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Publication Date

2013-09-01

DOI

10.1016/j.socscimed.2013.06.014

Published in final edited form as:
Soc Sci Med. 2013 September ; 93: . doi:10.1016/j.socscimed.2013.06.014.

Cultural health capital and the interactional dynamics of patient-centered care

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Abstract

As intuitive and inviting as it may appear, the concept of patient-centered care has been difficult to conceptualize, institutionalize and operationalize. Informed by Bourdieu's concepts of cultural capital and habitus, we employ the framework of cultural health capital to uncover the ways in which both patients' and providers' cultural resources, assets, and interactional styles influence their abilities to mutually achieve patient-centered care. Cultural health capital is defined as a specialized collection of cultural skills, attitudes, behaviors and interactional styles that are valued, leveraged, and exchanged by both patients and providers during clinical interactions. In this paper, we report the findings of a qualitative study conducted from 2010 to 2011 in the Western United States. We investigated the various elements of cultural health capital, how patients and providers used cultural health capital to engage with each other, and how this process shaped the patient-centeredness of interactions. We find that the accomplishment of patient-centered care is highly dependent upon habitus and the cultural health capital that both patients and providers bring to health care interactions. Not only are some cultural resources more highly valued than others, their differential mobilization can facilitate or impede engagement and communication between patients and their providers. The focus of cultural health capital on the ways fundamental social inequalities are manifest in clinical interactions enables providers, patients, and health care organizations to consider how such inequalities can confound patient-centered care.

Keywords

United States; Cultural health capital; Patient-centered care; Patient–provider interactions; Health inequalities; Bourdieu; Habitus

Introduction

Over the last 15 years, researchers, clinicians, governmental agencies and international health organizations have advocated for the adoption of a patient-centered approach in the delivery of health care (Institute for Patient and Family Centered Care, 2008, pp. 1–28; Institute of Medicine, 2001; International Alliance of Patients' Organizations, 2007; Kitson, Marshall, Bassett & Zeitz, 2012; National Health Service, 2005; Stewart, 1995, 2001; The Health Foundation, 2011; U.S. Department of Health and Human Services, 2008, pp. 1–302; World Health Organization, 2000). The goal of patient-centered care (PCC) is to provide medical care concordant with the patient's cultural values, needs, and preferences (Epstein et al., 2005). While PCC has been relatively under-conceptualized in the literature, the

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construct seems to be captured by three broad domains: 1) a provider understanding the patient within his/her biopsychosocial context; 2) shared understanding of the clinical condition; and 3) sharing power and responsibility (Epstein et al., 2005; Mead & Bower 2000; Stewart et al., 2003; Wanzer, Booth-Butterfield & Gruber 2004). The notion of being patient centered is valued because it reflects a moral philosophy that patients are unique human entities, recognizes the multidimensionality of the human experience of health and illness, offers opportunities for patients to participate in their care, and enhances the patient–provider relationship through mutual understanding (Epstein, Fiscella, Lesser & Stange, 2010; Epstein et al. 2005; Institute of Medicine, 2001; Mead and Bower 2000).

However, a number of factors have hindered consensus on what elements comprise PCC. For example, Gillespie, Florin and Gillam (2004) observes that the varying agendas, interests and professional roles of different health care providers make it difficult to operationalize the concept at the patient level. In a recent review, Kitson et al. (2012) acknowledge that while there may be core features of PCC that transcend professional boundaries (e.g., patient participation, the patient–provider relationship, and the context of care delivery), the value and priority given to these elements may vary among different professions. Thus, there is little consensus on the elements of PCC, what they mean, how to measure them, and most importantly, how they can be enacted on the one hand or constrained on the other (Epstein et al., 2005; Swenson et al., 2004; Wanzer, Booth-Butterfield and Gruber 2004). Therefore, as intuitive and inviting as PCC may appear, it is difficult to conceptualize, institutionalize, and operationalize.

It is at this nexus that we offer the concept of cultural health capital (CHC) to help to illuminate how PCC is accomplished through or confounded by the interactional work that patients and providers do in the clinical encounter. CHC is defined as a specialized set of cultural skills, behaviors and interactional styles that are valued and leveraged as assets by both patients and providers in clinical encounters (Shim, 2010). In the contemporary U.S., CHC may include: knowledge of medications and health conditions, the ability to communicate that knowledge efficiently, the ability to adjust one's interactional style, organizational skills, and cues of favorable social and economic status. These cultural skills and resources are critical to the ability of patients and providers to effectively engage and communicate with one another. In this paper, we employ CHC as a theoretical framework to analyze how patients' and providers' cultural resources, dispositions and interactional styles influence their abilities to achieve PCC.

The concept of CHC traces its intellectual roots to Pierre Bourdieu's (1977, 1980, 1986) notion of cultural capital, where cultural products and practices of all kinds—styles of dress, eating habits, verbal skills, scientific knowledge, educational credentials etc.—function as forms of capital. CHC also builds upon the work of other scholars who have noted the utility of using concepts of capital in understanding inequalities in health status and health care. Wall (1995) for example, defines cultural capital as the capacity to be and remain informed, thereby it disproportionately benefits those who are better educated, more financially secure and able to capitalize on public health prevention methods. Malat (2006) defines cultural capital as the “knowledge and behaviors that gain an individual advantage in a particular social environment” (p. 305). She suggests that patients' differential abilities to deploy particular strategies to improve physician perceptions and/or negate negative stereotypes in an attempt to reduce the perceived social distance between them and improve the care received may help explain racial disparities in health care. Abel (2008) also draws from Bourdieu to offer a theoretically derived definition of “health relevant cultural capital” as “culture-based resources that are available to people for maintaining and promoting their health” (p. 3). Such resources interact with social and economic capital in the structuring of people's health chances and choices.

