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Beyond Cultural Competency: Skill, Reflexivity, and Structure in Successful Tribal Health Care

Carolyn Smith-Morris and Jenny Epstein

The growing concern with cultural competency in health care settings is an ironic development from the perspective of tribal health care, where biomedical clinicians and patients have struggled for decades with the challenges of cross-cultural healing.¹ Both anthropological and other literatures on minority health have declared cultural competency to be a critical tool requiring both cross-cultural knowledge and specific skills. However, many approaches to this concept, such as brief trainings and cultural inventories for staff in multicultural health care settings, have failed to improve the quality of health care or the skill of health care providers.

Cultural competency is built on several assumptions regarding the boundedness and neutrality of “culture” within biomedical practice as well as the authority and power structures through which “competency” is determined. In this chapter, we deconstruct notions of cultural competency, rebuilding this important aspect of medical practice under Bourdieu’s model of reflexivity.² We outline a critical discourse of cultural competency based on a processual

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and distinctively anthropological model. Applying Bourdieu, we view the use of culture competency as a colonizing force within biomedical practice, one that stems from reluctance to subject categories of medical experience to cross-cultural comparison.

Using two case studies, we build a model that distinguishes between cultural competency and cultural capital. Our first case examines the complexities of incorporating community-based cultural capital into an ambulatory care practice. Our second case considers the practitioner's use of cultural capital in clinical practice and the institution's position and responsibility toward the community it serves. Together, these case studies illustrate a reflexive form of culturally competent care by which health care institutions in Indian country can promote a praxis that goes beyond cultural competency.

CULTURAL CAPITAL AND APPLYING BOURDIEU

Pierre Bourdieu's work helped create a reflexive form of sociology that reopened the field of societal institutions to critical examination.³ Set against what were considered "natural" categories of social life such as class, money, and labor, Bourdieu's reflexivity viewed those categories as made up of dynamic social relationships. Grounded in time and place, this reflexive method of comparing social categories cross-culturally has offered a more rigorous method for exposing social bias in social science research.

We draw upon a second major feature of Bourdieu's work: the recognition and use of culture as a form of capital, derived from information about Native traditions as social assets with value. Health care practitioners can employ cultural capital both in the promotion of health messages and the delivery of health care services. Patients who learn how to navigate and manipulate the biomedical culture (or dominant Western culture) successfully can also employ cultural capital. Ultimately, although cultural capital can be a resource used to achieve particular ends, its use can also reproduce class distinctions, create unequal power relations, and result in health inequities.

Initially, we need not distinguish, nor did Bourdieu, the value of one group's social capital over that of another. Cultural capital is simply valued cultural information and the ability to deploy it either for harm or good. As these notions are applied to health care, however, cultural capital is deployed to help biomedicine become more successful—and very likely more dominant—in cross-cultural settings. What are the resources available for the provision of medical care? What cultural features and history are defined as valuable, and by whom? By building relevant cultural beliefs and practices into treatment plans, both biomedicine and the patient can achieve better outcomes; however,

there are significant power dynamics in this process. In the discussion to come, we point specifically to the clash between communitarian and individualist ideologies as they compete for power in the health setting, all under the banner of saving individual patient lives.

Bourdieu's work gives us a methodology to critically examine the seemingly natural social categories of "health," "medicine," and "disease," and to view them instead as social constructions. By viewing cultural practices as a form of capital, we can understand what types of behaviors, knowledge, and values are emphasized, ignored, or made neutral within social practices such as biomedicine. While Bourdieu's work focused on the construction of class distinctions in a fairly homogenous, capitalist society—France—his analysis suggests how cultural practices are not "disinterested"; that is, we can view cultural practices as sources of knowledge, attitudes, and behavior that are either valued or marginalized in the reproduction of social relationships.⁴

This brings us to the increasingly popular concept of "cultural competency" in health care settings. A dominant, mainstream cultural approach to competency in health care settings relies solely on categorical information about the cultural features of ethnic groups such as their language, their core values, and their norms of behavior.⁵ This is an oversimplification of culture, of course, but more importantly, it promotes a static view of patients and their communities and fails to recognize the crucial role of social capital: the ability to use and apply information and resources correctly to exercise control over one's own social situation and that of others. In other words, cultural competency ignores the dynamics of power and how the mastery of particular types of knowledge and social skills are valued over others within medical practice. Without the deeper analysis of social categories that Bourdieu's work exemplifies, cultural competency becomes a loosely defined appendage that does not really challenge or change medical practices.

