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## Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment

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### Abstract

In this article, I propose and define the new concept of cultural health capital, based on cultural capital theories, to help account for how patient-provider interactions unfold in ways that may generate disparities in health care. I define cultural health capital as the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more optimal health care relationships. I consider cultural health capital alongside existing frameworks for understanding clinical interactions, and I argue that the concept of cultural health capital offers theoretical traction to help account for several dynamics of unequal treatment. These dynamics include the often nonpurposeful, habitual nature of culturally-mediated interactional styles; their growing importance amidst sociocultural changes in U.S. health care; their direct and indirect effects as instrumental as well as symbolic forms of capital; and their ability to account for the systematic yet variable relationship between social status and health care interactions.

### Keywords

cultural health capital; patient-provider interaction; cultural capital; health care disparities

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The U.S. system of health care continues to be plagued by social inequities in perceived quality, patient satisfaction, and service provision (Smedley, Stith, and Nelson 2003). This remains so despite the efforts of many well-intentioned health providers and administrators and despite significant investments of resources. The weight of this evidence has motivated a multitude of efforts to elucidate the social origins of unequal care. These efforts have largely focused on phenomena at either the micro-level of the patient-provider relationship, or at the macro-structural level. These distinctive foci recapitulate two long-standing sociological questions. First, how are macro-level phenomena manifested and actualized in lived experience and the day-to-day unfolding of social life? And second, how do micro-level interactions accrete and constitute larger-scale social processes and structures? In this article, I propose and describe a new concept—*cultural health capital* (CHC)—as a theoretically coherent framework for understanding how broad social inequalities operate in patient-provider interactions, and shape the content and tone of health care encounters.

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The concept of CHC argues that certain socially-transmitted and differentially distributed skills and resources are critical to the ability to effectively engage and communicate with clinical providers. It is substantially rooted in Bourdieu's ([1980] 1990, [1983] 1986) notion of cultural capital as a means to conceptualize cultural practices and products of all kinds—ranging from styles of dress, eating habits, verbal skills, scientific knowledge, educational credentials, and so on—as forms of capital. He explicitly linked their transmission, deployment, and systems of rewards to the struggle for social distinction, practices of domination, and the maintenance of class-based hierarchies. In a manner parallel to economic forms of capital, he argued, cultural capital contributes to the accumulation and exercise of power and the maintenance of inequality.

Bourdieu also noted that cultural capital is context-specific, that is, in different fields of social action, different kinds of cultural skills and attributes constitute valued resources. Within the context of health care, cultural health capital refers to the particular repertoire of cultural skills, verbal and nonverbal competencies, and interactional styles that can influence health care interactions at a given historical moment. At present, specific elements of CHC may include linguistic facility, a proactive attitude toward accumulating knowledge, the ability to understand and use biomedical information, and an instrumental approach to disease management. These kinds of cognitive, attitudinal, and behavioral resources can be deployed by patients and, depending upon providers' variable responses to them, may result in more attentive and satisfying engagements with health professionals.<sup>1</sup>

Several scholars have already noted the potential relevance of cultural capital in understanding disparities in health status and care. Wall (1995), for example, defines cultural capital as “a superior ability ... to keep oneself well informed about where in social interactions profits can be gathered” (p. 660). He hypothesizes that this capacity results in favoring the well-educated and middle class who are better able to capitalize on public health prevention measures. Malat (2006) considers how cultural capital might advance studies of racial disparities in medical treatment. Following Lareau (2003), Malat (2006) views cultural capital as “the knowledge and behaviors that gain an individual advantage in a particular social environment” (p. 309). She calls for research into the circumstances that promote mobilization of cultural capital, the kinds of cultural capital that effectively increase the care received, and potential racial variations in access to cultural capital.

Kuh and colleagues (2004) have proposed the term “personal capital” to describe “an individual's capacity to mobilize available resources, exploit opportunities, and be resilient to adversity. This capacity reflects the accumulation of social and cognitive skills, self-esteem, coping strategies, attitudes, and values” (p. 380). They view personal capital as a characteristic of the individual, but one that is shaped by family, neighborhood, school, and wider social and cultural dynamics. The development of personal capital, they argue, is critical to both “chains of risk” or “protective chains” that operate via psychosocial

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<sup>1</sup>This article is primarily concerned with the potential influences of CHC on patient-provider communication and interaction, and does not attempt to extrapolate to other endpoints, such as quality of care and health services provision. While enhanced communication might lead a clinician to provide more services (for which there is ample evidence, see Smedley et al. 2003), this does not necessarily correlate to better quality of care: more treatment might simply be overtreatment, rather than better treatment. I thank a reviewer for pointing this out.

and socioeconomic mechanisms to connect childhood socioeconomic environment to adult health. Finally, while Williams (1995) does not explicitly take up the concept of cultural capital, he does consider more broadly the work of Bourdieu in helping to articulate the relationships between health-related knowledge, action, and the circumstances that condition those actions—in a phrase, the structure-agency problem in relation to health behaviors.