What these concepts of cultural capital share in common is the sense that cultural skills and resources increasingly matter in contemporary health care in the West because of the intensified demands placed on providers and patients alike. Health care providers are being asked to do more with less, while patients are being asked to shift from being seekers of health care to informed consumers of medical services. Such consumerist logic requires patients and providers to have a broad set of skills and organizational savvy to navigate an increasingly complex health care environment (Clarke, Shim, Mamo, Fosket & Fishman, 2003).

CHC also has much in common with the concepts of health literacy and self-efficacy (Bandura, 1997; Schillinger, Bindman, Wang, Stewart & Piette, 2004, Schillinger et al. 2002). In fact, CHC often includes these very traits, in that health literacy and self-efficacy are cultural resources and skills that help patients interact with their providers. But the concept of CHC adds another dimension by suggesting patients' mobilization of these resources not only directly facilitate communication, but also can lead to providers' more favorable estimations of their patients, and subsequently to additional attention and health care (Shim, 2010). The interactional focus and transactional, give-and-take nature of CHC add to our understanding of how these resources impact clinical encounters by underscoring not just the instrumental, but also the symbolic, ways in which CHC operates as a means of exchange.

While this article is based on an empirical study whose original intent was to identify elements of CHC and how they work, our data also enabled us to analyze when and how patient-centered efforts were made in interactions. Below, we illustrate how the differential mobilization of CHC facilitates or impedes the achievement of the three domains of PCC noted earlier: a provider's understanding of the patient's biopsychosocial context, shared understanding of the condition, and shared power and responsibility.

Methods

The purpose of our study was to determine the types of CHC exchanged in patient–provider interactions and their interrelationships; the processes by which CHC is acquired, developed and deployed; and the impact (or lack thereof) of CHC on the content, tone, and outcome of interactions. A total of 17 clinic interactions and 23 in-depth interviews comprise the data upon which this article is based. From 2010–2011, we recruited 6 physicians from 3 health care facilities in the Western United States. Two to three patients who had a diagnosis of coronary artery disease and/or Type 2 diabetes were recruited from each physician's outpatient clinic. We selected these particular diagnoses because they are common and chronic in nature, and require active disease management and ongoing contact with health care providers and institutions. Five providers specialized in cardiology; one in internal medicine. We intentionally elected to recruit physicians from different health facilities to give us a range of physician experiences; we also recruited several patients for each provider to give us a range of patient perspectives for each provider. Provider and patient characteristics are described in Table 1. The Committee on Human Research at the University of California, San Francisco approved this study.

One clinical interaction between each patient and her/his physician was digitally recorded in its entirety. The recorder was left in an unobtrusive place in the exam room just prior to the physician entering the exam room, and retrieved by the research assistant when the clinic visit was concluded. The recordings lasted between 10 and 45 min.

In the weeks that followed, the first and second authors interviewed the patient participants while the PI (Shim) interviewed the physician participants. This division was intended to eliminate the possibility that information obtained from patients could be inadvertently divulged to their physicians, and vice versa. Interviews were 1–2 h in length. The patients were interviewed in their homes; providers were interviewed in their workplaces. Our semi-structured patient interview guide covered a range of topics including: the patient's understanding of their current medical condition, practices for seeking additional health-related information, expectations of providers, and views of themselves as patients. Topics for the physician interviews included: expectations of patients, approaches to patient communication, views of themselves as providers, and preferred patient characteristics. Additionally, during the course of the interviews, pre-selected segments of the clinic visit were played back to query patients and providers on how they experienced those moments.

All interactions and interviews were transcribed verbatim. We analyzed the data using a postmodern constructivist approach to grounded theory, which holds that no qualitative method rests solely on pure induction (Charmaz, 2006). CHC was a concept inductively derived from data collected in a previous study (Shim, 2002, 2005). Our codes and categories in the current study were therefore a combination of already existing codes capturing the constitutive elements of CHC and new codes that denote how CHC shaped clinical interactions. We used ATLAS.ti software to facilitate data management and the rapid extraction of text tagged with particular codes for further analysis.

Finding 1: the importance of patients' and providers' habitus for biopsychosocial context

According to many published accounts, the first necessary ingredient of PCC is to understand the patient in her/his biopsychosocial context, that is, as an “experiencing” individual rather than an object or host of some disease process (Epstein et al., 2005; Mead & Bower 2000; Stewart et al., 2003). This includes a sense of how the patient interprets illness and the significance that it holds, and the culturally shaped norms and beliefs s/he uses to understand, relate, convey, explain, describe and predict illness (Mead & Bower 2000). In our first exploration of the utility of CHC to illuminate patient-centered processes, we argue that the process of placing the patient in her/his biopsychosocial context is complicated by the influence of patients' and providers' habitus.

With the concept of habitus, Bourdieu (1991) points to the practical yet socially constituted sense we have of the practices and actions that seem common-sensical and natural to us when approaching an institutional situation. According to Bourdieu (1991), interactions in institutional settings—or “fields of action”, in his words—are situated encounters between individuals; each participant is endowed with socially structured and differentially distributed resources and competencies. The differential distribution of capital structures individuals' positions on those fields, and in turn, their relationships to other individuals (Bourdieu, 1977, 1980, 1986). Given this, Bourdieu viewed fields as sites of struggle for social status, where actors seek to maintain or improve their position on the field by deploying field-specific types of capital. Although those who possess valued resources do exercise agency on the field, those who are able to determine what resources hold value in the first place possess the power to set the rules of the game. As we explain below, our data illustrate the impact of patient and provider habitus within the “field” of health care interactions, and in turn on the potential for achieving an understanding of the patient's biopsychosocial context.

