside the "science" of biomedicine, and studies of medical education documented the process through which physicians-in-training acquire a clinical "gaze" (Foucault 1994) and learn to perceive of "human similarities and differences being essentially bodily" (Good and Good 1989).

Medical anthropologists examining the culture of biomedicine called for increased attention to the social and cultural context of sickness and for a greater recognition of the patient–provider relationship as an exercise in cross-cultural

communication (Kleinman 1980). This need was further highlighted by Anne Fadiman's (1997) influential portrayal of Lia Lee, the child of Hmong immigrants to California who began having seizures when she was 3 months old. While physicians at the local hospital diagnosed her with epilepsy and prescribed a complicated medication regimen, her parents recognized her condition, in which "the spirit catches you and you fall down," as the result of soul loss and treated it with amulets, animal sacrifices, and a visit to a *txiv neeb*, or shaman. At the age of 4, "the big one" ultimately left Lia comatose and brain dead. Fadiman tells the story as a "collision of two cultures" in which Lia's "life was ruined not by septic shock or noncompliant parents but by cross-cultural misunderstanding" (Fadiman 1997, p. 262), and she suggests that a greater attention to cross-cultural physician education and to anthropological insights could prevent similar tragedies.

Fadiman's book served as a rallying point for advocates of cultural competence, and in the years following its publication, efforts to develop cultural competence education grew (Gregg and Saha 2006). Cultural competence was positioned as a way to improve communication between patients and providers, thereby increasing patient trust in and compliance with provider recommendations (Brach and Fraser 2002; Betancourt et al. 2003, 2005), as a way to address the bias and prejudice identified by the Institute of Medicine as a contributing factor to health disparities (Smedley et al. 2002), and as a continuation of the Civil Rights movement and other struggles for social justice (Perez 2002).

While medical anthropologists emphasized the need to consider the culture of both biomedicine and its patients, they also became increasingly critical of the notion of culture employed in these efforts. Although culture is, as Geertz argues, the concept "around which the whole discipline of anthropology arose" (Geertz 1973, p. 4), what exactly culture means, and how it should be used, has never been fully agreed upon (Kuper 1999). Debates over the meaning of the culture concept highlight its significance not just as a scientific concept, but as a political one as well. The Boasian notion of culture was a liberatory idea, offering both an intellectual antithesis to biological understandings of difference and a politically significant challenge to the racialized social order (Armelagos and Van Gerven 2003; Caspari 2003; Boas 1962[1928], 1974; Baker 1998; Tapper 1997). More recently, however, scholars have become increasingly concerned with the way culture has been used not just within anthropology, but outside of it as well. Critics argue that the culture concept overemphasizes coherence and homogeneity, leading to understandings of communities as bounded and discrete and solidifying a dichotomy between self and other (Abu-Lughod 1991; Rosaldo 1989). Trouillot (2002) points to what he sees as a contradiction in the North American trajectory of culture: while the culture concept was significant as a political move in anthropological theory, in society at large it can operate as a theoretical move away from politics, preventing the ability to address issues of power and inequality.

In appropriating the cultural concept, biomedicine has also inherited the ambiguity that has surrounded the term throughout its history, and, as discussed above, many of the same critiques of the concept within anthropology have been applied to its use in cultural competence. Culture is positioned as a concept that will liberate us from the homogenizing biomedical focus on the body, and yet it often

relies on homogeneous understandings of cultural groups. It is invoked as a way to challenge the legacy of racism evident in health disparities, and yet it can reinforce understandings of racial difference. To address these issues, anthropologists call for more process-oriented approaches to cultural competence (Carpenter-Song et al. 2007) that emphasize flexibility, approach culture as mutable and multiple (Gregg and Saha 2006), and include ethnographic methods that identify what's at stake for patients and families in an illness episode (Kleinman and Benson 2006; see also Lakes et al. 2006). In the following analysis of shifting approaches to cultural competence education, I draw not only on these anthropological critiques of biomedicine and cultural competence but also on the recognition that the use of the culture concept can have significant political implications.

Gaining Knowledge: Negotiating Between "Stereotypes" and "Generalizations"

In his description of the features of good cultural competence training programs, Betancourt (2003) argues that a focus on "knowledge" should involve learning the attitudes, values, beliefs, and behaviors of certain cultural groups on the one hand, while avoiding the simplification of culture and tendency to stereotype on the other. This concern reflects attention to the most frequent critiques of cultural competence, which center around the danger of reifying "culture" as an objective, one-dimensional entity attached to particular racial and ethnic groups (Lee and Farrell 2006; Taylor 2003a; Shaw 2005; Santiago-Irizarry 1996; Carpenter-Song et al. 2007; Lakes et al. 2006; Gregg and Saha 2006). In their article on "the problem of cultural competency and how to fix it," Arthur Kleinman and Peter Benson explain that

> One major problem with the idea of cultural competency is that it suggests culture can be reduced to a technical skill for which clinicians can be trained to develop expertise. This problem stems from how culture is defined in medicine. … Culture is often made synonymous with ethnicity, nationality, and language. For example, patients of a certain ethnicity—such as, the "Mexican patient"—are assumed to have a core set of beliefs about illness owing to fixed ethnic traits. Cultural competency becomes a series of "do's and don'ts" that define how to treat a patient of a given ethnic background. [p. 1673]

Examples of this approach are easy to find, and in the early days of the cultural competence movement, "tip sheets" and "pocket guides" with alphabetized lists of racial and ethnic groups were especially common (Lipson et al. 1996).

