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**Using Critical Race Theory:
An Analysis of Cultural Differences in Healthcare Education**

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Abstract: Critical Race Theory (CRT) was used as a lens of analysis to examine cultural competency in healthcare. Fourteen articles were found related to race/ethnicity and equity. Four themes emerged from our thematic analysis, which were cultural differences, access to healthcare, healthcare disparities, and healthcare education. It is evident that disparities do exist within healthcare and vary among cultures. The healthcare industry must continue to address issues of race, ethnicity and equity through cultural competency. Although there is no simple solution to achieve cultural competency, it can be fostered within healthcare practitioners and education to change the way different cultures are viewed. Healthcare institutions and healthcare professionals must bridge the gaps that still exist between individuals to provide fair, equal and impartial care.

Introduction

Poor elderly blacks may not read the Journal of Public Health or the New England Journal of Medicine (which reports studies on biased treatment), but they have a gut belief that they do not receive the same care as white elderly. . . . Because of race, class, and ethnicity barriers, however, health care practitioners do not know the elderly poor black outside the clinical setting. To morally intervene in the lives of these patients, providers need to understand those patients' culture, including family and community norms. They need to be familiar with the life stories of these patients', for it is through stories that we get to walk in other people's shoes. . . . In a health care system in which the providers are mostly white and the sickest people are elderly African-Americans, a larger sense of each patient's story will improve the quality of everyday practice of medicine as well as the quality of communication with the person who is ill or approaching death. (Dula, 1994)

"The Life and Death of Mrs. Mildred, An Elderly Black Woman," (Dula, 1994) illustrates that social and economic differences exist between individuals in healthcare settings. The Civil Rights movement of the 1960s targeted various disciplines, including healthcare and healthcare education for reform. The Health Care Fairness Act of 1999 H.R. 3250, Titles I through Title V, (as cited in Dingell, 2001) describes processes for research with racial and ethnic minorities in healthcare, including data collection, medical and provider education, and other standards developed by the Office of Civil Rights. Critical race theory (CRT) can be used to critique cultural competency in healthcare and healthcare education. Cultural competency is defined "as a set of congruent behaviors, attitudes, and policies that come together in a system, agency or

amongst professionals and enables that system, agency or those professionals to work effectively in cross cultural situations" (Cross, Bazron, Dennis, & Isaacs, as cited in Brach, 2000, p. 182). CRT is critical of the slow progress of liberalism and antidiscrimination laws to impact change in the lives of racial and ethnic minorities. The purpose of this paper is to use CRT as a lens of analysis to expand our understanding of cultural competency in healthcare by examining the literature published in the American Journal of Health Education. First, we present an explanation of CRT, followed by the method, then discussion of the themes, and implications for healthcare.

Understanding Critical Race Theory

Critical race theorists attempt to inject the cultural viewpoints of people of color, derived from a common history of oppression, into their efforts to reconstruct a society crumbling under the burden of racial hegemony (Barnes, 1990). CRT investigates the assumptions behind the call for equal rights and seeks to re-evaluate and transform stagnant notions of equality, which serve to hide important differences of power between groups going beyond traditional civil rights and ethnic discourses to place these relationships in economical, historical, social, and group contexts. CRT originated in the mid-1970s, when Derrick Bell (an African-American), Alan Freeman (a White), Richard Delgado (a White Hispanic) and others began to challenge the "subtler forms of racism that were gaining ground" (Delgado & Stefancic, 2001, p. 3-4) following the early success of the Civil Rights movement. Critical race theorists concur that (a) racism is endemic to American life, (b) history must be confronted and a contextual and historical analysis of social issues pursued, (c) the experiences of those being oppressed should be known, and (d) storytelling (voice) should be recognized and employed as legitimate knowledge (Barnes, 1990).