Patients' habitus

We argue that patients' habitus fundamentally shapes their biopsychosocial context, and can complicate providers' attempts to locate patients within that context. Habitus is a set of dispositions and styles that incline but do not predetermine how we will act and react in different situations (Bourdieu, 1977, 1980). These dispositions become embodied over our life course from our earliest childhood experiences, and serve as a tool kit of resources that guides our general sense of how to act in our daily lives. Hence, our practices and actions are the products of the relationship between our habitus on the one hand, and the given situation in which we find ourselves, on the other. Importantly, habitus is both *structured* in that it integrates and reflects one's social conditions and experience, and *structuring* in that it shapes future practices, perceptions and ways of acting (Bourdieu, 1991; Bourdieu & Wacquant 1992).

To illustrate the concept of patient habitus and consider its relationship to biopsychosocial context, we introduce Louis. Louis is in his late fifties and suffers from congestive heart failure and cardiac arrhythmias. Born and raised in South America, the cultural influences of his heritage have a strong impact on his overall life philosophy which he described as “healthy body, healthy mind”. Louis had been an avid body-builder and had a successful career as a personal trainer and group fitness instructor. Thus, Louis embodied a highly ingrained health-conscious way of living.

When we met him, Louis was breathless, had been losing weight, and experienced severely swollen legs and feet. Yet although his condition was steadily declining, he continued to exercise to the extent his condition allowed, including walking 12–14 blocks twice per week to “work up a sweat” and to “take toxins from the body”. Louis also used sitting exercises and hand weights, as well as stretching maneuvers, which he found helped relieve his physical discomfort. Although he could no longer dance, he used music to relax, which in turn eased his symptoms of anxiety. In short, Louis had taken lifelong health-related habits and perspectives that were an integral and highly ingrained part of his everyday life, and modified them much more purposefully to manage his disease and find relief from his symptoms. That is, Louis' beliefs and understandings of health and illness—elements of his biopsychosocial context—are shaped by his habitus, which in turn is both structured by his past experiences, and structuring in that they shape his current actions. His example shows how an individual's habitus influences her/his biopsychosocial context and in turn, how s/he seeks health and health care.

Providers' habitus

For the provider's part, to understand a patient's biopsychosocial context requires a number of provider-specific behaviors as enumerated by Mead and Bower (2000): taking patients seriously, encouraging and valuing patient involvement in decisions, providing patients with information, and taking responsibility for non-medical aspects of care. The underlying suggestion therefore seems to be that providers can manifest PCC through these actions (Epstein et al., 2010). In addition, Mead and Bower (2000) hypothesize that patient-centered provider behaviors are influenced by providers' attitudes, knowledge, values, and expectations, which in turn are shaped by their cultural norms, socioeconomic background, personal experience and clinical training.

We supplement a PCC model that enumerates provider behaviors to achieve understanding of a patient's biopsychosocial context and multiple “shapers” of provider attitudes and beliefs with the centrality of providers' habitus. Providers' habitus is rooted in their upbringing, clinical training, socialization as doctors, their clinical experiences, and the organizational contexts in which they work; it then generates personal perceptions and expectations around responsibility, good doctoring and good patienthood.

For example, Dr. Barrow, who is Louis' physician, described his general style as influenced by a mix of reliance on “initial perceptions” (shaped, we would argue, on his experiences as an individual of a particular race, class, and gender), previous training on patient–provider communication, and a personal and organizational concern for clinical efficiency. He reflects that much of how he interacts with patients is determined by his “initial perceptions” of their characteristics:

> I think people have to give me relatively little before I'll give them a lot more…if they speak in a manner that suggests that they're educated, if they know their medicines…A lot of it is based on how they are dressed, how they carry themselves, how they speak, what information they can give me, how thorough that information is, how relevant it is, how organized it is, things like that.

Dr. Barrow recalled how his medical school training emphasized various communication techniques such as “listening”, “giving patients time to speak”, and “developing a rapport with patients”, behaviors identified as elements of PCC. But he also spoke extensively about the need for “efficiency,” and the “opportunity cost” of “wasting time” with patients who would not benefit due to continued substance use, non-adherence, or even simply ignorance about their medications and other important health information. He found such interactions being “less satisfying … [because] I feel like you accomplish much less” and “your wheels spin, you're really not doing good for anybody, and you may be just taking time away from other people who really you could be helpful with.” Dr. Barrow's personal emphasis on efficiency thus drives the importance of his assessment of patients who are “engaged … and take some responsibility for themselves” versus those who are “clueless” and “a complete waste of time.” In turn, he found himself responding to organizational demands to see more patients in less time with a different interactional style designed to quickly elicit specific information of immediate relevance and value to him:

> Early on you were kind of taught the way to do this was … ask open-ended questions and listen to everything somebody said…the biggest change over time has been…the number of patients you see in clinic gets larger… I now frequently find myself trying to redirect patients…so I don't ask, “How do you feel today”, because then you end up with a 20-minute speech about their cat—you try and get specific information that is relevant.

Dr. Barrow's example is emblematic of how habitus shapes the attitudes of providers, as well as their interactions with patients by determining their expectations for what patients should bring to the encounter—that is, the kinds of CHC patients need to have in order to optimize the time they have together. While achieving PCC might involve understanding a patient's illness experience, expectations and cultural norms in a biopsychosocial context, the realities, for example, of Dr. Barrow's clinic pressures and the influence of his habitus lead him to solicit only the kinds of information he perceives to be usable and expressed in ways that make their relevance clear.