More recently, however, as Betancourt's warning indicates, educators recognize the dangers of this approach and have made efforts to move beyond it. Kleinman and Benson's article prompted a brief flurry of discussion on a CLAS listserv about the "right" and "wrong" ways to do cultural competence. The original poster of the article suggested that "Dr. Kleinman has an inaccurate view of cultural competence

as it is defined and practiced by the best of us," and several others agreed. A medical anthropologist from Switzerland stated that,

> I had exactly the same reaction when I read Kleinman's article. Maybe I'm being too optimistic about what's going on in the field, or have a different take on things since I do not work in the US, but I felt that Kleinman was creating a bit of a straw man: I like to think that most people in the field have long ago moved away from (or never embraced in the first place) the notion of culture as technical skill, or culture as static, or culture as synonymous with ethnicity/language/nationality.

Other respondents also separated the good approaches to cultural competence from the bad ones that Kleinman and Benson critiqued. The president of a CLAS consulting group stated:

> I really don't think Kleinman was criticizing those of us who devote our lives to trying to improve the cultural and linguistic appropriateness of care and services by promoting an awareness of the impact of culture on healthcare, but was criticizing those who want a "quick (and superficial) fix" in order to be politically correct. I'm sure I'm not alone in having been approached to supply a single copy of my book because "JCAHO is coming next week." Or to write a 2–3 page list of "Do's and Don'ts" for dealing with each cultural group!

A medical anthropologist from California, however, addressed the challenges of working to introduce a more complex understanding of culture and cultural difference into biomedicine:

> I don't think Kleinman is setting up a straw man in his article. Unfortunately, not everyone practices cultural competency "as practiced by the best of us" and there are still a lot of cookbook approaches being practiced. There are reasons this happens.…
>
> As a medical anthropologist attempting to help clinicians understand how culture and healing interact in patients from different cultures, I have found it difficult to present to them what I know to be a highly complex and nuanced set of ideas that are considerably different from the concrete kinds of information that make up their medical educations.…
>
> To add to these difficulties, it has been my experience that most cultural competency trainers are often given a one or two hour shot at introducing clinicians to the concepts underlying the intersection of culture and healing…. On the one hand, there is an almost subliminal feeling that such a request is an insult to our discipline (o.k. guys, could you give us a one-hour training on childhood infectious diseases?) On the other hand, it is a chance to educate in an area we feel is really critical. … We know better, both intellectually and practically, to reduce such a training to cultural traits. What to do? It is a huge dilemma.

These reactions to Kleinman and Benson's critique highlight a central tension in cultural competence education over the relationship between a *categorical* approach, in which providers are taught information about specific groups, and a

cross-cultural approach, in which the focus is on general methods for communicating with and caring for patients from diverse backgrounds. While these anthropologists, consultants, and other educators work to move away from bounded, static understandings of culture, some simultaneously feel constrained by the dominant biomedical system that values concrete information, relegates "culture" to 1-h sessions, and often explicitly requests lists of dos and don'ts.

As they negotiate these challenges, cultural competence educators walk a fine line between presenting specific examples that highlight the relevance of cultural difference and discouraging health providers from assuming that all members of a particular group will be the same. In all of the training sessions, workshops, and presentations I attended, facilitators and educators made a conscious effort to emphasize that culture cannot be thought of as a bounded object or uniform list of traits and that providers must be careful not to make assumptions about how their patients will think or behave. But in practice, it was often very difficult to discuss culture without reinforcing these ideas.

For example, at the end of a cultural competence workshop that is required for all employees at a managed care organization, the facilitator introduced a Jeopardy-style game to test what the participants had learned. The game came at the end of a 2-h session that had used discussions of the culture concept and an activity showing the difficulty of categorizing people based on their appearance to explicitly challenge the tendency to stereotype. As the game began, the 18 participants who were present were divided into four teams and given noisemakers. The first person to ring in and answer a question correctly won points for his or her team. Under the category "Health beliefs," a question asked whether knowledge about groups should be used to (A) accurately predict what a patient believes; (B) become sensitive to differences; or (C) discourage the use of alternative medicine. The correct answer is B. Because there is a great deal of variation within cultural groups, we were told, knowledge about a particular group *cannot* predict individual patient beliefs and behaviors. Other questions asked why Asian cultures are resistant to surgery (Answer: They believe in the need to leave the body intact) and whether there is evidence that religion can play a role in healing. I answered that last question correctly ("Yes!") and was met with a joking objection. "Hey, no fair!" a participant on another team called out, "She's a ringer!" (Despite my best efforts, having an anthropologist around turned out not to be much of an advantage; my team came in last.)

Christine Rice is the cultural and linguistic specialist who designed this workshop. When she first showed me this game, she emphasized that it includes "knowledge questions" about particular groups, but that the overall focus of the workshop is not on learning a list of facts about specific cultural groups, but on learning about culture and difference in general and the need to get to know people as individuals. At the same time, specific facts about defined cultural groups are used to emphasize general lessons. Learning that "Asian cultures believe in the need to leave the body intact" may be a simplification that reinforces notions of "Asians" as a distinct, unified, group; but the recognition that understandings of the body can vary is an important challenge to ideas of biomedical universalism. This uneasy balance between a desire to provide specific examples to highlight the reality and

significance of cultural difference and a concern with addressing cultures as varied and changing was reflected in a distinction, cited in nearly every training session I attended, between "stereotypes" and "generalizations."