A HISTORY OF CULTURAL COMPETENCE

Among the older and most widely accepted definitions of cultural competency in the health care literature is the following, published by Georgetown University's National Center for Cultural Competence:

Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professions that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. "Competence" implies having the capacity to function effectively as an

individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities.⁶

The Office of Minority Health of the US Department of Health and Human Services largely adopts this definition and has created national standards for addressing cultural fluency in health care institutions.⁷ Yet in many instances, the above-cited “capacity to function effectively as an individual or organization” is severely restricted by the traditions and habits of biomedical practice. The kinds of severe problems discussed by Anne Fadiman—a paucity of trained interpreters, understaffed emergency rooms, and gross misinterpretations of patient beliefs and practices—are problematic enough.⁸ But as we will argue, remedying these problems alone still ignores the greater, more systemic challenges of biomedicine in cross-cultural settings.

In the past two decades, health care practices have come under increasing scrutiny for cultural sensitivity and ethnic/race inequities in health and health care in part because of the national problem of health disparities. Teaching hospitals have expanded course offerings and in-service trainings on these topics.⁹ Also, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), which is an international standard of quality and performance for hospitals, has devoted significant attention to culture and ethnicity in their accreditation requirements. More than 18,000 organizations and approximately 88 percent of US hospitals are accredited by the JCAHO, indicating the breadth of this organization’s impact. Many of the JCAHO standards now address cultural competency, including those grouped under “Information Management,” “Leadership,” and the “Provision and Record of Care.” “Patient-Centered Communication Standards” took effect in January 2011 and address such factors as the hospital culture, patients’ cultures (namely, “ethnic and cultural factors” in care), patient communication needs, dietary preferences, religious proscriptions and beliefs, and involvement of family.

Despite their current hegemonic status in health care, cultural competency trainings have relatively little known impact on health outcomes.¹⁰ Joe Kai and colleagues have shown, for example, that cultural competency training can actually make health care worse by heightening clinician anxiety over saying/doing the wrong thing, which produces uncertainty and a risk of inertia.¹¹

Arthur Kleinman and Peter Benson advocate that clinicians should offer empathic understanding for the cultural beliefs or “local worlds” of individual patients.¹² In many instances, clinicians state that identifying cultural differences does not lead to resolution and simply opens up issues far more complex than can be addressed in a clinical encounter.¹³ As will be discussed, these more complicated, systemic issues remain an important factor in daily clinical practice. Finding out “what matters most to patients,” as Kleinman and Benson

recommend, ignores issues of power and leaves both clinicians and patients trying to solve problems that take more than individual effort.¹⁴

The following case studies reveal some alternative approaches to cultural competency, and highlight the value of reflexivity and an effective use of cultural capital for better diabetes prevention in Indian country.

AN ANTHROPOLOGY OF CULTURAL COMPETENCE

Medical anthropologists have worked on the problem of cultural competency since the inception of the discipline. Only recently, however, has this problem received significant professional attention within biomedicine. The predominant anthropological critique of the cultural competence debates has focused on a tendency for health care practitioners to create and depend solely upon cultural “cookbooks”: training manuals which oversimplify cultural characteristics, draw broad generalizations about diverse groups of people, and shift attention away from more important goals—such as the need for practitioner communication skills in exploring cultural differences as well as institutional commitment to community health. Likewise, brief trainings (4.5 hours) aimed at improving physician cross-cultural knowledge and skills have shown little or no measurable impact.¹⁵ Longer trainings, such as a two-week Spanish immersion course or a multisession training with practice time between sessions, produced only modest changes in physician behaviors, which ultimately were not long-lasting.¹⁶

Data show that cultural competency demands not just improved knowledge of cultural norms, values, and history, but also more accepting attitudes, improved skills for interacting cross-culturally, and community involvement.¹⁷ All of these strategies require greater knowledge of cultural capital, and ability to correctly use it. Educational approaches that inspire or target self-awareness and reflexivity among clinicians may be the most useful place to start. The ability to recognize and talk about stereotypic, denigrating, or poorly informed beliefs and prejudices in clinical settings helped one Vietnamese medical student identify obstacles to improved care: “When I was talking with [my Vietnamese patients], the training kept me from like . . . just laughing you know, making an inappropriate response when they would express these unscientific beliefs.”¹⁸ Another student said her own personal prejudices were “something that the [training] originally made me aware of, because that never would have occurred to me. I think that I’m an empathetic person and that I would go into every encounter with an open heart but as it turns out I really do have a harder time with certain patients.”¹⁹ Indeed, even knowledgeable and well-intended clinicians may feel uncertain or ill-equipped to respond to the needs of their patients of ethnicities different from their own:

[The] Chinese don't have a word for cancer and it's absolutely considered taboo to actually talk to somebody with cancer and say they've got it . . . so how do you start to talk to them about giving them chemotherapy if you're not actually allowed to use the word "cancer"?²⁰

[He] had a leg ulcer and it took a very, very long time for him to be prepared to roll his trouser leg up so that I could get near it. . . . And I found that very awkward . . . feeling terribly vulnerable because I didn't want to insult any of their cultural beliefs and yet at the same time I was trying to do a professional job for somebody.²¹

When cultural competency is taught through cookbooks of norms and generalities, it can leave learners without the skills for negotiating cultural differences, which is a critical component of cultural capital. As Bourdieu conceived it, cultural information becomes valuable in social settings only when it can be used and applied correctly. Lists of cultural beliefs and practices become outdated or can reflect nostalgia for historical ideals, rather than what is actually practiced currently. These lists are of very limited value in clinical settings. However, if the cultural capital paradigm were to be employed, competency would include clinician skill and greater institutional capacity to effect change in communities, not simply cultural knowledge and linguistic competency.

These days, improving the cultural competency of biomedical practitioners is increasingly viewed as the best way to improve the quality of care across racial/ethnic groups.²² However, the assumption behind this claim is that health inequities across cultural or ethnic groups are attributable to a lack of cultural knowledge among clinicians. Anthropologists suggest instead that health inequities are structural problems within which practitioner biases may play out and are beyond the scope of individual practitioner skills and his or her cultural awareness. Furthermore, by placing our focus on the cultural competency of individual practitioners, the self-sustaining biases of biomedicine's structural inequities and failures remain intact.²³ These approaches not only place an enormous burden on health care practitioners, but also minimize the impact that practitioners and health care staff can have.

Bourdieu's stress on reflexivity applies to both a patient's local world and to biomedical practitioners, recognizing the limitations and employing the strengths of each. This more leveled gaze does not marginalize subjective experience but instead harnesses it—for example, in the effective management of diabetes. Traditional emphasis in biomedicine on biology and pharmaceuticals allows treatment to be kept separate from other considerations, such as the individual's embeddedness as a social actor. In diabetes treatment, the traditional biomedical emphasis is especially problematic because of the great

need for lifestyle changes as a part of the treatment protocol. For patients with diabetes, simply taking medication generally does not control disease symptoms. However, Native patients with diabetes are often reluctant to make many of those lifestyle changes.

ACHIEVING CULTURAL COMPETENCY IN TRIBAL HEALTH CARE

The experience of American Indian communities with biomedicine, and particularly with federal programs that implemented biomedical health programs on Native reservations, are instructive case studies in the history of cultural competence. The introduction of disease, not warfare, was the major destructive force to Native culture in the Americas.²⁴ As infectious epidemics of tuberculosis, smallpox, and influenza spread, Native populations were decimated, falling from an estimated population of approximately 5 million pre-contact to perhaps 400,000 by 1900.²⁵ Culture loss, poverty, and the resource stress of colonization and reservation life also contributed to the generally lower levels of health of Native populations.²⁶

Beginning in 1849, federal responsibility for medical care was shifted from military to civilian control when the Bureau of Indian Affairs (BIA) was transferred from the Department of War to the Department of the Interior. During the next half century, Indian medical care consisted of a patchwork of missionary, philanthropic, and federal programs that met the medical needs of Indian people with varying degrees of success. Beginning in the early 1900s, however, federal provision of medical services slowly increased, with the BIA sharing physicians, nurses, and administrative services from the Public Health Service. In 1954, medical care was transferred completely from the BIA to the PHS. The creation of the Indian Health Service (IHS) as an internal branch of the department took place a year later. Tribes began exercising greater control of their own medical care with passage of the Indian Self-Determination Act of 1976, which allowed clinic management to be transferred from the IHS to tribal governments.²⁷

Throughout this history of medical care, the federal government has treated Indians as both wards of the state needing assimilation and as members of autonomous tribes. The provision of medical services by the federal government reflects this contradiction. Medical care has been a tool used for assimilation even as services specific to Indian people were created. This tension continues today despite the fact that many clinics once managed directly by the IHS are now tribally run. Today, IHS services are delivered in three ways: through direct IHS services; through tribal services; or by contract with non-IHS service providers. The IHS now serves approximately 2.1 million American

Indians on reservations, in rural communities, and in urban areas through a system of health centers, hospitals, and health stations managed by 168 service units and twelve area offices.²⁸

As an institution run largely by non-Natives in communities of Native peoples, IHS hospitals and clinics have always faced distinct challenges in terms of cultural contact, cultural knowledge of the staff, and cultural competency. While we acknowledge the variations in different IHS clinic approaches to these issues, now there are also accreditation pressures to achieve or demonstrate cultural competency. The cases below illustrate two variants in how Indian communities address cultural competency, both as a normal process for health care on reservations and as a new, accreditation-driven paradigm. In the Puyallup example, the accreditation process prompted staff to think about what “culturally appropriate” actually meant. For the Gila River Indian Community, accreditation processes lag behind the more assertive measures that the community has taken in culturally competent diabetes care.

