

Welcome. You're listening to UC Davis Center for Poverty Research seminar series. I'm the center's director, Ann Stevens. This series brings scholars and policy experts from around the country to discuss their work on poverty and poverty research. In April 2012 we hosted Janet Shun, an assistant professor of sociology and nursing at the University of California San Francisco.

Her ongoing research examines how epidemiologists conceptualize and use race, socio-economic status and sex or gender in their work. And how lay people think about the effects of social differences on their health. Here is Shun presenting her seminar, social inequalities in healthcare treatment. So thank you so much for the invitation to come and speak with you today, it's, really a pleasure.

and, first I just wanna ask a little bit for your indulgence. This is a bit of a work in progress. I've, these are a sort of ideas and reflections and. Based on empirical work, but, these are ideas that I've trying to been working out for the past several months and going forward into the future, and Ming Chen said that that was permissible in this kind of a seminar, so, and I know as was said that we have an interdisciplinary audience.

So I'd be really curious and would love to hear how what I'm gonna share with you today, you know, to what extent it travels. And, you know, other kinds of disciplines and other, social institutions and social worlds that you all are, engaged in. Doing research in. So I'm really looking forward to comments and questions and discussion during the Q and A.

So, thanks. I also need to acknowledge two very important people Jamie Chang and Lovely Dublin, are my collaborators on this project and they've been, there's graduate finished but very full collaborators in every sense of the word so,. You know, my thanks obviously goes out to them. So I wanna start out first of all by taking a poll.

How many of you have either yourself been a patient in our health care system, or had a loved one who was a patient in the health care system? And by patient I mean going for outpatient services, clinic visits, in a hospital, any of, any of that.

>> I'm sorry, no.

Are, the US healthcare system. Yeah. Anyone can't not go up. Okay. One person? Okay. So, this, your experience as a patient is something I kind of wanna ask you to keep in the back of your head as I'm gonna go through my talk. And. And for me, this project is very much, personal as it is academic.

And so I'm hoping that by drawing on your own personal experiences as patients in our healthcare system, you'll be able to, make some connections, and related to what I'm talking about. So I mentioned that this project is personal as well as academic, and I want to talk a little bit about why.

How I came to this project and why it matters to me, why I care about it. So about ten years ago, or a little over ten years ago now, when I was working on my dissertation, I was interviewing, people of color who had been diagnosed with heart disease.

And for the most part I was asking them about their causal accounts of heart disease. So what they sent put them at risk in terms of their health you know, why they thought that they had gotten cardiovascular disease in the first place. And so our interviews were mostly about that kind of material.

But all along the way the kept bringing up their experiences. In healthcare. About getting healthcare. About the healthcare they got and the healthcare they didn't, or weren't able to get. And when they talked about these experiences they would often use phrases like, you know, it's so important. To be able to learn things quickly.

You have to have charisma. You need to be really savvy. You need to have confidence. You need to learn things quickly. And so all of those sorts of phrases, you know even though my dissertation wasn't centrally focused on patient experiences all of those phrases like just, you know really echoed.

And I ended up in my dissertation spending part of one chapter looking at this notion that in the healthcare context you need cultural capital. You need savvy and confidence and the ability to learn things and things like that. So that was ten years ago and about five years ago This whole issue of how people navigate through and approach and encounter, and experience the healthcare system and our in, and our, in our unequal inability to do so successfully.

That really became, came home to me in an intensely personal way when my mother was diagnosed with, stomach cancer. And, you know, even though we had, you know, that whole experience really confirmed for me. Just how critically important it was that you learned things quickly. That, you tried to be as savvy as possible.

That you, like, walk that really fine line between being a assertive and yet not too assertive. That you. And that you have to accrue a whole host of other skills, like, in really short order. In order for my mom to get the care that we felt she needed and that she deserved.

So that really put, there's nothing like a personal experience to put the fire in your belly to let go and figure something out, to go do research on something. And so that really motivated me to Go back to my, to some of the ideas that I had just began to work out in my dissertation.

And, to really do something more with it. It's a part of what I'm gonna share with you, today. It's some of th additional thinking and some empirical work that I've done in the ensuing five years. So then, fast forward to the present. and, I really wanna emphasize that I think it's as important as ever.