Intentional and unintentional discriminatory practices affect access to healthcare and healthcare outcomes for racial and ethnic minorities (Mayberry, Mili, & Ofili, as cited in Brach & Fraserirector, 2000). Although much progress has been made since the Civil Rights movement, discrimination still echoes within healthcare, and the struggle for equity still continues. Race and ethnicity are seen as fluid social constructs that have changed over time (Waters, 2000), have no genetic or biological basis (Krieger, 2000), are associated with a set of physical characteristics, which are perceived by others in ways that determine one's social power and privilege (Giroux, 1997). However, *Webster's Dictionary* (1991) defines race as a class or kind of people unified by communities of interests, habits, or characteristics. The goal of CRT is to reshape power relationships, as "power, access, status, credibility, and normality are all manifestations of privilege," (Rocco & West, 1998, p. 173). To change the health outcomes of Blacks, Hispanics and other minority Americans public policy must address issues such as access, economics, and research.

Method

The *American Journal of Health Education* publishes articles on healthcare education. The journal was first published in 1977. We reviewed the last ten years of articles published between January, 1992, and August, 2002, based on the assumption that CRT was established enough by 1992 to have had some impact on fields other than law. Articles include literature reviews, empirical studies, and theoretical pieces. Book reviews, debates, editorials and

rejoinders were not reviewed. Based on the tenets of CRT our analysis was guided by (a) race or ethnicity as central to the consideration or interpretation of the research problem and (b) the research problem as grounded in equity in healthcare. A hand search was conducted of the journal indexes looking for the descriptors race, ethnicity, and equity in healthcare in the titles. The results were recorded on separate tables. The tables contained two descriptors, race/ethnicity and equity in healthcare with a column for each articles' year, volume, and page numbers. We did this independently to reduce the risk of being influenced to include or exclude any titles. After completing the lists, we correlated our results. If we disagreed on whether an article should be included we reviewed it together. Forty articles were found and were listed by year and according to race/ethnicity and equity in healthcare. A noteworthy finding was that there were no titles from 2000, 2001, and 2002. Second, we independently read the forty abstracts to verify that all were related to race/ethnicity and equity in healthcare. We correlated our results leaving fourteen relevant articles. Third, a thematic analysis (Boyatzis, 1998) was conducted, to categorize the articles by the inclusion or exclusion of race/ethnicity and equity in healthcare. Race, ethnicity, and equity were classified by degrees of acknowledgement: radical view (present and meets criteria), liberal view (small incremental changes - no drastic steps), minimally mentioned (used as a characteristic in the article) and absent (not present).

Findings and Discussion

We discovered that disparities in healthcare exist and varied among cultures. Healthcare institutions and healthcare professionals must bridge the gaps that still exist between individuals to provide fair, equal, and impartial care. Using a thematic analysis we identified four themes, which are cultural differences (11 articles), access to healthcare (3 articles), healthcare disparities (4 articles), and healthcare education (7 articles). Articles are not exclusive to one theme and can appear under multiple themes.

Cultural differences are variations according to tradition, custom and practices that define an individual and communities' beliefs (Glasgow, 1985). These differences and beliefs impact how various people from different cultural backgrounds view healthcare. Southeast Asian refugees have to adapt to a new environment and are reluctant to seek out social services because of suspicions about care and traditional use of alternative medicine. On the other hand, Russian refugees have higher expectations of healthcare based on their prior experiences with socialized medicine (Wei & Spigner, 1994). Other cultural differences explored in the articles include differences between Southeast Asian refugees and Russians (Wei & Spigner, 1994), indigenous model for health education (Chen, Zaharlick, Kuun, Li, & Guthrie, 1992), consideration of ethnic and racial issues in the development and planning of health education programs (Lacey, 2002), Curandismo and its value to the Mexican-American Culture (Stauber, 1994), inequities among blacks and whites in healthcare (Spigner, 1994), health education programs for Hispanic Latino populations (Pinzon & Perez, 1997; Balcazar, Valdez, Tafoya-Barraza, & Guevara, 1998), and white researchers in poor inner city multicultural neighborhoods (Krauss, Goldsamt, Bula, & Sember, 1997).