Indeed, in our study, we found that all of our physician participants had certain feelings, perceptions, and expectations of what makes a capable and proficient patient. They each enumerated a set of highly engrained and taken-for-granted expectations of the CHC elements their patients, at a minimum, should have to help move the interaction forward. For example, Dr. Crawford expects a patient to be “a thoughtful communicator” of her/his medical condition and who has taken the time to “memorize the names of medications they take everyday”. Dr. Weinstein's overarching expectation is that “they have to comply. They have to believe that I know what I'm talking about. They can argue, but they do have to comply”. Dr. Franklin expects her patients to convey “certain levels of respect”, “understand treatment”, “be involved” in their health care, and “ask questions”. Thus provider habitus, and the expectations for patienthood that it produces, indelibly shape their assessments of their patients, and therefore complicate the notion that understanding a patient's biopsychosocial context can be straightforwardly accomplished through provider behaviors specified in the PCC literature.

Moreover, even when providers achieve a deeper understanding of their patient's biopsychosocial context, as per the PCC mandate, understanding alone is not sufficient. Rather, patients must also meet their physicians' expectations with respect to communication and self-management. To illustrate this, we consider the interaction between Louis and Dr. Barrow. When he first began seeking treatment for his condition Louis quickly understood that his inability to clearly express himself posed a major problem in obtaining care:

> It's my English…I need help because I heard what you say but I still have some kind of problem to comprehend it, what you ask of me…I have a problem for reading. My teachers used to hit my head and pull my ears—“Are you stupid?”… And this caused a problem for my learning skills…Now imagine understanding English! I forget things. That's the other that comes with the…learning disability… the more I get older, I forget things very easily…If you ask me a lot of questions…I have difficulty to answer exactly.

To bridge this gap in his own ability to efficiently convey clinically useful information, Louis enlisted the help of his close friend Ana, who possesses the requisite CHC (organizational skills, some basic medical knowledge and sophistication, as well as efficient communications skills) from which Louis derives benefit. As Dr. Barrow related:

> [Louis] would probably drive me crazy except for the woman [Ana] who comes in with him who has everything in line and is on top of things. She comes in with a notebook. She can tell you anything you want to know. She has enough medical knowledge to kind of understand the importance of record keeping and following up with things…if he were by himself, I think it would be a very different story. He's like a free-spirit artist-musician; kind of dresses all wacky and he's fun to talk to but… I think if I was only working with him—getting him on the phone and getting him to show up to things—anything like that would have been much more difficult…She's [Ana] not medically sophisticated necessarily but she is so organized and so put together, and takes such good care of him that it's rewarding to take care of him…Interacting with him is very pleasant… So, between the two, you get a lot done…and they're also very appreciative.

As this exemplar demonstrates, providers often do evince an understanding of and appreciation for their patients as unique individuals. Dr. Barrow very much likes Louis as a person and enjoys interacting with him, but acknowledges that providing care for him would be quite difficult if left to his own devices. But Louis' ability to compensate for the lack of his own CHC by including Ana in his health care visits is key in Dr. Barrow's rewarding Louis in material, tangible, and patient-centered ways. For example, the tone of their clinical interaction was relaxed, informal and conversational. Dr. Barrow inquired about Louis' overall health and progress, not just about symptoms for which Louis is primarily seeing him. Dr. Barrow was proactive in coordinating care with Louis' dentist for an upcoming dental procedure and encouraged Louis' continued self-surveillance behaviors. Dr. Barrow took care of non-clinical aspects of care by taking time to fill out disability forms (usually the role of the primary care provider). He took time during the clinic visit to print laboratory results Louis and Ana had requested, rather than sending them to the medical records department. He gave his private office phone number to Louis and Ana and invited them to call him. He also provided them with additional medical information regarding the underlying cause of Louis' clinical condition through special access to a website about his genetic disorder, and Dr. Barrow discussed the implications of his genetic disorder for Louis' daughter.

For all of his usual concerns about clinical efficiency, Dr. Barrow spent over 45 min with Louis and Ana, far longer than any other interaction we observed. These 45 min, and the extensive list of additional care provided, surely evince PCC. Yet our analysis shows that they are not simply the products of the provider's behaviors as the PCC model suggests, or the provider's customary norms, expectations, and values, but rather these outcomes have been "earned" and achieved through the successful mobilization of CHC on the part of Louis, with Ana, to meet the habituated expectations that Dr. Barrow has for his patients.

Thus the concept of CHC forces us to think much more broadly and deeply about what it takes to locate the patient in a biopsychosocial context. While understanding of a patient's biopsychosocial context is surely important, the CHC framework highlights that pre-existing dispositions and styles of thought and action, borne out of habitus, influence whether and how such an understanding impacts the patient—provider relationship. CHC highlights the requisite importance of a mutual recognition and matching of the social and cultural experiences, expectations and resources of *both* patients and providers. Hence, PCC may actually constitute rewards given in response to how well a patient has displayed and deployed her/his repertoire of cultural skills, the degree to which they meet the provider's expectations of what patients should possess, and the extent to which providers are flexible in their expectations for their patients. In this way, the provider possesses disproportionate power to set the rules of the interaction, the kinds of CHC that are valued, and the specific gains to patients who deploy them.

Finding 2: the transactional nature of shared understandings

According to Epstein et al. (2005), a second domain of PCC requires a provider to recognize and understand the patient's concerns, needs, feelings and functioning in order to come to a shared understanding of the clinical condition and the treatment options consistent with the patient's values, wishes and beliefs. A successful encounter entails the patient and provider being "on the same wavelength", a concept that researchers have termed concordance, where there is a match between the patient's and provider's narratives and cultural resources (Kovandzic, Chew-Graham, Reeve, et al, 2011; Stevenson & Scambler 2005). There is little clarity, however, as to when and how these shared understandings are achieved in practice.