One Friday morning, I attended "culture day," the fourth session of a six-session course designed for health interpreters. The day's activities were designed to highlight the role that culture can play in health beliefs and behaviors and to teach the participants to recognize the ways in which cultural difference can affect communication between patients and physicians. The facilitator, Kano, began the 8-h day by asking, "what is culture?"

> "Values," participants answered. "Background. Tradition. Beliefs."
> But, Kano asked, "can anybody *define* what culture is?" We paused to think for a moment.
> "It's hard," one person said, "because it can be education, so many things."
> "Everything that affects the way you think."
> "It's hard to define."

"It *is* hard to define," Kano agreed. "And there are so many definitions." After presenting several possible options—culture as a "set of values, beliefs, traditions, and practices shared by a group of individuals within a certain environment" or "a body of known behaviors common to a given human society"—Kano concluded that culture is analogous to a template:

> Have you ever made a website? If you have software, they have tons of templates that are already laid out for you. So culture is something like that. You put your own, individual characteristics into that culture, but the template is already there, the basic foundation of how you think, how you relate, is already there.

He addressed the relationship between this group-based foundation and individual variation by emphasizing the distinction between "stereotypes" and "generalizations." There is a large amount of diversity within the same culture, Kano stressed, particularly within the same language group:

> There's a lot of factors [that affect culture]: birthplace; how many years you've lived in the U.S. … What is your experience outside of the U.S.? … It depends on what kind of religion your family has. Education, social class, age, gender, language, sexual orientation. Experience with the Western health care system.

He warned the interpreters not to stereotype, explaining that a stereotype is superficial knowledge with no further attempt to learn; it is an ending point. A generalization, on the other hand, is a beginning point that indicates common trends but leaves room for individual differences.

Shortly after this introduction, the interpreters were instructed to break up into groups according to their native languages—Cantonese, Vietnamese, Spanish, and Arabic were all represented on this afternoon—and to prepare a presentation on "the traditional health beliefs and practices in your ethnic language community." I joined what was identified as the "Spanish culture" group, and our conversation and

presentation highlighted the difficulty of distinguishing between stereotypes and generalizations. Three interpreters from Mexico agreed to list *mal de ojo* as one traditional illness, but they disagreed over the precise definition of the term. Sylvia, a young woman from Spain, had been nominated to present to the class on behalf of our group:

Sylvia *Mal de ojo*—the evil eye. When someone says something that can cause some kind of damage to you.

Kano Like a curse?

Sylvia If someone says, "you have nice hair," it can be the evil eye. If they don't touch it, your hair can fall out. If someone says you have a cute baby, the baby can later get sick. … In some places like Spain you only get evil eye from someone who has bad intentions; it is deliberate, you want to harm someone else. But in Mexico you can get evil eye even if someone has good intentions. But not everyone can give you *mal de ojo*. It's something that people have within.

Kano highlighted this case as a good example of the importance of an interpreter being aware of the cultural variation within a language group:

Kano If I went to a session and the patient was talking about having evil eye, and I was not aware that the evil eye is different in Spain and Mexico, I could be interfering with the communication. I wouldn't be helpful. Even if I hear "evil eye," and I think I know what they're talking about, [I have to] be aware of that.

While this activity stressed the importance of recognizing cultural variation within language groups and of not assuming everyone in a particular group will have the same beliefs, it simultaneously reinforced taken-for-granted notions of "traditional Spanish culture" or "traditional Vietnamese culture" as meaningful and important categories.

At a larger workshop for hospital nurses, Sharon Reedell, who has a doctorate in anthropology and teaches at a local university in addition to conducting cultural competence workshops, began with this same distinction between stereotypes and generalizations. She pointed to a woman in the group and asked about her background. Jina's family is Mexican, and Sharon explained that a stereotype would be "Mexicans have large families, so I won't invite her for dinner because I won't have enough room." A generalization would be "Mexicans have large families, so I should ask her about that." Like Kano, Sharon stated that a stereotype is an ending point, but a generalization is a starting point that should be used to ask further questions.

Sharon asked Jina about her family, and the room erupted in laughter when Jina revealed that she has three brothers and three sisters and they all have children. Sharon used the distinction between stereotypes and generalizations to suggest that the nurses in the room should seek to learn more about their patients, but this example simultaneously reinforced both the idea that "Mexican" is a clearly defined cultural group and that group-based assumptions will often prove to be true.

During this same session, participants received a packet of materials that included specific information about "Asians," "Latinos (Primarily Mexicans)," "Middle-Easterners," and other groups. Each of the lists addressed communication, family/gender issues, expression of pain, pregnancy and birth, end of life issues, and health-related practices. The list for "Asians," for example, suggested that providers allow family members to fulfill their familial duty by spending as much time with the patient as possible. The list for Middle-Easterners was the only one to explicitly address religion, explaining that "Islam is a dominant force in the lives of most Middle Easterners," that patients should be allowed the privacy to pray several times a day, and that many may have a fatalistic attitude about death: "it's all in Allah's hands, so their (health-related) behavior may be of little consequence." At the bottom of each page a caveat states: "These are generalizations. Use them only as general guidelines. Do not stereotype your patients."