To understand at a deeper level what it takes for individuals to access quality, to access and receive quality healthcare. So, recent events of course, have a whole lot to do with this. In 2010, the land mark patient production and affordable care act. Or the ACA or Obama care or any number of other ways that is has been referred to.

It put in place a number of fundamental changes to our nation's healthcare system. And that last you know the one that's like upheld in like 2012, you know that's a reference to the Supreme Court's decision that validated much of the content of the affordable care act. I don't actually think like Barack Obama's signature actual signature was like stamped over it.

It was just a graphic I think you know people put up to make the point, sort of in your face point about, you know, look it's done, it's passed, it's gonna happen. So that, so the ACA, what exactly does it include? Obviously a huge amount of attention and media was rightly placed on its provisions to expand access to insurance into care.

But a whole lot less visible and a whole lot less controversial aspects of the ACA includes measures institutionalizing what has come to be known as patient centered care. So some of these measures include the establishment of a patient centered outcomes research institute. Did that click happen? Here we go.

A Patient-Centered Outcomes Research Institute, or PCORI, to compare the clinical effectiveness of medical treatments. The development of a national quality improvement strategy to improve the delivery of medical, of health care services. The encouragement of pilot projects to test something called Patient-Centered Medical Homes. And the establishment of a community based collaborative care network program to support coordinated services for a low income uninsured and underinsured population.

So all together, the ACA qualifies image inmates patient centered care as the primary means to which to pursue this circle called triple aim. And their triple aim consists of getting improved health outcomes, obtaining better patient experiences. And lowering costs. And, as we shall see, the codification of patient centered care, or P-C-C, actually leads to an imperative that patients be activated, engaged, and health literate.

So in this presentation, I want to position cultural health capital, or C-H-C, as a sociological intervention as we embark on these changes. Aimed at making healthcare more patient centered, and particularly for populations who are historically underserved by the existing system. So through the concept of CHC, I hope to illustrate how patient centered care is accomplished or undone through these complex, interpersonal, and interactional work that's really

highly dependant on access to stratified resources.

That both patients and providers bring to the healthcare interaction. So I'm gonna be using data from, I'm gonna give you some tidbits from a qualitative study that we conducted. And using that data to show how both the patient and providers cultural assets their dispositions their interactional self influence their abilities to achieve patient centered care.

So, let me first provide a little bit of background into patient centered care. And there's a companion notion of patient activation as well that I'm gonna talk about. So patient centered care is actually not that new. People have been tossing around the term and advocating for it for probably close to 30 years now.

But the notion of patient summit care really burst onto the public, the health policy landscape in 2001 hen the institute of medicine issued this landmark report called Costing the Quality Chasm. Right so it's, the implication is there's a huge variability in quality. Not everybody is getting quality health care all the time and that this report was all about how we're going to.

Across that, that quality divide. So in this report patient center care was featured as one of six aims to achieve high quality healthcare. So while there is some variability in what patient centered care means and how its defined. By most account it aims to provide medical care. That accords with a patients cultural values, our needs, and our preferences.

So in the literature, the constitutive domains of PCC include one, understanding the patient within his or her biocycle social contacts. Two, shared understanding, and three, shared power and responsibility. So let me just say a few words about each of these. Are there any more chairs? Or spaces to sit?

No? Okay, all right. okay, so regarding the first domain The biocycle social perspective. I mean clearly this is a term where they tried to glob everything into one hybrid term, right? Hyphenated term. This biocycle social perspective recognizes the patient as a person. Who. Who is influenced by their individual biography, their social context, and there cultural norms and beliefs.

That's the meanings and significance of an illness will vary person from person and providers need to understand the patient's story of their illness.

>> And, their expectations, feelings, and fears. So again, going back to the, you know, the poll where I asked people: have you been a patient in a health, in our healthcare system.

Think back to that when you're thinking about, when you're looking at each one of these three domains. So, moving on to the second domain of shared understanding. This one refers to the patient and the provider coming together to a mutual sense of the clinical condition, and the treatment options that are concordant with the patients values, wishes, and beliefs.

Achieving this shared understanding requires that the clinician frame and customize information in response to their understand of the patient's concerns and needs. The clinician should also take account of a patient's level of health literacy and ability to understand and apply information to his or her clinical situation. And finally, we have shared power and responsibility.