The objective of this article is the conceptual elaboration of CHC through applying existing sociological theories of cultural capital to the arena of health care interactions. I first provide an overview of what CHC is, positing its key constitutive elements. The concept of CHC owes an intellectual debt to, and is in conversation with, existing psychosocial, epidemiological, and sociological concepts and frameworks that address inequities in medical care. However, I argue that the concept of CHC helps to account for several issues significant to understanding the social production of unequal treatment that are not fully addressed by the current literature. I therefore show how CHC serves as a useful complement to and elucidation of existing explanations for the production of health care inequalities. I thereby aim to elaborate how the concept of CHC offers a coherent framework for understanding the impact of important changes in the U.S. health care system, complex interactional dynamics within the clinical encounter, and the relationships between health care and larger social relations.

## CULTURAL HEALTH CAPITAL: AN INITIAL ARTICULATION IN THE THEORETICAL LEGACY OF BOURDIEU

First, I offer in this section an initial articulation of the concept of cultural health capital, its constitutive components, and several aspects of its nature that I view as particularly important.<sup>2</sup> I argue that the notion of CHC, true to its intellectual lineage in the work of Bourdieu, is adamantly grounded in a view of society as a social hierarchy. Bourdieu's unique contribution to the sociology of culture was to understand how cultural practices contribute to social stratification and the reproduction of hierarchical social systems over time. He argued that culture in the broadest sense is a form of capital that, when accrued and deployed, can be used as a key asset in establishing and maintaining one's social status. Different arenas of social action—"fields" in Bourdieu's parlance, where particular kinds of goods, services, knowledge, and status are produced and circulate—call for different kinds of cultural skills and attributes. Cultural capital is thus context-specific and defined operationally and functionally, as resources that enhance social status in varying spheres of social life.

I propose that the notion of cultural capital has theoretical relevance for the "field" of health care interactions. In particular, I conceptualize *cultural health capital* as a specialized form of cultural capital that can be leveraged in health care contexts to effectively engage with medical providers. Congruent with the operational and functional definition of cultural

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<sup>2</sup>The concept of cultural health capital initially emerged inductively from interview data from two qualitative studies whose other findings are reported elsewhere (Kaufman, Russ, and Shim 2006; Kaufman, Shim, and Russ 2004, 2006; Russ, Shim, and Kaufman 2005, 2007; Shim, Russ, and Kaufman 2006, 2007; Shim 2002, 2005; Shim, Russ, and Kaufman 2006, 2007). Validation of the concept of CHC will have to await future results from a pilot study currently being conducted.

capital, the particular attributes that comprise CHC are specific to a given historical moment. That is, what constitutes an asset in a medical encounter, and what behaviors or characteristics afford advantages to patients, are likely to vary across time and circumstance. In the current U.S. health care system—with its emphasis on consumerism, patient initiative, self-knowledge, self-surveillance, and self-management—particular characteristics tend to be rewarded in clinical interactions, including the following:

Knowledge of medical topics and vocabulary, which in turn depends upon an understanding of scientific rationality and health literacy (Institute of Medicine 2004);

Knowledge of what information is relevant to health care personnel;

The skills to communicate health-related information to providers in a medically intelligible and efficient manner;

An enterprising disposition and a proactive stance toward health, both of which presuppose a sense of mastery and self-efficacy;

The ability to take an instrumental attitude toward one's body;

Belief in the value of, and the resources to practice, self-discipline;

An orientation toward the future and its control through calculation and action;

A sensitivity to interpersonal dynamics and the ability to adapt one's interactional styles; and

The ability to communicate social privilege and resources that can act as cues of favorable social and economic status and consumer savvy.

These components of CHC are not disparate attributes, but rather a coherent collection of skills. Together, these cognitive, behavioral, social, and cultural resources are theorized to serve as a “tool kit” for patients to enable particular “presentations of self” (Malat, van Ryn, and Purcell 2006) and thereby to optimize their relationships with health professionals and the care they receive.