CASE STUDIES OF TRIBAL HEALTH CARE

Pharmacy Practice in the Puyallup Tribal Health Authority

As a pharmacist in the IHS, one of the authors of this article (Epstein) has found that creating effective diabetes treatment requires a structural change in medical practice that is culturally reflexive. Patients who have been told they are diabetic for the first time are usually overwhelmed, wondering how diabetes will affect their lives and how they will manage with this new burden. The myriad ways diabetes affects a patient’s life are condensed into quantified instructions about dietary change and exercise and medication regimens, a perspective that assumes treatment can be kept separate from the broader social demands of the individual.

Over many years of reviewing medical charts for diabetic medication refills and talking to patients about their diabetic medication, I began to understand the social meanings that underpinned many diabetic medication practices of patients. For example, many people with diabetes are torn between their need to control symptoms of diabetes and their unwillingness to be dependent on medications; diabetic medications are sometimes considered “too strong,” and thus an untrustworthy technology. Other patients become frustrated at the ineffectiveness of their medications, despite taking them as prescribed. For some, simply taking medications is far more tolerable than making lifestyle changes that could disrupt responsibilities to family, jobs, and social relationships.

In discussing these diabetic medication issues, tribal members often spoke to me of living in two parallel worlds: their life as an American Indian, and their

life with diabetes. For some people who live with diabetes, to incorporate the biomedical treatment of diabetes into daily practice means creating a personal narrative that bridges two worlds that are difficult to reconcile. Among older patients, the medical need for daily diabetic medications conflicted with the pharmaceutical-free lifestyle of parents or grandparents, or an individual's own expectations that, as an American Indian, she or he should be able to control diabetes symptoms through individual efforts to live morally. One man stated that he felt as if he were living between two tracks: the one his mother lived without pharmaceuticals, and the one his physicians, nurses, and pharmacists explained and urged him to follow. To another patient, stopping diabetic medications periodically allowed her to "be herself." Another woman told me of her surprise after seeing a Native healer who was having as much difficulty coming to terms with his own diagnosis of diabetes as she was.²⁹

However, other individuals developed effective strategies to live with diabetes, incorporating medically prescribed regimens and self-care behaviors based on cultural beliefs. Instead of being in conflict, biomedical treatment and cultural traditions sometimes augmented one another, so that an individual's need to use diabetes medications to keep blood glucose levels low fit within positive definitions of culture and identity and not simply within a definition of "compliant patient." In other instances, biomedical treatment was rejected almost completely, and diabetes was managed through lifestyle changes guided by spiritual beliefs. Constructing self-care practices seemed to be a series of small decisions made over years which utilized multiple forms of cultural capital. Unfortunately, within my daily clinical activities, there was no process to incorporate these subjective experiences into clinical practice. My patients and I fumbled to construct common narratives of diabetes that could bridge two different worldviews.

My patients and I both lacked a clinic-supported method of bridging the gap between a biomedical treatment of diabetes and knowledge acquired through the lived experiences of diabetes. Most important for me to learn is how effective treatment for diabetes is a dynamic process created from both of these perspectives.

Throughout its various legal and social manifestations since the nineteenth century, the Puyallup tribe has managed to survive and remain an important and dynamic presence in the urban center of Tacoma, Washington. The Medicine Creek Treaty ceded rights to land in exchange for a reservation, hunting and fishing rights, and cash and medical services to be provided by the federal government. It is one of the few federal treaties with American Indians that specifically mentions the provision of medical services, so that medical care is a treaty right paid for by the cession of land. From the mid-nineteenth century to the present, the incorporation of new medical technologies into

the social, cultural, and historical fabric of the Puyallup community has been an ongoing process that includes the 1974 negotiation by the tribe for what is now the Puyallup Tribal Health Authority (PTHA). This process gives nuance to a binary model of federally sponsored medical care imposed on a local Native community.