So, there are some proponents of patient-centered care who will acknowledge that there's not sure whether we could ever get to a point where patient-provider relationships are completely symmetrical. But the general idea with the shared power and responsibility notion is that the patient and provider. Together create a therapeutic alliance and so they jointly consider the patients needs and preferences which may change over time.

Right? We're not static. And that they deliverit, deliberate together over what we imagine our future health to be, and then what kinds of treatment choices we want to make based on that. So, the power and responsibility of making decisions about course of care are shared, allowing, in theory, for a consensus on an approach to care to be reached.

So, this all sounds easy, right? Super easy, no problem, everyone who's been a patient in the system has experienced

something like this.

>> So, as you can probably surmise, the rest of my presentation is gonna to unpack this black box, and try to explain how complicated, and how illusive an endeavor, this kind of endeavor is going to be.

So back to patient centered care and just it's promise and how it's being talked about in the literature. So the aim of patient centered care is quote: "To improve clinical practice by building caring relationships that bridge demographics, social and economic differences between clinicians and patients". Now a particular note to me and to those of you in the audience here, I think.

Is that PCC is really seen as a critical way to address health disparities and healthcare disparities. So one prominent group notes that, quote, "Patient-centered care is critical to addressing racial, ethnic, and socioeconomic disparities in care and outcomes. Patients who are ill, have low health literacy and numeracy, are members of marginalized groups, and have cognitive deficits tend to ask fewer questions and get less information than their peers without these obstacles".

They are also less likely to understand technical and non technical language. They go on to say the practice of patient centered care helps bridge differences among physicians and patients in health beliefs, race, ethnicity and culture. And mitigates disparities in prevention and treatment. Yet. The contemporary healthcare landscape in which we have all experienced as patients, and in which patient-centered care is being implemented is characterized by an emphasis on time and cost efficiency, as well as a real reduction in the range and kinds of ancillary services that we have access to.

So, just recall that patient centered care is intended to address, remember that triple aim that I was talking about, so we have improved health outcomes, better patient care experiences, and lower costs. But, in order to accomplish this, healthcare systems are increasingly interested in understanding how the patient's role, our role as patients, affects our healthcare experiences.

And, how changes in our behavior, can improve health and reduce costs. So these incentives are driving the current policy emphasis on patient centered care. Both in healthcare policy and in healthcare provision. And in particular, the goal here is in theory, to try to activate patients to be better managers of their own health, and healthcare.

So, patient activation, but first, to quote, patients' willingness and ability to take independent actions to manage their health and healthcare. With understandings one's role in the care process and having the knowledge, skill, and confidence to manage one's health and healthcare, patients have the skills and confidence to elicit what they need from their providers.

So this activated, engaged, savvy health literate patient is really seen, is seen as critical to the future health of the healthcare system and to the success of healthcare reform. So, as many of you I'm sure can appreciate, if you're recalling back to when you were a patient, becoming and being this activated and engaged patient is no small task.

So, just in my own family's experience with my mom's cancer, we had a, a wealth of medical expertise. So. My father, my sister, my husband all work in the medical field or used to work in the medical field so we had all of that, you know, medical expertise in our own family.

We had a considerable amount of informational resources at our disposal. Educational, cultural, interactional. Other, you know, other kinds of skills and advantages that we really drew on. Yet, even with all of these resources, even with all of these advantages, my experience was that we really found ourselves repeatedly struggling to articulate clearly what our questions and concerns were.

Like we didn't even know what questions to ask. We didn't know what we didn't know. And so it was really difficult to articulate, you know, what questions we needed to ask here. We found it difficult to make ourselves heard quite often. And we also found it really difficult to discern like what kinds of information we wanted and what exactly we needed and wanted from our mother's, my mother's providers.

So, I also came to realize through this personal experience, and, you know, this is something that I suspected and heard

from my from the participants in my dissertation research before. But it's really brought home to me just how consequential it was that I see aspects of ideal patienthood, of being confident, of being savvy, of being knowledgeable, of being literate.

All of those things, they are consequential because of how you mobilize them, how you display them, how they get recognized or not by the healthcare providers that you are seeing. And they're consequential because these processes play out and they have effects on the kinds of care and the amount of care, quite frankly, that we that we received.