Our analysis of our study data from a CHC perspective revealed two processes that interrogate the PCC notion of shared understanding of the condition or illness. First, we found that "shared understanding" was often equated with "shared biomedical understanding". Second, rather than PCC being *constituted by* a shared understanding, we found that it often was *the outcome of* providers' favorable impressions of patients' ability to display biomedical ways of thinking about their health condition. That is, shared biomedical understanding indirectly and symbolically enhanced a provider's perception of the patient, leading to more satisfying and patient-centered care.

We offer two examples from our data of these two processes. First, Clarice is a 72-year-old African American woman who was seeing her cardiologist, Dr. Crawford, for clearance to undergo knee surgery. Clarice had a history of hypertension, and on the day of her clinic visit her blood pressure was high:

> Clarice: I think the pain from the knee …I think [the abnormally high blood pressure] is due to this pain.
>
> Dr. Crawford: You know, before I used to wonder when people told me that, but I had a guy come in here who had a bad knee, and when he's sitting down his blood pressure is low, and as soon as he walks and gets up on the table it goes sky high 'cause it hurts so bad. Is that the thing with you, too?
>
> Clarice: Yes. `Cause usually my blood pressure's good.
>
> Dr. Crawford: I'm just looking back like when Dr. W. has seen you in clinic. And you're right. Like when you were seen in April, your blood pressure was 110/66.

> Clarice: Yeah, that's why I think it's the pain.

In this scenario, Clarice's blood pressure control is of primary importance as to whether or not she can be safely cleared for surgery. Here, the provider weighed the evidentiary value of the clinic's blood pressure measurement against Clarice's own knowledge of what she knows her “normal” blood pressure to be and her understanding of why her blood pressure is currently higher. Clarice's explanation made sense to Dr. Crawford, and they can be said to have jointly achieved a shared understanding of the clinical situation. Clarice was cleared for surgery without any additional testing that could have delayed her surgery.

What was being valued in this scenario was that Clarice “figured out” the *biomedical* understanding of her clinical condition. Furthermore, she communicated this understanding to the provider in a way that conveyed her intelligence and medical sophistication. The ability to do this not only facilitated efficient information exchange, but also increased the personal regard Dr. Crawford has for Clarice, as illustrated by Dr. Crawford's comments in her separate interview with us:

> That's why I talk to these guys because they know a lot about themselves. I don't think she has any medical training, but people figure stuff out and I think that helps…So, I really love patients like that because it's more of a give and take. It's not just me saying, “Okay, here's what you need to do”.

As this exemplar demonstrates, “shared understanding” often effectively means that patients' understandings match those of their providers. In turn, this biomedical understanding, and the attendant capacity to use language, ask questions, and deliver information based on that biomedical understanding serve as a means of exchange, as a form of CHC. Patients are then viewed more as partners in interactions that are patient-centered, more flexible and less authoritative.

Conversely, we discovered that there are real consequences when there is a mismatch in the understandings a patient has of the situation and the resources s/he leverages, and those that the provider expects and values. To illustrate, we explore an interaction between Dr. Edwards and his patient, Betty. Betty is an African American woman in her late sixties who lives with her daughter, is active in her community, socializing with a large network of family, friends and church members. Betty completed two years of college and all of her children are university graduates. She is extremely proactive in terms of her own health, and considers herself to be “the boss” of her own life. She has been diagnosed with Type 2 diabetes and at the time we met her, was being treated concur-rently for lymphoma. Betty has a pacemaker to treat an underlying cardiac arrhythmia; Dr. Edwards is her cardiologist.

Betty is a patient who would be regarded as having a rich toolkit of CHC. She has a strong social support network. She has a good grasp of her clinical conditions and treatments, and she took time to learn about her medications by reading the pharmacy inserts. She marked her pill bottles to identify what they are for and also noted their alternative uses as well. In the course of her appointment with Dr. Edwards, Betty was able to describe her complex conditions and medical care, and how she handled them on a daily basis.

Yet from Dr. Edwards' perspective, the fact that Betty was proactive and engaged in active surveillance over her clinical condition by taking her own blood pressure and checking her heart rate, for example, was not that helpful to him in understanding her clinical course. Rather, according to Dr. Edwards:

> It tells me a little bit about her diligence in participating in her own care…[But] they want me to just really study and see all the work that went into this and it's

> hard to manage that expectation…and reward them…You give them too much positive feedback and suddenly…they're obsessed!
>
> Instead, he said,
>
> The piece that I really want is someone who shows that their heart rate has always been steady, between 60 and 80, every time they check it, as a way that reassures me that they are looking for sneaky episodes of an arrhythmia that would otherwise go untreated. I do find that reassuring.

Through the lens of CHC, we can see that the possession of individual skills in and of themselves on their own does not shape the interaction. Instead it was also critical that patients' understandings of their conditions were consonant with their physicians', and therefore the information and skills they offered to their providers were readily recognizable by and useful to the provider. What Dr. Edwards would find valuable in Betty's case is if she were savvy enough to understand to monitor not her blood pressure, but rather “sneaky episodes of an arrhythmia” and the physical signs that indicate such episodes.

On some level, Betty seemed to discern this. She related in her one-on-one interview with us that she felt ignored and dismissed by Dr. Edwards: “I've asked myself, `Wow. Do I sit up here and act like I've got any knowledge about what they're saying?' Or I wonder, do they think that I don't understand what they're saying?” While Dr. Edwards expected to see Betty for a check-up six weeks following this visit, Betty never returned. She explained, “I didn't get the feeling that I could really be a human being with him…He's a really professional man…it's just like doctor/patient, that's it…I just don't feel like I could talk to him.”