For educators like Sharon, it is not the "list of traits" alone that is problematic—indeed, these traits are seen to provide helpful examples that can prompt a discussion of why culture matters in health care. What is problematic is the tendency among providers to treat the lists as if they were comprehensive and apply to every patient. And yet the very organization and presentation of these lists may reinforce common assumptions. As Willen et al. (2010) have noted, participants in cultural competence programs are not "blank slates"; they arrive with already established understandings of the idea of "culture," of the role of cultural difference in health care, and of particular cultural and/or racial groups. Stated caveats about the difference between stereotypes and generalizations may have little significance when information is presented according to well-established, taken-for-granted racial and ethnic categories and highlight factors that are already thought to be significant in—or "different" about—these groups.

The uncertain movement along this line between "stereotypes" and "generalizations" has, in fact, frustrated many trainees. One second-year medical student discussed his cultural competence class by saying:

> We spent a lot of time on culture in general and things that don't seem to apply to us—"oh, people think differently." Yeah, I know, we've got that. But getting specifically *how* each culture views one specific thing—instead they make a big point of saying, "don't stereotype." But you have to. If someone comes in from a specific culture that you've read about in books, you kind of have to stereotype. … Sometimes you use a stereotype and 5% of the population won't fit into it, but 95% will be dead on. But if you didn't know that stereotype, you'll be wrong 100% of the time.

Providers are told that people are different but that they can't know for sure how. They are given information about particular groups and told that they shouldn't try to apply it to their specific patients. This approach is particularly frustrating for many medical students because it conflicts with the rest of their medical training. Another medical student highlighted the ambiguity over the usefulness of categorical traits as one of the main "problems I have with the whole idea of cultural competence":

> I think a lot of people want to have categories. But what is your typical Black patient or your typical Latino patient going to be like? Are they going to not speak English or have diabetes out of control? People want to have some kind of framework going in. The idea of just treating each patient as their own separate entity is too broad or a little too uncertain. In medicine you do need to have a framework. If a patient has chest pains, there are only so many things they can have or that are going to be relevant. So you need to be thinking about those things so you don't miss something.

As Fuller (2002) points out, essentialism is a core precept of medicine in general; diagnosis focuses on deviations from whatever has been defined as "normal" (p. 199). "Culture," then, can easily become another factor to be considered in a differential, and the culture of biomedicine itself, increasingly focused on the assumption that evidence-based medicine can improve care through standardization (Hasnain-Wynia 2006), can encourage an essentialized approach to culture.

Despite concerns that a focus on group-based differences can lead to stereotypes, many of the people I spoke with emphasized that there are also dangers in ignoring distinctions among groups. As she discussed the cultural competence training she had received, Carolyn, a medical student, expressed concern that the "stereotypes of patients we're presented with" could lead students "down an incorrect path." But, she said, it is not "insignificant to have these discussions. Because I think that you do want to screen Black patients for hypertension and diabetes, and you do want to remember stuff like sickle cell." Carolyn points to another central factor that prevents a complete break from the notion of bounded, group-based differences: the explicit link between cultural competence efforts and the alleviation of health disparities. As Gregg and Saha (2006) note, attempts to address *racial and ethnic* disparities through *cultural* competence conflate the very different concepts. As a result, the politically defined racial categories used to document and address health disparities can become bounded cultural categories as well.[4]

The potentially negative effects of a move away from attention to distinct groups were highlighted by the organizer of a multicultural health conference for medical students, who spoke of trying to balance demands for a focus on specific groups with a more generalized approach that would focus on the need to care effectively for all patients:

> I remember last year at our conference we got an email from someone from the Native American Health Association saying they were really upset that the conference doesn't have a special talk on Native American health. [There were special talks or workshops on issues related to African American, Latino, and Asian-Pacific Islander health.]

[4] Carolyn's comment raises questions not just about the conflation of race and culture in discussions of health disparities, but about the possible *biological* significance of race in clinical care. While increasing numbers of scholars in the second half of the twentieth century have argued that race is a socially constructed rather than biologically meaningful category, notions of biological race continue to have an important effect on health research, pharmaceutical development, and clinical care. For further discussions of these issues, see Livingston (1962), Duster (1990, 2003), Marks (1996), Graves (2001), Wailoo (2001), and Whitmarsh and Jones (2010).

> Our response was, "we can't have a speaker on every culture out there, and the point of the conference isn't to know what specifically to do when you encounter an API [or other] patient, but to be culturally competent with all patients from all ethnic backgrounds or different nationalities." She was ok with that answer, but it did get us thinking about why we didn't do a stronger push to get a Native American population. Even though [Los Angeles] has a large population, you don't really see their presence like you see pockets of other races and ethnicities.

Reflecting the slippage between race/ethnicity and culture, this conference organizer emphasized that the event wasn't really designed to address the specific needs of various cultural groups, although several groups were, in fact, highlighted. She draws on the rationale that, to avoid the problems associated with stereotyping, it is important for students to learn general strategies that will allow them to interact with patients from a variety of backgrounds. And yet, Native American advocates challenged this approach. As Omi (1996, p. 180) has discussed, the collapsing of cultural and linguistic difference into simple racial categories is often part of an explicit strategy to raise political consciousness about the problems of marginalized groups and to assert demands on institutions. An emphasis on the need to learn strategies that work with all groups, rather than focusing on the needs of particular groups, may have the effect of reinforcing the invisibility and marginalization of some populations.