So I wanted to offer the concept of cultural health capital as a way to better understand how patients and providers engage with one another. How the outcomes of such interactions are mutually achieved. And whether, when, and if these outcomes reflect a patient centered approach. So, what I'm trying to argue today and what I hope to illustrate is that CHC or Culture Health Capital illuminates the dy, the complex interactional dynamics it takes to accomplish something called patient, that looks like patient centered care.

And these interactional dynamics their unfolding of them is really highly dependent on the kinds of specialized cultural resources and skills that both patients and providers bring to the clinical encounter. Okay, so what I wanna do now is just walk you through what our definition of Cultural Health Capital is, and describe a little bit of the study, in which we, examined this operation.

And then I'll move on to, some of my reflections on what Cultural Health Capital can say about patient-centered care, okay. So, in 2010 the year that crossing the quality chasm and the Affordable Care Act, actually it was the Affordable Care Act was signed, I published, finally, my article on the concept of cultural health capital.

And I did so because I wanted to offer it at, offer it up as a potential framework to help account for how these interactional dynamics that I'm talking about, that take place between patients and providers. How they may produce unequal treatment. So CHC is a concept that's rooted in the sociologist Pierre Bourdieu's theory of cultural capital.

So, Bourdieu came up with the Bourdieu came up with a notion of cultural capital after observing that the French public education system, rather than being an avenue for social mobility, in fact often worked to reproduce class inequality. And I'm sure for those of you who work in education or you know, have read the papers about our public education system were finding the same thing in our country as well, right?

So. So, Bourdieu argued that this was because, the reason why the public education system in fact contributed to inequality as opposed to contributing to social mobility was because success in school was predicated on what he called cultural capital. So, Bourdieu defined culture, not just as cultural objects like art or literature, it's not just beliefs and rituals that we engage in, but they're sort of the practices and the dispositions and the skills that we engage in, like every day, every day of our, of our lives.

So these, cultural practices operated as forms of capital, which like economic capital were important means of exchange in students' and parents' interactions with educational institutions. But, because cultural capital is unequally distributed, the education system's demand for cultural capital for success in school served to maintain inequality. So, consummate with Bourdieu, we theorize that both patients and providers activate leverage and deploy a whole slew of skills, competencies, resources, interactional styles, that we term cultural health capital, in order to effectively engage and interact with our providers and that providers also use to interact with patients.

And we hypothesized that work constitutes cultural health capital at this historical moment in our national context may include elements like medical knowledge and health literacy. This enterprising, proactive, instrumental attitude towards one's own health. And this ability to adapt to one's interactional style. So, as you can see, many of the elements of CHC include aspects of patient activation, and engagement.

But, what the notion of cultural health capital points out, is that some providers and patients have a great deal of these valued elements in their tool box of skills, while others have much less. And because of these resources, are of, are form of capital and they have exchange value in healthcare interactions, the stratified distribution of CHC shaped the kinds of relationships particular patients have, with particular providers and for the kinds of medical care that is

offered and received.

And so we offer CHC as the framework that can augment the notion of patient centered care by emphasizing interactional dynamics that both shape and surround the pathways through which patient activation impacts clinical encounters. That is, CHC is a concept that can help us to understand why patients and providers sometimes struggle to find common ground and a common language.

And why engaging patients in their own care is a far more complicated affair than the definition of patient centered care depicts. So the data that I'm drawing on here come from a qualitative study, in which we aim to understand the elements of CHC and exactly how they operate in interaction, so we recorded clinic visits and we conducted separate in-depth interviews with patients and with physicians, and I could talk more about the methods and the Q and A if people are interested in this.

So, I wanna move now to sharing with you three vignettes from our from our qualitative data and through this vignettes, I wanna make some observations about the relationship of CHC to PCC, of Cultural Health Capital to Patient Centered Care. Okay. So, one of the first arguments that I wanna make it has to do with something that Bourdieu called habitus.

And this is sort of the last bit of like, theory that we'll get before we get into the before we get into the data. So Bourdieu, Bourdieu's notion of habitus and, of course, Ming-Cheng and, and other people have written about this and studied this extensively. And in order to introduce the notion of habitus I want all, all of us to sort of engage in a thought experiment here.