This particular patient–provider relationship derailed because of a mismatch between what Betty understood about her condition and the kinds of work required for proper surveillance, and the cultural skills and competencies valued by Dr. Edwards. Importantly, through his own inability or inclination to adjust his interactional style or provide Betty with the additional knowledge to understand what symptoms to look for, Dr. Edwards was unable to bridge the gap between the assets that Betty leveraged in the interaction and those he considered useful in treating her clinical condition.

As these exemplars demonstrate, shared understandings in clinical interactions require patients and providers to engage in complex interactional work where cultural skills and resources are leveraged, valued and exchanged. With its focus on interactional dynamics, a CHC perspective points out that shared understandings are much easier when they are on the providers' terms; in this sense, the clinical arena is not an even playing field. While the asymmetric nature of the interaction is in part based on the promotion of the biomedical model over lay understanding (Maynard, 1991), interactional asymmetry also emerges from the power of the provider to define the kinds of cultural knowledge, resources, behaviors and skills that have value. A match between what the patient leverages and what the provider values is what allows for a jointly orchestrated understanding of the clinical picture, greater patient–provider compatibility, and the provision of patient-centered care.

Finding 3: rethinking “shared” power and responsibility

The third domain of patient-centered care frequently invoked in the literature is the notion of shared power and responsibility, which is envisioned as collaboration between a patient and provider. PCC therefore requires the provider–patient relationship to shift from an asymmetric “top-down” model where patients are passive players, to one in which they are viewed as active and discerning consumers of care (Epstein et al., 2005; Mead & Bower 2000; Stewart et al., 2003). This is accomplished through finding common ground, cooperative strategies regarding treatment and management of care, and the development of a therapeutic alliance (Epstein et al., 2010, 2005).

Following a Bourdieusian perspective, however, CHC highlights how power relations, and the accumulation, mobilization, and exchange of capital, are endemic to all interactions, including clinical ones. Even the simplest verbal exchange “brings into play a complex ramifying web of historical power relations between the speaker, endowed with a specific authority, and an audience” (Bourdieu & Wacquant 1992, p. 142). Thus while PCC is commendable in its promotion of an egalitarian patient–provider relationship, CHC also reminds us that the underlying architecture of the power relations at play structure the ground upon which interactions unfold, as we demonstrate in our next exemplar.

Iosepha is a Samoan woman in her fifties and was diagnosed with coronary heart disease one year before we met her. Over the course of several months, she had had worsening symptoms to the point that surgery was being considered. Iosepha admitted that she was not very compliant with her medication regimen, because it gives her terrible headaches: “Sometime I feel I don't know if I should do it, take the medicine or should I leave it … When I take my medicine, sometimes I feel worse and then I say, “Forget it. I'm not listening to what the doctor say.” Iosepha believes that physicians should make her feel better and when they don't, she no longer fully trusts them.

Iosepha's cardiologist, Dr. DeLuca, tries to foster Iosepha's understanding of her illness in a collaborative way in order to manage her symptoms. During their clinic visit, Dr. DeLuca explained that the goal of the medication was not to cure her heart disease, but rather preserve her overall heart function. She carefully reviewed the medications and patiently listened to Iosepha's concerns about headaches. She identified the drug likely to be the cause and marked the pill bottle with a large X to indicate that Iosepha should stop taking it. An alternative medication was then prescribed. Dr. DeLuca tailored a plan of action for dealing with any future headaches, involving over-the-counter medication, adjusting the timing of the medications, and strategically taking specific medications to forestall cardiac symptoms related to exertion. Dr. DeLuca then asked for a commitment from Iosepha to try this new plan for a two-week period.

At our interview one week after her visit with Dr. DeLuca, Iosepha reported that her headaches were indeed better and that she was able to take her medications as prescribed: “I have control of the medicine right now… I know if I control the [the medication] now… then it'll be easy to control in the future.” Dr. DeLuca, in a follow-up interview, described a remarkable difference in her patient: “[Iosepha] left me a message the other day about a pharmacy problem with one of her medications and I didn't recognize her at first. She has become much more articulate and precise about relating the issues to me.”

Dr. DeLuca's collaborative efforts and Iosepha's receptiveness to the plan net them the benefit of a more consistent medical regimen, better odds for staving off the adverse effects of heart disease, and a more enhanced relationship where the patient feels “in control” and empowered. By fostering Iosepha's knowledge about her medications and her condition, changing her understanding of how to assess the costs and benefits of different health-related actions, and imparting to her an awareness of the longer-range view required by a condition like heart disease, Dr. DeLuca is actively cultivating Iosepha's CHC. As this example shows, there is tremendous value in patients' developing additional stores of CHC and for providers' efforts in helping patients to do so. These benefits redound not only to the specific patient–provider relationship in which power and responsibility can be more equitably shared, but also to other health care settings, as we see with Iosepha's problem-solving at the pharmacy. CHC—whose cultivation can result from equipping patients with the ability to shoulder more care-related responsibilities—allows patients to optimize their own care.

At the same time however, Dr. DeLuca's actions explicitly induce particular types of patient behaviors that the physician finds valuable, communicating not only the type of actor a patient *can* be, but also the type of actor the patient *should* be. A patient-centered approach then does not necessarily relieve the asymmetry of the interaction. Rather, conceptualizing these resources and skills as CHC—as a form of capital and a means of exchange in the field of health care—underscores that health care organizations and providers maintain disproportionate power to define what kinds of skills and attributes carry value in a clinical encounter, and to determine the outcomes of their successful mobilization.

Conclusion

Recognizing and responding to individual characteristics of patients is fundamental to the construct of PCC, which makes it an attractive and intuitive way to deliver medical care. We have offered the concept of CHC as a way to analyze the interactional dynamics at play that precede, underlie and go beyond PCC, and the influences that cultural resources and attributes have on patients' and providers' mutually shaped abilities to achieve PCC.