As these preceding examples show, many cultural competence education programs have made efforts to move away from uncritical "lists of traits" for distinct, bounded, ethnic groups. The success of these efforts, however, is unclear. In an attempt to show that *culture matters* in health care, many of these sessions do, in fact, identify specific beliefs, practices, and behaviors associated with particular groups. The oft-repeated warning that not all patients will conform to these traits may do little to challenge taken-for-granted assumptions about "Asian," "Latino," or other groups. At the same time, clinicians may read the distinction between stereotypes and generalizations through the lens of biomedical essentialism, approaching culture as another, albeit slightly imprecise, factor to be included in a patient differential. Finally, efforts to move away from a focus on bounded groups run up against a larger American sociopolitical system in which group-based advocacy is often the only way to draw attention to the needs of marginalized populations.

Health providers are often left with the ambiguous lesson that categories of difference matter (as generalizations) and that they don't matter (as stereotypes). The result is an increased shift away from a focus on the need for knowledge about static, group-based cultural difference and toward a focus on the need for awareness of unpredictable, individual-based difference. My concern is that, in the debate over the relative importance of the group or the individual, the reasons that cultural differences may matter and the process and contexts through which group-based and individual identities are formed are ultimately left unexplored. In the struggle to emphasize individual variation over homogeneous groups, cultural competence programs continue to approach culture as an object that is divorced from any social

and cultural context. Culture remains a collection of beliefs, behaviors, and traits that, while perhaps not the possession of a group, can be the possession of an individual. As the following section shows, this decontextualized approach to culture is reinforced through efforts to encourage providers to reflect on their own cultural backgrounds.

Changing Attitudes: "Everyone Has Culture"

Medical anthropologists have argued that, in addition to promoting notions of culture as a bounded whole, many cultural competence efforts reinforce the assumption that biomedicine is culture free (Taylor 2003b) and that culture matters most in cases where patients are most different from an unmarked "mainstream" (Santiago-Irizarry 2001; Willen et al. 2010). Efforts to improve cultural competence education have sought to change attitudes toward "Others" by encouraging health providers to reflect on their own cultural backgrounds, norms, values, and biases (Betancourt 2003). However, the approaches used to help trainees engage in this "ethical self-fashioning," as Shaw and Armin (this volume) call it, can have several repercussions. While highlighting the presence of diversity among groups of practitioners, these specific activities reproduce an individualized approach to culture, fail to fully examine the culture of biomedicine, and often prevent more challenging discussions of racism or other forms of bigotry.

"I'm white," a medical student said at the beginning of a cultural competence course. "I don't have any culture." Cultural competence training sessions often begin by emphasizing that *everybody* has culture. Many of the opening "ice-breaker" activities conducted during training sessions are designed to make the point that there is a great deal of diversity even in a room full of people with similar jobs. At the training session for hospital nurses described earlier, Sharon began the workshop with a "cultural scavenger hunt." We were given a list of characteristics and told to move around the room and find someone who can say "yes" to each one. The list included finding someone who speaks English as a second language, bundles up when sick with fever, knows how to protect against the evil eye, has experienced acupuncture, or believes that prayer can heal a person.

The "Diversity Shuffle" at the beginning of a training session for employees at a managed care organization reflected a common variation of this activity, and one that worked better with smaller groups. In this case, all eighteen participants lined up against one wall of the meeting room. Tomás, the facilitator, called out a list of characteristics, and we were told to cross to the other side of the room each time the characteristic applied to us. "Everyone who's left handed," he said, and only one other man and I crossed the room. "Everyone who has brown eyes." "Everyone who has lived in another country;" two people had lived in the U.K., and two had lived in Indonesia. "Everyone who has siblings;" "everyone who had a parent who went to college;" "everyone who has used home remedies." In no case did only one person cross the room, and as we returned to our seats, Tomás emphasized that this activity shows not only the diversity in the room but also how much we have in common.

Other portions of trainings are designed to emphasize the participants' own cultures by focusing on traditional health care practices. Following the diversity shuffle, for example, workshop participants were each given a paper entitled "My Health Care Culture" and directed to answer questions about the special foods and medicines we use when sick. As we discussed our health care practices afterward, people mentioned using coke syrup for upset stomachs; cloves and olive oil for a toothache; and lemon juice, honey, and whisky for a sore throat. Similarly, at a meeting for cultural and linguistic staff from a number of health organizations around Southern California, the facilitator, Kevin, tried to draw out information about the cultural backgrounds of people in the room:

Kevin How about traditional beliefs and practices? Things you take for granted? [silence]

Kevin [pointing to a man at the front of the room] Jim, how about you—anything different or unique from when you were growing up? Home remedies?

Jim Not really.

Kevin Chicken soup?

Jim Well, one of the things is my grandmother is half Dutch, and when we were growing up, if we were sick, Hot Toddies. I was 9 years old. It serves no purpose really, but you feel better. Other than that we were pretty cut and dry. I'm trying to think as we're going through this, how does it relate to me, but so far, not a lot.