And you, you know maybe for some of you like it was for me this is, you know much more reality, unfortunate reality than it is a thought experiment. So here's the thought experiment, imagine for a moment that you or a loved ones has just been diagnosed with cancer.

So, you're sitting in the physician's office and you've just been given the news. So a couple of questions for you then. What would you do first? Who do you wanna talk to? What kinds of questions do you have? What do you want to know? And conversely, what don't you wanna know?

Where do you go to look for information, and what kinds of information do you look for? Would you be content to see a local specialist, or might you wanna go elsewhere? Okay? So the options that, hopefully, you all are imagining, or, you know, recalling, taking, I would argue feel almost instinctual to all of us.

It's makes, it makes sense to us that we would upon this, being given this diagnosis we would do x, y and z, 'kay? And this is what Bourdieu tries to get at with his notion of habitus. So, he views human actors not as always deliberate and strategic individuals pursuing planned goals, but as possessing habitus or general styles, habits, dispositions, and ways of thinking about viewing and being in the world.

He argues that our general sensibilities about how the world works, are deeply embodied, rooted in our past experiences, our socialization as children and as adults, and the kinds of worlds in which we have traveled throughout our lives. Habitus shapes the kinds skills, styles, competencies and resources that is the cultural capital that one possesses and acquires.

And habitus, in Bourdieu's view, indelibly influences the direction, manner, and shape of all of our actions. So, in the healthcare context, we argue that each patient and each provider involved in a clinical encounter possesses a specific habitus that guides our general styles of acting, within that encounter. So as I was trying to show with the thought experiment, we very often pursue better health in largely habitual ways, and these ways are gonna be rooted in our experiences, our long lasting lifelong ways of thinking and acting and organizing action.

And our general sensibilities of how does the world work and how do I navigate through it? So as such, the ways in which patients and providers interact towards one another and the kinds of actions that we take to maintain our health are often hybrid combinations of purposeful actions and habitual embodied ways of thinking and conducting our lives.

So, what does patient and provider habitus mean for patient centered care. So, let me now introduce the first vignette from our qualitative study. So, this vignette features a provider that I'll call doctor Barrow, these are all syno, pseudonyms, and his patient Luis. First let's hear from Doctor Barrow about how his communication style has changed over time.

Quote, early on you were kind of taught the way to do this was just sit there and ask open-ended questions and listen to everything somebody said. The biggest change over time has been the number of patients you see in clinics gets larger. You have less and less time, and 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 get and try, you try and get specific information that is relevant. 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.

So that's a pretty exhaustive list, right? So Dr. Barrow is Luis' physician. And the relationship is one that actually seems really quite successful. So, Luis is in his late 50s. He was born and raised in South America and he immigrated to the United States as an adult. And he suffers from severe congestive heart failure and cardiac arrhythmia as well.

Where the rhythm of your heart is not regulated properly. When Luis first started getting sick, he quickly understood that part of the problem for him was that he could not clearly and efficiently articulate his medical and social history. So here's Luis talking now. Quote, 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 hair. Are you stupid? And this caused the problem for my learning skills. Now imagine to learn 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. So, to bridge this gap in his own abilities Louis has enlisted the help of his close friend Ana who possesses many a cultural resources from which Louis derives benefit.

So here's Dr. Barrow speaking again about their interaction. Quote, Luis would probably drive me crazy except for the woman, Ana, who comes in with him who has everything in line and is so on top of things. She comes in with a notebook, she can tell you anything you wanna 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 it would be harder for him to manage his medication and things like that by himself. I think if I was only working with, if I was only working with him, getting him on the phone and getting him to show up to things. Anything like that would be so, would be much more difficult.

Ana is not medically sophisticated necessarily, but she is so organized and so put together and takes such good care of him that it's very rewarding to take care of him, and interacting with him is very pleasant. If I was dependent on him for medical decisions, that might be a different story.

So between the two, you get a lot done. And they're also very appreciative. Now to return to the question of the significance of habitus for patient centered care, recall that the first pillar of patient center care was to understand the patient and her bio cycle social context. So we are experiencing individuals, we're not an object, we're not...

A disease, right? Not a condition. So providers are called upon with this with this principle of patient-centered care to learn how a patient interprets illness, the significance that that illness holds for the patient and the culturally determined norms and beliefs that she uses to understand, explain, and describe that illness.