As our exemplars suggest, CHC functions when patients can communicate cultural skills and attributes in ways that are recognized and usable to providers in return for patient-centered behaviors and actions. The CHC framework illuminates that the skills and attributes that comprise CHC directly facilitate or impede patient-centered engagement, communication and delivery of medical care. But in addition, CHC also works indirectly, in that the ways CHC resources are presented and mobilized shape the tenor of the health care interaction, and in turn, patients' and providers' propensity and ability to engage in patient-centered care. CHC also emphasizes the role of inequality as a barrier in interactions: providers have the power to define the kinds of resources, behaviors, and skills that have value, as well as the relative weight that value has in terms of subsequent actions generated.

We acknowledge the limitations of our study include, first, our relatively small sample size. However, our decision to collect multiple data sources for each interaction enabled us to analyze each clinical encounter with significant depth. Second, our physician participants consisted mainly of medical specialists, i.e. cardiologists; more research is needed to learn how CHC functions in other provider groups such as primary care physicians, nurse practitioners, and surgeons. Third, our patient participants consisted of low-income English speakers. Since CHC is differentially and systematically distributed by social status, we expect it will likely operate differently for non-English speakers or those with different socioeconomic statuses.

It is important to note that we do not offer the concept of CHC as an individual patient or provider intervention per se. We do not anticipate, for example, that efforts to “train” or “skill-build” CHC behaviors will significantly reduce the stratified nature of health care. Such strategies may in fact exacerbate health inequalities by heightening the demands and expectations placed on individual patients and providers. To focus solely on individual patient skills or provider behaviors would ignore CHC's Bourdieusian legacy, which argues that cultural resources and practices contribute to social stratification and that the distribution of all forms of capital are tied to persistent social hierarchies and inequalities. Therefore, while such training could be effective on a patient-by-patient, provider-by-provider basis, it would likely be self-limiting because it relies on an individual-level approach to intervention. As a result, CHC is vulnerable to the same critique leveled at Bourdieu: the concepts of habitus, cultural capital and field focus primarily on how systems of inequality are reproduced and perpetuated over time, leaving little room to consider processes of structural change.

The utility of CHC lies in its ability to direct our attention “upstream”, beyond the factors of individual characteristics, attributes, and experiences, to the socially constituted structural patterns that affect the development of habitus and, subsequently, interactions in health care settings. It also accounts for the effects of race, class, gender, and other social categories that may be reflected in the types of CHC one has access to and its relative “purchasing power”. In this way, CHC illuminates just how complex the biopsychosocial context really is; it is fashioned by habitus and linked to the social structure that shaped its character is the first place. CHC also demonstrates that the biopsychosocial context cannot be conceptualized as a one-sided phenomenon. Instead, the provider's habitus is fundamental to how s/he approaches “doctoring”, the perceptions s/he has of the patient and the expectations of what constitutes good patienthood. Such pre-existing dispositions and styles must therefore be taken into account when considering providers' capacities to understand patients' biopsychosocial contexts.

CHC's conceptual emphasis on structural conditions also helps to explain the “downstream” dynamics at play between patients and providers at the intersection of organizational settings and the resulting care that is offered and received. As we demonstrated, the notion of shared understanding can be thought of as a transaction, where the cultural resources a patient has to leverage must be consonant with what her/his provider values. Conveying a biomedical understanding of the clinical condition functions as a form of CHC, that can be exchanged for a relationship in which the provider sees the patient in a more favorable light, and as more of a partner in the treatment plan. Thus a truly shared understanding of the clinical condition—one that is neither wholly determined by the provider nor by the patient—must be a mutual achievement that explicitly counters the frequent tendency to see the condition in largely biomedical terms.

We have also demonstrated the third domain of PCC: sharing power and responsibility can be achieved by a provider actively cultivating a patient's stores of CHC. However, it is at this juncture that both CHC and PCC constitute a double edge. While the acquisition, mobilization and exchange of CHC can advantage patients, the mileage one gets from it is dependent on who has it, who is able to get it, when, where, and how it is deployed, who receives it, and the actions that subsequently stem from it. This underscores that pursuing the desirable goal of sharing power and responsibility requires attending to and mitigating the ways in which the provider and the health care institution maintain disproportionate power to determine what cultural skills are valuable and exchangeable in the first place.

With the recent organizational transformations in health care delivery, the demands being placed on patients and providers alike have intensified and heightened the degree to which cultural resources and skills matter in clinical interactions. We offer the concept of CHC as an analytic to uncover some of the dynamics at play between patients and providers, and how their cultural resources, skills, dispositions and interactional styles influence their ability to obtain and deliver patient-centered care.

Acknowledgments

The authors deeply thank the physicians and patients who participated in our study and shared their thoughts and experiences with us. We also gratefully acknowledge Susan Forsyth, Quinn Grundy, Kate Horton, Gina Intinarelli, Kathy Lee and Ruth Malone, for their thoughtful comments and careful review of this article's many iterations. This study was supported by an intramural research grant from the UCSF School of Nursing Research Committee. Ms. Dubbin is supported in part by training funds from the T32 Nurse Research Training in Symptom Management (5 T32 NR 07088).

References

Abel T. Cultural capital and social inequality in health. Journal of Epidemiology and Community Health. 2008; 62(e13):1–5.

Bandura, A. Self efficacy: The exercise of control. W. H. Freeman; New York: 1997.

Bourdieu, P. Outline of a theory of practice. Cambridge University Press; Cambridge: 1977.

Bourdieu, P. The logic of practice. Stanford University Press; Stanford: 1980.

Bourdieu, P. The forms of capital. In: Richardson, JG., editor. Handbook of theory and research for the sociology of education. Greenwood Press; London: 1986.