Kevin I think if you think about it, you'll find some insights in parts of your life. For as much exposure as I've had to the medical field, I was in my grandmother's house the other day and dropped a glass and cut my finger. And normally I would put on Neosporin, but my grandmother saw me and said, "Oh, I've got something." She took out a little vial of something, this dark stuff, and put it on me. And I let her because she's my grandmother. I didn't go back and wash it off and put on the Neosporin. Later on that night, I started getting kind of dizzy, and it so happens I was with a friend who is a physician, and I asked if this had anything to do with it. And he said, "Who knows what's in there? What are you doing letting your grandmother put this stuff on you?" [laughter]

This is a little slice of how we take things for granted, and yet these traditional beliefs and practices hinge on how we look at health care, how receptive we are to health care. If that makes such an impact with us with all of our backgrounds, think about the patients we work with, the members of the communities we work with.

Each of these exercises is designed to challenge what Willen et al. (2010, p. 250) call the "mainstream clinician/'Other' patient" model by drawing attention to diversity among health professionals and encouraging these professionals to reflect on their own cultural backgrounds. These approaches tend, however, to emphasize individual characteristics (eye color, handedness, college attendance, etc.) and involve very little discussion of the significance of these characteristics and behaviors in everyday life. We never discussed, for example, how our appearance

might affect our life experiences or the role that having a parent who went to college might play in structuring our current social positions or understandings of the world.

While the exercises emphasized that everyone has culture, this culture tended to be defined as those practices that are outside of the norm of biomedicine (implied by Kevin's question about anything "different or unique"). Culture included the evil eye, "alternative" treatments, and home remedies administered by grandmothers. It never included encounters with biomedicine; when asked what cultural practices we engage in when sick, for example, nobody ever said (or was expected to say), "I go to the doctor and ask for a prescription for an antibiotic."

This approach has two effects. First, biomedicine remains unmarked and culture free, or, as Taylor (2003b) emphasizes, the "culture of no culture."[5] Interestingly, culture in these training sessions was not simply positioned in opposition to biomedicine but can exist on a gradient; the most "cultural" traits are those that are most different from the unmarked "norm"—if culture can matter to "us," Kevin suggested to a room full of health professionals, just think how much more it matters to "the communities we work with." At the same time, these exercises positioned cultural practices as individual rather than socially structured choices. I may choose to use a home remedy because it is part of my culture; other factors that may structure my health care decisions—how much do various treatment options cost? do I have insurance that will help cover these expenses? can I take time off from work or from my other responsibilities to seek biomedical care?—were rarely discussed.

Other approaches to the examination of one's own background returned to group-based categorization with an emphasis on individual variation. At a cultural competence training for hospital employees, we were given a form asking "Who Are You," which explained that:

> awareness of your own cultural background is the first step in becoming culturally aware. Below are words that describe some characteristics of culture. Circle words from this list or add your own words to describe your cultural identity.

The words were divided into several categories. Under "Race/Ethnicity," African American, Asian American, Native American, European American, and Latino/Hispanic were listed. A category labeled "Sexual Orientation" gave the options of heterosexual, gay, lesbian, or bisexual. We could be male or female; upper, middle, or lower class; Protestant, Jewish, Muslim, or Catholic; and rural, urban, or suburban. The exercise emphasized that each of us has many aspects to our identities and that not all "Native Americans," "lesbians," or "Catholics" will be the same. I may identify myself as African American, but one should not assume that I have everything in common with other African Americans; my gender, sexual orientation, class, religion, and upbringing matter as well.

The activity had several important purposes. It was designed to encourage health providers to reflect on their own identities and to demonstrate, as Gregg and Saha (2006) recommend, that we all invariably belong to multiple cultural worlds. At the

[5] Taylor takes this term from Sharon Traweek's (1988) study of high-energy physicists.

same time, however, the activity not only approached the categories as if they were objective and obvious traits but suggested that they are all equivalent to each other. I may be gay or straight, Muslim or Christian, upper or lower class. Each term was presented as describing an innate part of my identity, not a historically produced and ultimately unequal social position. The roles that each category may play in structuring everyday social experience or in social inclusion or exclusion were ultimately ignored.

This limited approach can prevent the sessions from achieving their goal of promoting reflection on personal biases. Dorothy Franks, a medical school administrator who has created and evaluated a cultural competence program for medical students, explained the importance of this effort:

> We talk to students and say, "you bring your own biases in that room, it's not just the culture of the patient, it's your culture interacting with the culture of the patient. It's not like you're a blank piece of paper walking in—you're bringing all of your cultural stuff with you when you walk in the door."

Although many arguments for cultural competence training focus on the need to address biases and prejudices among health practitioners (Smedley et al. 2002), the training sessions I attended ultimately avoided these issues or positioned them as problems resulting simply from a lack of cross-cultural awareness. Reflection on one's own "cultural stuff" rarely went beyond the recognition that "I have culture, too."

The reason for this limited approach may lie in Willen et al.'s (2010) important observation that cultural competence initiatives often "ignore the powerful emotional valences associated with culture, race/ethnicity, and other forms of difference" (p. 251). "Ouch—then educate," one training session's "ground rules" stated: "Sometimes someone might say something that's an "ouch!" but rather than take offense, use it as a chance to teach them and explain your point of view." While this statement may be an acknowledgment that discussions of race, culture, and difference can be emotionally fraught, it does little to guide participants through the process of engaging with these issues.