Access to Healthcare includes having health insurance, knowing how and when to seek medical attention and in what form (private physician instead of emergency services). We think of minorities without health insurance who don't utilize preventive healthcare because of social and economic factors. The goal of organizations like Health Resources and Service Administration (HRSA) is "to assure quality healthcare to underserved and vulnerable

populations promoting primary care and education practice" (Gordon, Kavanagh, Crump, Heppel, & Fiori, 1998, p. 34). African Americans are perceived as "being products of a dysfunctional culture of their own making" (Spigner, 1994, p. 213). Therefore, the traditions and practices of this dysfunctional culture contribute to the health problems of African Americans (Spigner, 1994). On the other hand, Cross, Bazron, Dennis, & Isaacs (as cited in Denboba, Bragdon, Epstein, Garthright, & McCann Goldman, 1998) maintain that African Americans have limited access to political and economic systems that plan and administer health services (Denboba et al., 1998).

Healthcare disparities are differences in the time spent trying to get healthcare, information about healthcare not being available in the same ways by different groups, quality or availability of insurance, transportation, and other factors that act as deterrents. These deterrents are often culturally specific being visible to some and invisible to others. The development of cultural competence among healthcare professionals is one mechanism used to decrease disparity (Denboba, et.al. 1998). Having numerous threats and constraints in the delivery of healthcare in certain rural and urban areas of the United States, the development of health promotion cooperatives is "an important strategy to improve health status and enable economic development" (Wagner, 1994, p. 77). Although HIV/AIDS in the United States has impacted all racial groups, healthcare services have been tailored to white homosexual males and were not available until recently to minorities with HIV/AIDS (Chng & Fridinger, 1994).

Healthcare education is a way to disseminate information to the medical community and the general public about the prevention, diagnosis and treatment of symptoms, conditions and disease. Traditional methods used to disseminate healthcare education such as pamphlets may not be appropriate for specific ethnic groups. Healthcare professionals need to design educational programs for specific populations like Hispanics (Pinzon & Perez, 1997), Mexican Americans (Stauber, 1994), African Americans (Chng & Fridinger, 1994), and various other racial and ethnic groups (Lacey, 1992). Other healthcare education explored in the articles includes the use of calendars for Asians to deliver accurate heart health messages (Chen et al., 1992), HIV education messengers (Thomas & Quinn, 1993), and a futuristic approach for health education in black communities (Thomas, 1992).

Implications for Healthcare

The healthcare industry must continue to address issues of race, ethnicity and equity through cultural competency. Although there is no simple solution to achieving cultural competency, healthcare professionals and researchers need to look at the whole person regardless of race, culture or religious background. Understanding Critical Race Theory plays an important role in achieving cultural competency. Healthcare practitioners must practice a holistic approach, which includes the physical, mental, emotional, social, and spiritual health; this approach goes beyond the color of someone's skin.

Cultural competency should be included as part of the continuing education curriculum for all licensed professionals and those seeking licensure in an attempt to deconstruct predetermined biases before entering the health professions. In an attempt to understand and identify patients with multicultural needs, the Culture Connection Continuous Quality Improvement Team at South Miami Hospital developed the Culture Tool (as cited in Burden, 2000) that can be used in didactic and clinical settings. The tool describes the ethnic group's culture and language, belief practices, nutritional preferences, communication awareness and

patient care/handling of death for twenty-one different cultural groups including northern and southern Europeans to promote equal and fair medical treatment for all patients. The Joint Commission on Accreditation of Healthcare Organizations (2002) states:

Patients have a fundamental right to considerate care that safeguards their personal dignity and respect their cultural, psychosocial, and spiritual values. These values often influence patient's perception of care and illness. Understanding and respecting these values guide the provider in meeting the patient's care needs and preferences. (p. 67)

Healthcare professionals and educators must continually nourish the awareness and understanding of the cultural differences and needs of our patients, peers and students.

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