Many of these components of CHC have been identified and explicated in the literature on patient-provider encounters (as later sections will discuss), but their conceptualization as health care-specific forms of cultural capital makes certain claims that I believe are particularly important to understanding how inequality is produced in health care interactions. First, although patients' acquisition and mobilization of CHC are sometimes strategic and deliberate, its accumulation and use are also often tacit and pragmatic. Bourdieu did not view actors as calculatingly deploying cultural means to achieve planned goals. Instead, he argued that cultural capital is developed through enacting cultural practices and appropriating and consuming cultural goods—for example, through cultivating an appreciation of art or fine dining, or through assimilating scientific knowledge or styles of social interaction. These processes of what Bourdieu termed “embodiment” gradually build up “habitus,” or “a system of lasting, transposable dispositions” that integrates past experiences and “makes possible the achievement of infinitely diversified tasks, thanks to analogical transfers of schemes permitting the solution of similarly shaped problems”

(Bourdieu 1977:82–83). Cultural capital thus serves as a tool kit of resources that can be used to construct “strategies of action” (Swidler 1986), not in the sense of a conscious plan, but as general styles and habits of action.

Like cultural capital, which accrues as one engages in cultural practices, I posit that CHC develops in and through the repeated enactment of health-related practices, such as consuming biomedical knowledge, exercising calculative and future-oriented approaches to decision-making, and engaging in self-surveillance and risk-reduction practices. While some patients may be quite purposeful in engaging in these practices and deploying the accumulated cultural resources they have in health care interactions, many others are likely responding in largely habitual ways that are rooted in their experiences, schemes of thought and perception, long-lasting ways of organizing action, and their general sensibilities about how the world works.

Second, the concept of CHC clearly gestures toward its nature as a resource, and to its holders as actors with a means of exchange, and therefore some measure of agency.<sup>3</sup> But, as with cultural capital theory, holders of CHC are not individual free agents who can simply acquire and deploy resources at will. The notion of cultural capital emphasizes that there are systematic inequalities in the ability to both accrue cultural capital and convert it into advantage. My own reading and use of cultural capital emphasizes its embeddedness within durable social processes that produce inequality. In this spirit, through the concept of CHC, aspects of patient-provider encounters can be linked to and understood as manifestations of broad inequalities permeating social structures, institutional arrangements, and social life.

Finally, the concept of cultural capital is deeply relational; it refers to the power of dominant social groups not only to shape institutional arrangements, but also to define the kinds of activities, resources, and behaviors that carry value in those contexts. In fields of social action, Bourdieu (1977) used the metaphor of a “game” to characterize the quest for social privilege. Every aspect of this game, he argued, is stratified, from who gets to play, to the “cards” (i.e., resources or capital) that are dealt, to the rules of the game (i.e., the exchange value of different resources, who gets to determine that value, when and how exchanges may occur). The distribution, transmission, movement, and exchange of cultural capital thus carry the indelible imprint of hierarchical domination. In articulating the concept of CHC, then, I emphasize this relationality by underscoring the critical role of the health care provider and institution, as agents who can solicit, evaluate, shape, and foster CHC. Providers do not simply respond to the CHC that patients mobilize, but actually contribute to their capacity to do so. In the interactive give-and-take of the clinical encounter, clinicians can signal to patients and encourage them to be the kinds of actors they would like them to be. Through the information that providers communicate to patients, and the ways in which they do so, providers can actively cultivate CHC. Cultural health capital is thus a collective achievement of patient-provider interactions.

In short, the CHC concept is intended to effect a kind of “double vision”—“the simultaneous focus on biography and social structure” (Lareau 2003:311, note 6), the “subtle interplay

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<sup>3</sup>.But see Williams’ (1995) critique of Bourdieu in this regard.

of freedom and constraint” (Williams 1995:582–83), as well as the reciprocal influence of patients and providers. In so doing, the CHC perspective seeks to look both “upstream” toward macro-level factors that structure the distribution of capital, and “downstream” toward health care interactions in which different forms of capital are mobilized and exchanged. In the sections that follow, I discuss the theoretical relationships between CHC and existing frameworks for understanding health care disparities, and, in so doing, elaborate the cultural health capital concept and how it explicates both upstream/macro-structural and downstream/micro-interactive pathways.