But actually found with the interaction with the coach today that I showed you, one clear barrier to this, is that providers bring their own habitus, their own assumptions about how the world should work into their interactions with their patients. So in our study we found that all of our physician participants like Doctor Barrow held highly ingrained and taken for granted expectations of the CHC element their patient at minimum should have to help boost the interaction forward, to get things done.

We argue that these expectations around responsibility and good patienthood are generated from providers' habitus. Which in turn is rooted in their social stratified ex, their stratified social experiences as racialized, classed, and gendered individuals. It also comes out of their clinical training and their socialization as, as physicians and as healthcare providers, and it is also shaped by the organizational context.

In which they were, by the hospitals and the, the internal culture of the, of the places where they work. So even with the example of Luis and Anna, who clearly demonstrate quite a lot of agency in their health care interaction. It's actually Dr. Barrow who determines what cultural resources or what kinds of CHC hold value in the first place.

Do their expectations for the kinds CHC patients have and we need to have in order to optimize the clinical encounter. Providers possess unequal power in that they get to set the rules of the game. So there are two conceptual contributions that I believe habitus makes to analyzing healthcare interactions.

First, as we saw with Luis. Because of Habitus, the kinds of attributes that define being an activated and engaged and savvy patient, aren't simply skills that people can just pick up. Habitus is a part of that one social experiences and these social experiences are highly stratified. So this in turn means that the kinds of actions that people engage in, the questions that they have and the kinds of information that they want or don't want, when faced with illness.

How they build about managing that illness. So even if they think about the illness is something to manage or whether it's just something you bear and that you put up with, all of these are socially stratified as well. So the second contribution that I think this notion of habitus makes is that provider habitus has an impact in that it shapes expectations about patients' responsibilities and behaviors.

And again this means that the provider has, possesses disproportionate power to set the rules of the interaction. And to state what kinds of CHC are valued, and what kinds of gains a patient is going to have who successfully deploys, culture health capital. So this patient center charge to get to know the patient in her bio-psycho-social context, ignores that this context is actually laid on top of an already existing landscape that's.

Structured and shaped by power and inequality. So then let me turn to the second vignette. So, we have Clarice and her cardiologist Dr. Crawford. Clarice is 72 years old, or at the time of our interview she was seventy 72 old. She's African American. And she's seeing Dr. Crawford in order to, because she needs to have knee surgery done.

And in order, because she has a preexisting heart condition, she needs the. To get medical clearance in order from a cardiologist in order to be able to clear, to be clear to go to get surgery. So on this, on the particular day that we met Clarice in the clinic, her blood pressure was actually high.

And so she has an excerpt from their exchange. Clarice, I think the pain from the knee, I think the abnormally high blood pressure is due to this pain. And Dr. Cropper replied, you know, before I used to wonder when people told me that, but then I had a guy come in here who had a bad knee, and when he is sitting down, his blood pressure is low and as soon as you walks up and, walks and gets up on the table it was sky high because it hurts so bad.

Is that the same with you, too? Yes. Cuz you say my blood pressure's good. I'm just looking back to, like, when Dr. W. has seen you in the clinic. And, you're right. Like, when you were seen in April, your blood pressure was 110/66

which is very good blood pressure And Clarice replies, 'yeah.'

That's why I think it's the pain. So in this scenario, Dr. Crawford is weighing the blood pressure reading that was done by the nurse, in the clinic, against Clarice's own understanding of what she considers her normal blood pressure to be, and her understanding of why her current blood pressure that day in the clinic is higher.

Clarice's explanation made sense to Dr. Crawford, and Clarice was cleared for surgery without any additional testing or delay. As Dr. Crawford elaborated separately to us in her interview, quote, that's why I talk to these guys because they know a lot about themselves. I don't think she has any medical training.

The people figure stuff out, and I think that helps. So I really love patients like that because it's much more of a give and take. It's not just me saying: okay, here's what you need to do. So again, to bring this back to patient-centered care, recall that the second essential ingredient of p-c-c was.

To try to achieve this, this shared understanding of the patient's perspective and concerns, of what the clinical condition involved, and what the treatment options might be. Yet in our study, we found that shared understanding was actually often equated to shared biomedical understanding, so instances of and efforts to build shared understanding were most often predicated.