With the 1993 move to a new medical building, clinic staff and administrators created a new mission statement: "To provide quality health care and promote wellness in a culturally appropriate manner."³⁰ A permanent position of cultural coordinator was created as part of the medical staff, whose goal was "for all people to understand who the Tribe is, where we came from, and how we got here."³¹ For the first time, clinic staff members were mandated to participate in activities that centered on Puyallup cultural traditions. After 1993 an annual potlatch ceremony and the Puyallup Tribal Canoe Family programs began.

These programs helped clinic staff to understand some of the history and cultural traditions of the people coming to the clinic and broke down barriers between non-Native and Native clinic staff as well as between clinic staff and community members. However, these projects were not uncontested. At the start of the program, many non-Native staff questioned the need for daylong clinic closures and the appropriateness of time spent on activities that had little direct application to patient care. Some Native staff questioned the appropriateness of assigning staff to "clans" which are not typically associated with the local South Salish social organization and the decontextualizing of Native culture to a clinical setting. The manner in which the potlatch ceremony was conducted in the clinic and the appropriateness of trying to mix local customs into a biomedical setting were also questioned.

Most significantly, during a JCAHO inspection shortly after the new clinic opened, staff were surprised to find they could not explain the meaning of one phrase from the clinic's mission statement: "in a culturally appropriate manner." What had seemed vaguely obvious when it was written turned out to be difficult for staff to articulate. We answered the JCAHO question by describing the preferential treatment of elders and the provision of traditional healing services at the clinic.

Over time, however, the new clinic clans gained widespread acceptance among staff. Clan activities became a way of making social connections between clinic departments and clinical and nonclinical staff, and at least temporarily, these activities decreased clinic hierarchy. Finally, clan activities culminated in an annual potlatch for the community, a ceremony that created a new social relationship with the community. Clinic clans and the potlatch began to have less to do with mimicking an "outside" social structure and became more about creating new social relationships between clinic staff and patients. In addition to clan and potlatch activities, the mandatory in-services given by Native

healers and intellectuals introduced clinic staff to a variety of perspectives on Native culture. Many of the speakers exposed us to conceptions of life, self, and healing that were new and different to both Native and non-Native staff, provoking much discussion.

Note that none of these programs had a direct impact on medical treatment. What did change, slowly, was the clinic staff's awareness of the complexity of a worldview much different from conventional biomedical practice. Over time, many staff members came to view learning about local Native cultural traditions as a responsibility of working at PTHA and to view the mission of providing medical care as being within community history, not apart from it.

However, these changes happened over years and were never complete, nor did they come to represent a definitive community standpoint on Puyallup culture. I no longer work at PTHA, but recent events show that defining how biomedical practice and local cultural traditions intersect is an ongoing process. Recently, the clinic has implemented new programs to manage chronic medical conditions, including diabetes. Based on a model developed by a task force comprising large national groups, including the American Diabetes Association, the Indian Health Service, and the Veterans Administration, these programs focus on the individual as a social actor, utilizing many of the ideas discussed by Kleinman and Benson.³² Cultural perspectives are addressed through an assessment of each patient. Augmenting this shift to individual assessment, the position of cultural coordinator has been moved out of the medical clinic so that it now focuses on tribal youth and broader cultural programs. Coordinating the services of Native healers is still a function of the position, but the mandatory cultural programs, potlatch, and canoe club activities that functioned within the clinic framework have stopped. In short, the construction of culturally competent care, even within the confines of a tribally run clinic, is a dynamic process, reflecting the evolving nature of what the phrase "in a culturally appropriate manner" means.

During my tenure at PTHA, we did not attempt to measure how these cultural activities might impact clinical care. In part, this lack reflects how providing these services was viewed by myself, other clinical staff, and community members not as an integral part of medical care, but as a service to make patients feel more comfortable or to feel better about themselves. We lacked the critical thinking skills needed to visualize medical practice within a larger historical and social framework. Because we defined effective medical treatment as what happened strictly within the clinic setting, we did not attempt the evaluation of cultural activities in terms of clinical markers such as weight or blood sugars. Perhaps with more time, resources, and a greater diversity of involved community members, relationships between program activities and clinical markers would have been made.

However, how to incorporate cultural knowledge/capital into biomedical practice and to what degree was, and continues to be, highly contested by both medical practitioners and community members. While they saw value in these activities, many medical practitioners, patients, and community members did not feel that cultural programs should be a part of the clinical treatment. Another highly debated point was the nature and implementation of the cultural programs at the clinic. In hindsight, our implementation of “culture” was perhaps too simplistic and reflected little of the wide variations of perspective that existed within the community that the clinic served.