In a conversation at a campus coffee shop, three second-year medical students, who are also three of the few African American students at the school, described their experience in Dorothy Franks's course. While they generally value the course, they laughed at their colleagues' pronouncements of being culturally competent. "There's lip service to [cultural competence]," Carolyn said, but "they make the same remarks now that they did when they came in as first years, under their breath or to their friends." Michelle pointed to a specific comment that bothered her:

> We were discussing health care policies in different countries, and one issue that came up is why access to insurance is so different among different populations of this country. One of my classmates said, "well, why worry about insurance when you're trying to have $300 rims?" Basically, saying it's about priorities, and that $300 rims is a priority over health insurance. That's one that will always stick out in my mind, showing how relatively ineffective the efforts for cultural competency are.

In this case, Michelle expected that cultural competence efforts should make students more understanding of others or better able to see the world from another point of view. Challenging these comments, however, proved difficult because they are not necessarily inconsistent with the lessons taught by cultural competence. Choosing rims over health insurance could be identified as an individual choice influenced by group-based culture that has no larger meaning or significance; the responsibility for a lack of insurance is shifted from a dysfunctional health system to an individual's values and decision-making process.

These students suggested that one problem in more fully addressing the goal of cultural competence is that many people refuse to acknowledge that the biases of providers may play a role in health care. Carolyn described a discussion in class about the Institute of Medicine's (IOM) report *Unequal Treatment* (Smedley et al. 2002), which found that disparities in care persist even after controlling for factors like health insurance and socioeconomic status. The study concluded that bias and prejudice on the part of healthcare providers may contribute to these disparities in care and outcomes and recommended cultural competence education as part of a solution. Carolyn explained:

> One thing that resonates for me is that towards the end of last year we talked about the IOM study, which I'm sure you're familiar with. Instead of students looking at this study and agreeing that it was somewhat valid and saying, "where do we go from here," the entire discussion revolved around trying to invalidate the study. "Oh, it wasn't done properly, they didn't look at this." As opposed to admitting to ourselves that there's a problem in health care…. It's still not an issue that people want to confront. … I don't know how effective discussing these things are, if we're going to sit and discuss how invalid the findings are.

"Everyone," she added, "says 'it's not me.'" While addressing these biases is an explicit purpose of cultural competence education, this purpose is undermined by the inability to discuss racial bias as a real and significant phenomenon. Cultural competence efforts are rarely able to successfully address these issues. Michelle expressed her frustration:

> Every session they try to get [at it], but for the most part it always kind of boils down to the same thing, which is people not understanding or being challenged about their own beliefs and preconceived notions, and not really liking that challenge.

But, she recognized the difficulty of challenges that are too direct:

> It's tricky because you want to educate people and you want to make better doctors out of people, but you also have to make sure that people are going to be open to your content. And if you make it so harsh, no one's going to be open to the topic in the first place. It's tricky because you don't want to turn people off with the very mention of your program.

More than one of the program developers I spoke with also reflected this sentiment, stating that they sometimes consciously avoid discussions of race and ethnicity to avoid uncomfortable and inflammatory conversations (see Jenks 2010).

Gregg and Saha (2006) highlight a central danger of the conflation of race and culture in cultural competence work: "by subsuming race under the rubric of culture, racism and discrimination become part of 'cultural differences' and are thereby more palatable and easier to ignore" (p. 545). Carolyn would agree with this statement. A discussion of culture and cultural competence, she concluded, "hurts a little less" than discussions of racism or bias. It may be, however, that it is only when culture is approached as an apolitical object separate from any social context that it becomes more palatable. Culture is a more comfortable topic than race in these conversations precisely because culture is presented as a neutral set of beliefs and practices that everyone has and that are therefore equivalent. Exploring cultural competence "hurts less" than exploring racism because it ultimately requires providers to recognize variation and difference but not inequality.

Conclusions: Becoming Open-Minded

Recent interventions in cultural competence education have called for an increased focus on meaning-centered or process-oriented approaches to culture (Carpenter-Song et al. 2007; Lakes et al. 2006). Betancourt (2003), for example, emphasizes that providers-in-training must learn a framework that can guide their communication with individual patients. Cultural competence educators have responded to these calls by increasingly drawing on models that emphasize general cross-cultural communication and interview techniques [see, for example, Dobbie et al. (2003) and Levin et al. (2000) for descriptions of the BELIEF and ETHNIC frameworks]. The most common model cited by the educators and students I spoke with was Arthur Kleinman's series of eight questions that can be used to elicit patients' explanatory models (Kleinman et al. 1978; Kleinman 1980, p. 106):

(1) What do you call your problem? What name does it have?
(2) What do you think has caused your problem?
(3) Why do you think it started when it did?
(4) What does your sickness do to you? How does it work?
(5) How severe is it? Will it have a short or long course?
(6) What do you fear most about your sickness?
(7) What are the chief problems your sickness has caused for you?
(8) What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

Dorothy Franks explained the benefits of Kleinman's approach. When the program at her medical school was started, they had used a series of books on African Americans, Latinos, and Asian and Pacific Islanders offered by Kaiser Permanente ("because Kaiser's willing to share them," she said, "and we don't get much for free"). The books include overviews of demographic data, health beliefs and behaviors, and major health issues related to each group. Dr. Franks, however,

was uncomfortable with the books' division according to race and ethnicity and was hesitant to use them again. "You know," she said,

> I'm African American, and I look at the African American book and I'm going, "some of this works, and some of it doesn't." It was a little too—how do you cut between stereotypes and [hesitates] then that leads to more biases. And we don't want to teach bias.
> So that's why I really like Kleinman's model. … To me using Kleinman's questions gave us a process; it didn't give us stereotypes and biases, it gave us a process. Because you could have any set of beliefs under the sun, and if a doctor were to take time and ask you those questions, they would elicit a lot of information that would be useful to help take care of you. No matter who you are, it doesn't matter. Because you're not going to learn about all cultures, so that's the process.