On patients sharing providers biomedical understandings of the clinical condition, rather than the converse or some hybridized under, coming to some hybridized understanding. So in this vignette with Clarice and Dr. Crawford, Clarice's understanding of the situation made sense biomedically and made sense to Dr. Crawford and her existing understanding of what causes high blood pressure.

So the shared biomedical understanding, obviously, it facilitates really information, really efficient information exchange. But it also communicates something about Clarice's medical sophistication. And it increases the personal regard that Doctor Crawford has for Clarice. And for this patient provider relationship. And for others in our study, we saw that provide us favorable impressions of patients, then generated cascades of additional action that led to more satisfying and more, in fact, more patient centered care.

So to go back to these two vignettes that I've presented, so in the both the examples of Clarice and Dr. Crawford as well as Luis and Dr. Barrow. The attention and care that providers may offer may actually constitute rewards given in response to how well the patient has displayed and deployed the repertoire of skills.

That is their interactions. Can be seen as social transactions, and CFC underscores the significance of work that these cultural resources do in these transactions. So if you have a sense of initiative, you have the ability to take action to manage your health, you have medical knowledge, you have health literacy all of these.

Things about being an activated and engaged patient can directly facilitate communication and appropriate treatment. But it also indirectly and positively influences providers' perceptions of patients, and in turn, it generates sort of these cascades of extra treatment, extra care, extra attention, extra time. That can often enhance outcomes. So in this sense, see functions as symbolic capital.

That is, a kind of capital that's accorded approval and rewarded. And it's this dual nature of see-see as both instrumental and symbolic capital, as having direct effects as well as indirect effects, that I think offers a conceptual elaboration of what it takes to achieve patient-centered care. Let's see, how we doing on time here?

Okay. Alright. So, I wanna turn to my final vignette. So, this is, It involves Ia Sepha and her cardiologist, Dr. De Luka, Ia Sepha, she is some Samoa. She's in her fifties and she was diagnosed with coronary heart disease about a year before we met her and she's been seeing Dr. De Luka for much of that, that, that in-term year.

Eve says that this is regular sort of you know, check-in for her. And on that clinic day, she admitted that she's not very compliant with her medication regimen because it gives her terrible headaches and here's what she says. Sometimes 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 doctors say. To tell you the truth, I get confused, what should I do? Is the doctor right? Or am I right? Should I take it or should I not?

So what happens in their appointment is that Doctor Deluca really tries to foster Eoseffa understanding of her illness and her symptoms and just like market the extremely collaborative kind of way. So she explains to Eoseffa that the goal of the medication is to actually preserve her heart function rather than to.

Sure it's. to, it's to preserve her heart function and not to cure the coronary heart disease. She would use the medication and actually goes through, physically goes through each of the pill bottles that Eoseffa has brought with her. And she identifies what she thinks is probably the cause of the headaches.

And she puts a big black x on the pill bottle to signify to herself that she should stop taking the medication. And she really listens to Eoseffa during this appointment about, you know, when do the headaches come on, when are you taking this medicine, when are you taking that medicine, and, and then she's able.

Through that process to figure out this alternative medication that Eoseffa should try. That hopefully will alleviate the headaches and prevent the headaches. And she also gives Eoseffa a bunch of different strategies. You know? Timing the medications in a different kind of way, using a over the counter medications when you know, she starts feeling a headache coming on.

And taking medication to right before she you know, there's something that requires physical exertion. And she at the end of the clinic appointment she says, okay these are all the things that we're gonna try. I want you to commit, make a commitment to me that you're gonna try these things for one week.

And then we'll see how you do. We're gonna check in by phone in a week and see how you do.

>> So at an interview one week after her visit with Dr. Deluca reported that her headaches were indeed better and she was able to take her medications as prescribed.

So here she says, I have control of the medicine now. I know if I control the medication now than it'll be easy to control in the future. And Dr. Deluca, in her follow-up interview with us, described this remarkable difference that she saw in her patient. Quote, left me a message the other day about a pharmacy with one of her medications.