From my present perspective, I see that clinicians and patients of any social background jump between various constructions of diabetes that are often at odds. The relationships between the biological explanations of diabetes, the social and historical forces that give rise to the condition, and the ways individuals cope with the disease are not easy to reconcile. I continue to discover new ways of balancing the theoretical knowledge of medical practice with knowledge constructed from an individual’s daily life and dealing with diabetes. This includes identifying the limitations and strengths of each perspective, viewing the boundaries around medical knowledge as fluid, and most importantly, understanding the ways in which both perspectives do indeed affect one another.

The gaps I still feel when talking with patients have become clues that I need to push further rather than assume I’ve reached a dead end. These moments are indications of opportunities for learning through practice in the same way patients are learning to live with diabetes.

Gila River

The Puyallup case study illustrates how individually and culturally defined categories of sickness, or more specifically, diabetes, are connected to a social history through individuals living with diabetes. The second case study in this article, by co-author Smith-Morris, instead takes the perspective of health care providers in another American Indian reservation hospital and the larger social and professional context within which they work. As part of the case study, I explore some of the institutional structures defining “cultural competency” for clinicians on a professional level and suggest that “cultural competency” has a role in the dialectic between biomedical care and its culturally diverse patients. Since cultural capital is already being employed to promote particular health messages, this case considers potential conflicts within these dialectics of cultural capital and the culture war played out in tribal hospitals over individual forms and processes in opposition to communal ones.

That “culture” is central to health and to health care is rarely questioned among Gila River hospital staff. I begin this case study by illustrating the good and sometimes quite robust knowledge that many health care personnel have about the cultural norms, values, and communication styles of their Pima patients at Gila River. These health care practitioners include both Native and non-Native professionals as well as a number of community members. Still, the majority of professional staff is non-Native, and this presents a significant and endemic difficulty for provider-patient communication. My research, conducted at Gila River over a period of nine years, included a focused study among hospital employees about notions of their patients’ culture, and it is from these data that I draw my discussion.³³

The narratives of most of the providers at Gila River demonstrate a substantial amount of cultural knowledge about Pima culture, their history, and their epidemic of diabetes. Their narratives also illustrate their substantial capacity for using that cultural information correctly and appropriately, particularly through locally appropriate communication strategies. However, these staff narratives do convey a reminder that “culture” in the health care setting has both positive and negative attributes. When asked to describe their Pima Indian patients, staff offered these responses:

These are a friendly people, very kind. But it takes time for them to accept you. But once they have, they are very caring (an Anglo staff member with 1.5 years’ work on the reservation).

[Their greatest strength is] their unity and sense of family and community (a non-Pima Indian staff member with 3 years’ work on the reservation).

And, more negatively:

[I] am disappointed in the apathy regarding health among the population. [They are] apathetic regarding health and preventive measures. . . . This population is overly dependent on the health care system. They seek care for minor afflictions while avoiding care for major chronic conditions. . . . Very pleasant people, otherwise (an Anglo staff member, 1.5 years’ work on the reservation).

[This patient population is] a passive aggressive people with significant medical problems (an Anglo staff member, 13 years’ work on the reservation).

The balance in these narratives about the Pima resists an overly positive, or nostalgic, representation of culture.

Cultural capital as conceived by Bourdieu does not have an inherent value.³⁴ The same might be said for the cookbook content of cultural competency trainings that focus solely on attributes and value systems of a cultural group. Alone, this information is neither helpful nor harmful; however, it must be put

to work in clinical action in order to demonstrate cultural competence. Putting knowledge of culture to work to meet productive use requires both communication skills and the support of institutional resources.

Several Gila River practitioners have expert levels of cultural knowledge and expressed sensitivity to Pima patterns of communication, knew some of the Pima language, had attended local festivals, and generally worked to develop rapport and trust across the cultural divide.

They have the variety and diversity of any group—they are essentially a group of people with a diversity of needs (Anglo staff member, 14 years' work on the reservation).

[I] treat every patient the same with attention, respect and dignity. Listen. Don't pass the buck. Try to help each person or if you pass them on, be sure they were taken care of (Anglo staff member, 1.5 years' work on the reservation).

Perhaps most noteworthy is that having cultural capital/knowledge was not necessarily the most important thing to practitioners. Instead, these professionals suggest that the most important knowledge is the skill to communicate despite differences, to establish rapport and to listen:

[What helps me be effective is] good patient rapport, knowledge and concern with community activities, making patients a part of the decision making process, being open-minded, listening (Anglo staff member, 4 years' work on the reservation).