The increasing emphasis on "open-mindedness" among health providers is linked to this process. Culturally competent providers are not seen to be those who have learned a technical skill or who can recite facts about various cultural groups. Providers are culturally competent when they recognize that differences exist, welcome more knowledge about these differences, and seek to treat each patient as an individual. While this awareness of difference and willingness to listen to individual patient situations reflects a significant counter to standardized trends in the culture of biomedicine, it can carry unintended consequences.

The approach toward culture that emerges in these efforts can actively prevent an examination of larger social structures. One medical student I talked with suggested that cultural competence efforts need to address "more of why people are in the situations they're in":

> I think if people haven't had a lot of interactions with minorities, and you come here and there are mostly minority people across the street [at the hospital], you think, ok, most black patients are homeless, or on drugs, or don't take their medicine. Those are just really drastic assumptions or stereotypes. But [you need to] take the time to say, "why is this person homeless?" Maybe it's because they lost their job and didn't make much money to begin with and didn't have a way out. … I think [it's important to help] people understand why patients are like that. Why is their diabetes out of control? Maybe they can't afford their medications. … So I think getting more at the root of why people are in the situations they're in would be a little more helpful.

Throughout my fieldwork, I often saw this move away from an examination of the way individuals are affected by social or economic factors. I heard multiple times, for example, about the "cultural beliefs" that prevented many patients from complying with diabetes treatments: Black patients believed that insulin caused blindness and leg amputations, and many Latino immigrants believed that diabetes is not related only to sugar, but to stress and their experience of living in the United States. Health providers had learned from their cultural competence training to recognize that patients may have different views from themselves and to ask these

patients more about their beliefs. But inquiries stopped after patients had been convinced to test their blood sugar levels and take their insulin. I would argue, however, that these patient responses were not simply individual views that providers must remain open to hearing. They are serious critiques of a larger culture that produces illness and suffering in the United States. The identification of culture in individual beliefs and practices prevents a further interrogation of the social context: Why do Black patients see so many friends, relatives, and neighbors with poorly controlled diabetes? Why are some diabetics more likely to experience blindness and limb amputations than others? What is it about life in the United States that has produced such high rates of diabetes for many populations, but not for others? Rivkin-Fish (this volume) offers further examples of the way attention to culture as an individual—not necessarily racial or group-based—set of values can lead providers to define acceptable standards of care according to patients' supposedly autonomous priorities and "choices."

Medical anthropology can play an important role in the further development of a more culturally competent health system. Anthropologists have offered essential critiques of the way culture is defined and taught to health providers, highlighting the tendency to approach "culture" as a static collection of fixed racial or ethnic traits that belong primarily to patients who are outside of the "mainstream." This article argues that these critiques have not been ignored. Many of the cultural competence educators I spoke with expressed familiarity with these critiques, have similar concerns, and struggle to present a more complex approach to culture. A closer examination of these efforts shows that they are not always successful. Ideas about bounded cultural groups are often qualified with warnings about the dangers of stereotyping, but they are not abandoned altogether. An increased emphasis on the culture of providers can simultaneously reinforce the unmarked nature of the culture of biomedicine and prevent an analysis of the role of bias and prejudice in health care, undermining the central purpose of cultural competence efforts.

At the same time, these attempts to improve cultural competence have had important effects with potentially unintended consequences. Although cultural competence began as a political movement committed to the delivery of equal care and focused on the alleviation of heath disparities, recent approaches can work as an "anti-politics machine" (Ferguson 1994). As educators work to move beyond essentializing, Othering approaches to culture, they also direct attention away from a social understanding of difference and toward an individual one. Such an approach prevents any recognition of the social production of health inequality, as being culturally competent comes to signify an impartial, uncritical, "open-mindedness."

Two future directions for medical anthropology research on cultural competence can help to further elucidate this process and its consequences. First, while medical anthropologists have made important critiques of the culture concept in cultural competence work, greater attention must be paid to the way these critiques have been received and to the contexts, both small and large, within which efforts to reform cultural competence education operate. As Willen et al. (2010) emphasize, "it is striking how little is known about the on-the-ground challenges, problems, and pitfalls" (p. 247) of cultural competence education. Second, increased attention must be paid not just to how cultural competence is *taught* but to how it is *learned*.

How do medical students and other health providers-in-training negotiate the process of becoming culturally competent? While they identify "open-mindedness" as the core feature of cultural competence, how do they come to embody and enact this open-mindedness in their interactions with patients? These two areas of focus have the potential to significantly contribute to our understandings of the everyday struggles, conflicts, and consequences of becoming "culturally competent."

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