And I didn't recognize her at first, she has become much more articulate and precise about relating to issues to me. So I wanna use this vineyard of Eoseffa and Dr. Delucca, to reflect on the third pillar of Patient centered care which is this notion of shared power and shared responsibility.

So, healthcare's envisioned as this collaboration between the patient and the provider rather than just the provider giving directions and the patient receiving them and complying with them. So it's this shift from like an eighth metric top-down model to one, something that seems much more equitable and egalitarian and, and collaborative.

And indeed I think it's probably safe to say, that looking at the interaction between Eoseffa and Dr. Di Luca. It is one, it is an interaction that we can see some element of shared power and shared responsibility. Obvious there's a real instrumental benefit to this. You know, Eoseffa headaches were in better control.

She no longer suffered from those side affects that caused her to avoid medication. You know, because she's taking the medications as prescribed, her condition is gonna be better. Her overall heart function is gonna be better. And the long term consequences of her condition are going to be reduced.

And it also obviously, you know, within genders it's, it's sort of, it's, this is sort of a pivotal step in their relationship for the two of them. And talks about where she felt like she's in control and sort of empowered in a sense. And in many cases, as far as we can tell from my interview with her, this is one of the first times that she really felt like this, about her healthcare and about her relationship, with the healthcare provider.

And like you could see Dr. DeLuca sort of actively cultivating sort of ability to weigh the costs and benefits of this action versus that action, and importantly it has the spillover benefit for her too. She able to take kind of what some of the skills that she learned from Dr. DeLuca, and use it to negotiate and manage a problem that she had with the pharmacy, right?

But on the other hand, Dr. DeLuca's actions and talk explicitly induce particular types of patient behaviors that the physicians find valuable. And it communicates not only the type of actor a patient can be, but the type of actor that patient ought to be. So a patient-centered approach doesn't necessarily relieve the asymmetry of the interaction.

Rather asymmetry is being accomplished and being reinforced in a different kind of way. So all along I'm trying to use CHC as this concept that really tries to interrogate what PC, this egalitarian model, that PCC is really promising. And we're trying to, we keep trying to point to the underlying architecture of inequality, on top of which PCC, this new model of providing care is being laid on top of.

Okay, so to start summing things up, I just wanna reiterate that, recognizing and responding to individual characteristics, cause that's really what patient-centered care is meant to do. It's mean to talk about the, you know, every, there is no one universal one size fits all kind of medical care.

We have to look at each patient as an individual, and we have to tailor medical care to that particular individual. And so it's a really attractive model. And it's also a fairly intuitive way to think about building a therapeutic relationship, a relationship in which care is being offered and received, and in which we as individual patients wanna receive care, right?

We don't want the one size fits all model. But we believe however that CHC helps us to understand, and helps to illuminate these interactional dynamics that precede underlying and go beyond PCC. So CHC emphasizes that cultural resources and attributes influence patients and providers mutually shaped abilities to achieve PCC.

And it all happens through this process of evaluation that, that providers, engage in, in which I tried to illustrate with the three vignettes. So, CHC, again to reiterate, it's conceptualized as a means of exchange, and these healthcare interactions are really, are, are kinds of social transactions. And so, therefore the effects of social inequalities like race, class, gender, and other markers of social status are gonna be reflected in the amounts and the kinds of CHC that we all have access to.

And the extent to which we're able to deploy them successfully in a healthcare interaction, and the extent to which actually providers recognize or are willing to give you quote unquote credit for the kinds of resources and skills and assets that you have. So I started out this talk by pointing out some of the opportunities we have as we move forward with the Affordable Care Act, because it is a pretty significant opportunity.

And in particular you know, there's a really explicit aim of the ACA to improve care for our most vulnerable and sickest population. And yet at the same time as I've tried to show, there are these really strong currents that keep running against the, the, the achievement of health equity and healthcare equity.

And some of these are actually embedded as I was trying to argue, within the ACA itself, and in the ways in which it tries to engage with the sort of this discourse of virtuous patienthood.

>> I'm Anne Stevens, the director of the Center for Poverty Research at U.C. Davis, and I want to thank you for listening.

The Center is one of three federally designated poverty research centers in the United States. Our mission is to facilitate non-partisan academic research on domestic poverty to disseminate this research and to train the next generation of poverty scholars. Core funding comes from the U.S. Department of Health and Human Services.

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