Indeed, health care is not always about culture at all. Kleinman and Benson remind us that cultural factors are sometimes completely irrelevant to clinical cases.³⁵ Some of these data suggests that cultural details are certainly less relevant than processual factors in health care. That is, a relatively uninformed but empathetic and skilled practitioner can be far more effective in Indian country than one who is culturally knowledgeable but inflexible.

One critical element of culture in health care for Gila River is the communal, as opposed to individual, nature of diabetes and the corresponding placement of responsibility for its prevention or control. In this community, where epidemic levels of diabetes have been present for multiple generations and where both genetic and gestational (or intrauterine) factors contribute to younger and younger ages at diagnosis, many Pima believe that diabetes is a permanent and nearly unavoidable part of the community.³⁶ The high rates of disease are attributable as much to their history of colonization, their loss of groundwater, their traditional lifestyle based on farming, and the dilemmas of development as they are attributable to bad eating habits or failure to exercise. Personal responsibility for disease is a biomedical paradigm that, while present in many Gila River community members to varying degrees, remains an issue

of contention and power. Of course, the vast majority of treatment occurs individually, but there remains a communal undercurrent in this tribe, and arguably many others, that helps disperse responsibility for diabetes to the Tribal Council, to health care practitioners, to colonial events and history, to genetics, and to the sometimes overwhelming sum of all these factors.

The individualist focus is emblematic of the biomedical worldview. Yet it is inconsistent with local cultural values that describe diabetes as a disease of the community and something expressly connected to the Pima history of colonization and water loss. A simple application of cultural knowledge does not begin to address this clash of worldviews. To achieve cultural competency in settings of such power imbalance and worldview differences requires recognition of institutionalized reflexivity from the clinic staff.

In other words, the institution of the hospital—specifically, the biomedical culture within that institution—attempts to separate Pima diabetes from its communal and historical roots. Pimas, on the other hand, maintain cultural values and perspectives that irreversibly link these deeper causes to individuals' experience of diabetes. In short, biomedical culture clashes with local, communal culture in ways that weaken the efforts of both sides to curtail the epidemic.

As at Puyallup, major transformations of the quality and character of tribal health care have been taking place at Gila River that begin to rebalance tribal health care in favor of community values. The tribe has offered community and cultural components to its new hospital employees for many years. Although limited, the orientation includes an address by community leaders and elders, a tour of the reservation, and didactic information about the tribe and its history. However, a more sophisticated brand of cultural competency began when the tribe took over the management of its own health care from the federal government.

Dissatisfied with IHS and NIH progress toward stemming its diabetes and obesity epidemics, in the late 1990s the Gila River Indian Community changed much of its approach to diabetes. The tribe eliminated the majority of biomedical research on the reservation and instead focused its resources on community-based field nursing, exercise and fitness resources for all tribal members, and new facilities for diabetes management and prevention.³⁷ Tribal diabetes services were restructured to include new and broader case management strategies that embraced community-based methods such as home visits, holistic approaches to diabetes care and treatment, and greater awareness of the context in which patients lived with this disease. New case managers, many of them tribal members, were assigned to spend more time in the community. Their job duties were refocused to ensure they promoted diabetes prevention through an understanding of the economic, cultural, spiritual, and familial

factors relevant to their illness. The political and institutional support of more field-based strategies, for nursing and case management, were viewed as a more culturally competent and effective approach than an institution-centered strategy. The shift represents not only the Gila River Indian Community's exemplary approach to cultural competency in clinical care, but also reveals that such paradigm-shifting achievements are made only through enormous dedication on the part of major institutions within the community: the health care corporation and the community's tribal council.

DISCUSSION: USING CULTURAL CAPITAL TO REDEFINE CULTURAL COMPETENCY

In *The Spirit Catches You*, Fadiman offers two lessons, only one of which is typically remembered.³⁸ First, there can be great cultural and linguistic differences between practitioners and their patients, turning even the most basic interactions into potentially offensive and dangerous events. Understanding these differences means both developing one's cultural knowledge and employing that knowledge correctly in context: using what Bourdieu termed cultural capital.

The second of Fadiman's messages involves the structures in society and hospitals that are equally limiting to good health care. The availability of competent, professional interpretation resources, adequate clinical staffing, and a more porous boundary between hospital and community through which expert field nurses and emergency responders travel are equally relevant to providing care and to avoiding the catastrophic tragedies experienced by the Hmong family in Fadiman's account. What is necessary is a truly reflexive perspective on: first, biomedicine and its strengths and limits vis-à-vis treatment; and second, our institutional approach to health care.