Bourdieu, P. Language and symbolic power. Harvard University Press; Cambridge: 1991.

Bourdieu, P.; Wacquant, LJD. An invitation to reflexive sociology. University of Chicago Press; Chicago: 1992.

Charmaz, K. Constructing grounded theory: A practical guide through qualitative analysis. Sage; Los Angeles: 2006.

Clarke AE, Shim JK, Mamo L, Fosket JR, Fishman JR. Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine. American Sociological Review. 2003; 68(2):161–185.

Epstein RM, Fiscella K, Lesser CS, Stange KC. Why the nation needs a policy push on patient-centered health care. Health Affairs. 2010; 29(8):1489–1495. [PubMed: 20679652]

Epstein RM, Franks P, Fiscella K, Shields CG, Meldrum SC, Kravitz RL, et al. Measuring patient-centered communication in patient-physician consultations: theoretical and practical issues. Social Science & Medicine. 2005; 61:1516–1528. [PubMed: 16005784]

Gillespie R, Florin D, Gillam S. How is patient-centered care understood by the clinical, managerial and lay stakeholders responsible for promoting this agenda? Health Expectations. 2004; 7(2):142–148. [PubMed: 15117388]

Institute for Patient and Family Centered Care. Advancing the practice of patient and family-centered care: How to get started. Institute for Patient and Family Centered Care; Bethesda: 2008.

Institute of Medicine. Crossing the quality chasm: A new health system for the twenty-first century. Institute of Medicine; Washington, DC: 2001.

International Alliance of Patients' Organizations. What is patient-centered health care? A review of definitions and principles. International Alliance of Patients' Organizations; London: 2007.

Kitson A, Marshall A, Bassett K, Zeitz K. What are the elements of patient-centered care? A narrative review and synthesis of the literature from health policy, medicine and nursing. Journal of Advanced Nursing. 2012; 69(1):4–15. [PubMed: 22709336]

Kovandzic M, Chew-Graham C, Reeve J, et al. Access to primary care mental health care for hard-to-reach groups: from “silent suffering” to “making it work”. Social Science & Medicine. 2011; 72:763–772. [PubMed: 21272968]

Malat J. Expanding research on the racial disparity in medical treatment with ideas from sociology. Health. 2006; 10:303–321. [PubMed: 16775017]

Maynard DW. Interaction and asymmetry in clinical discourse. American Journal of Sociology. 1991; 97(2):448–495.

Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Social Science & Medicine. 2000; 51:1087–1110. [PubMed: 11005395]

National Health Service. Creating a patient-led NHS: Delivering the NHS improvement plan. National Health Service; London: 2005.

Schillinger D, Bindman A, Wang F, Stewart A, Piette J. Functional health literacy and the quality of physician-patient communication among diabetes patients. Patient Education and Counseling. 2004; 52:315–323. [PubMed: 14998602]

Schillinger D, Grumbach K, Piette J, Wang F, Osmond D, Daher C, et al. Association of health literacy with diabetes outcomes. JAMA. 2002; 288:475–482. [PubMed: 12132978]

Shim, JK. Sociology. University of California; San Francisco: 2002. Race, class, and gender across the science-lay divide: expertise, experience and “difference” in cardiovascular disease.

Shim JK. Constructing “race” across the science-lay divide: racial formation in the epidemiology and experience of cardiovascular disease. Social Studies of Science. 2005; 35:405–436.

Shim JK. Cultural health capital: a theoretical approach to understanding health care interactions and the dynamics of unequal treatment. Journal of Health and Social Behavior. 2010; 51(1):1–15. [PubMed: 20420291]

Stevenson F, Scambler G. The relationship between medicine and the public: the challenge of concordance. Health. 2005; 9(1):5–21. [PubMed: 15576420]

Stewart M. Effective physician-patient communication and health outcomes: a review. Canadian Medical Association Journal. 1995; 152(9):1423–1433. [PubMed: 7728691]

Stewart M. Towards a global definition of patient-centered care. British Medical Journal. 2001; 322(7284):444–445. [PubMed: 11222407]

Stewart, M.; Brown, J.; Weston, W.; McWhinney, I.; McWilliam, C.; Freeman, T. Patient-centered medicine: Transforming the clinical method. Sage; London: 2003.

Swenson SL, Buell S, Zettler P, White M, Ruston DC, Lo B. Patient-centered communication: do patients really prefer it? Journal of General Internal Medicine. 2004; 19:1069–1079. [PubMed: 15566435]

The Health Foundation. Person-centered care. The Health Foundation; London: 2011.

U.S. Department of Health and Human Services. Personalized health care: Pioneers, partnerships, progress. US Department of Health and Human Services; Washington, DC: 2008.

Wall S. Epidemiology for prevention. International Journal of Epidemiology. 1995; 24:655–664. [PubMed: 8550260]

Wanzer MB, Booth-Butterfield M, Gruber K. Perceptions of health care providers' communication: relationships between patient-communication and satisfaction. Health Communication. 2004; 16(3):363–384. [PubMed: 15265756]

World Health Organization. The World Health Report 2000-improving performance. World Health Organization; Geneva: 2000.

Table 1

Provider and patient sample characteristics.

Provider sample	***N* = 6**
Race/ethnicity	
White	4
African American/Black	1
Asian American	1

Patient sample	***N* = 17**
Race/ethnicity	
White	5 (29%)
African American/Black	6 (35%)
Latino/Hispanic	1 (6%)
Age	
31–40 years old	2 (12%)
41–50 years old	2 (12%)
51–60 years old	4 (24%)
More than 60 years old	9 (53%)
Annual household income	
$15,000–$25,000	5 (29%)
<$15,000	11 (65%)
Refused	1 (6%)