The Puyallup Tribal Health Authority, while it demonstrates cultural capital as a form of power, is just one example among many described in this special issue that illustrates the contested nature of cultural categories of health and illness. The PTHA provides not only access to medical technology and treatment-driven health care, but also provides institutional belonging and cultural identity. The manner in which diabetes treatment is practiced is a reflection of the larger relationship between the tribe and biomedicine as an institution. Whether cultural capital will be incorporated within biomedical practice, and how, are dynamic and challenging questions, and the answers will be slow to unfold. It took years for clinic staff to accept "nonwork-related" cultural activities as part of their responsibilities. Sensitivity to the collective memories of the tribe and their impact on local explanations for diabetes, for

example, will take many years more. And while these forms of capital are difficult to incorporate into biomedical practice, they form a reality that must be addressed for medical care to be effective. Perhaps one method of approaching this complex process is to think with Bourdieu: to begin by reflexively examining “health,” “sickness,” and “appropriate treatment” as cultural categories.

Likewise, transformations in diabetes care in the Gila River Indian Community occurred as a result of shifting political will toward cultural self-determination. Tribal priorities largely matched those expressed by health care providers, such as the need for rapport and for more opportunities to listen and respond to the experienced needs of patients. Cultural knowledge alone—that is, having cultural knowledge or Pima language skills—was not necessarily the most important thing to either patients or practitioners. Instead, both practitioners and patients needed structural support for their ongoing communication and interventions. This took the form of better case management so that communication could happen via phone or in the patients’ homes and communities rather than solely in the clinic. This structural support also required vehicles and a larger budget for field nurses to do their work with patients who could not, or would not, come to the clinic. Such changes do not grow out of an unrealistic or nostalgic representation of culture, but rather out of a reflexive respect for the patients’ current circumstance, and to some degree, the history that brought them to it.

These two case studies represent two different challenges of getting beyond simplified, cookbook uses of cultural capital to move towards achieving a reflexive and engaged strategy of cultural competency. The first case relates a clinician’s experiences of patients being torn between two worlds and of the differences between a Native way of living with diabetes and biomedical practices of diabetes management. Common to many tribal communities, this challenge was met at Puyallup Tribal Health Authority with creativity and bravery by the community members and by clinic staff who shared cultural knowledge in order to construct a more blended style and structure for diabetes treatment and care. The Gila River case suggests that many of the best health care providers seek out these “blended styles” independently by exploring cultural information on their own, then applying what they can in their work with community members. With reform of the Gila River diabetes programming in the late 1990s, the community-based methods for nursing and case management became institutionalized. These later structural reforms bolstered the efforts of Gila River’s most culturally competent clinical staff and helped to ensure more culturally and historically sensitive approaches throughout their treatment system.

These two cases from Indian country point to several clear strategies for a truly reflexive cultural competency both in clinicians as well as in the institutions

they serve. First, health care structures must include strong components of field nursing; school- and church-based interventions and education; community-based education that reaches both patients and their social networks; and intensive case management. These are strategies for applying cultural capital in constructive ways. These components create a network that responds to local information and needs because it is designed explicitly to move “health care” outside of traditional health institutions, buildings, and spaces.

Second, implementing programs in equal partnership with the communities that a clinic serves is a strategy for cultural competency that Indian country best illustrates. In tribal communities, a tribal council of elected or appointed leaders monitors the workings not only of tribal governance, but also of health, spiritual, economic, and other cultural practices, so that newly proposed programs have a unique opportunity for tribal input into design and implementation. This is another way in which cultural capital can become institutionalized in the very structures of newly proposed programs. Although tribal review processes differ, and meaningful input at this level is not guaranteed, the system of reviews inherent in tribal council governance of health care on reservations remains unique across the United States. It is for this reason that tribal strategies for employing cultural capital will be instructive even outside of tribal territories. Non-Indian health care structures will benefit from the models set by the unique characteristics of tribal communities, their governance, and the way they manage and design their health care in culturally competent ways.

For this work Bourdieu’s concepts of cultural capital and reflexivity can offer guidance, but achieving culturally competent care in which cultural capital is used productively to facilitate health care delivery demands far more than an academic understanding of tribal circumstances. Reflexivity requires a certain degree of structural flexibility that allows, or forces, the blending of biomedical paradigms with patient culture and history. The tribal communities we have discussed are two examples of culturally competent health care. In Indian country, health care must be particularly responsive to community-felt needs and political patterns, and cultural competency should be viewed not only as a clinical skill, but also as an opportunity to use cultural capital so that the customs, perspectives, and social networks that make up local culture can be incorporated into clinic culture. Where cultural competency has real meaning, it has been initiated fully into medical practice by the community that the clinic serves, helping to sustain a dialogue between that community and its medical institutions.

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