## **CHC AND FUNDAMENTAL CAUSES: HABITUS AND THE IMPORTANCE OF SOCIOCULTURAL AND ORGANIZATIONAL CHANGES IN HEALTH CARE**

A major body of work inspiring the cultural health capital concept engages with the theory that social conditions constitute “fundamental causes” of disease (Link et al. 1998; Link and Phelan 1995, 1996; Lutfey and Freese 2005; Phelan and Link 2005; Phelan et al. 2004). These scholars argue that social conditions act as fundamental social causes of disease, mediated through but distinct from the more proximate biological, behavioral, and other risk factors that contribute to ill health. These fundamental social causes involve resources, such as knowledge, power, money, social connections, and prestige, that profoundly shape people’s ability to avoid risks and to minimize the consequences of risk exposure and disease once they occur (Link and Phelan 1995). These resources—as the fundamental general means upon which individuals depend for making their way in the world—forge concurrent and multiplicative links with many different risk factor mechanisms.

The fundamental cause principle is most relevant under conditions of change: When new diseases, risks, and knowledge about risks emerge, those with access to broadly serviceable resources are better able to adapt them to changing historical circumstances to avoid risks and cope with disease (Link and Phelan 1995). Thus, the most well-off benefit disproportionately from improving capabilities to prevent and control disease. In this fashion, new causal pathways linking fundamental social conditions to health outcomes are continually being forged, and existing distributions of knowledge, money, power, and other social conditions are repeatedly reproduced over time, preserving and even exacerbating disparities in morbidity and mortality.

It is important to note that, while Link, Phelan, and their co-authors do not explicitly address health *care* or clinical encounters per se, they do assert that fundamental social conditions “directly shape individual health behaviors by influencing whether people know about, have access to, can afford and are motivated to engage in health-enhancing behaviors” (Phelan et al. 2004:267). Some of these behaviors are, of course, directly related to actions involving clinical care, such as knowing when and how to seek preventive care and medical treatment, and knowing about and asking for specific screening tests and therapeutic interventions. In addition, Lutfey and Freese (2005) demonstrate the applicability of the fundamental cause perspective to clinical care by identifying how socioeconomic status (SES) is multiply realized in diabetes care, via differences in such factors as continuity of care, clinic-based educational resources, social support, and costs of compliance. Together,

these links repeatedly connect social status to health status (or in their case, SES to the sophistication and presumed effectiveness of diabetes treatment regimens). In so doing, health benefits tend to redound to the resource-rich, and health risks to the resource-poor.

While there is much that cultural health capital shares with the fundamental cause perspective, the concept of CHC problematizes at least two aspects of this body of scholarship that warrant some further consideration. First, the fundamental cause proposition “posits that the use of resources to benefit health, by groups and individuals, is *purposeful*. Thus, the health advantage of high socioeconomic status is not primarily a coincidental side-effect of ‘the good life’” (Phelan et al. 2004:268, emphasis added). In contrast, the notion of CHC is embedded in a Bourdieusian view of actors, not as consciously and deliberately calculating individuals strategically pursuing planned goals, but as possessing *habitus*, or general styles, habits, and dispositions that indelibly influence the direction, manner, and shape of their actions. In this view, the acquisition and use of health-promoting resources are not always or wholly purposeful. Instead, accumulation of these resources and the ability to mobilize them derive from past experiences and largely habitual, embodied ways of thinking and organizing action. They are cultivated through the sometimes deliberate but often unintentional and unplanned enactment of health-related practices, such as accumulating medical knowledge, calculating future possibilities, and undertaking self-surveillance. In this way, the concept of CHC complicates the fundamental cause framework’s emphasis on purposefulness and intentionality by accounting for the myriad pathways through which the acquisition and use of cultural resources to improve health are simultaneously strategic yet also tacit, deliberate yet also highly ingrained.

Importantly, habitus is tied to social stratification, in that schemes of thought, perception, and action originate out of class- or status-specific conditions of existence. These conditions shape social trajectories by constraining what individuals regard as probable, accessible, “for us” or “not for us” (Bourdieu [1980] 1990). Thus, the notion of habitus shows how CHC complements the fundamental cause explanation of the accumulation and compounding of social and health advantages. The efficacy of efforts to accumulate and cultivate CHC often depends upon preexisting knowledge and dispositions. For example, having some familiarity with medical vocabulary affords one better access to and understanding of new and additional health-related information. Alternatively, the capacity to adopt an instrumental attitude toward one’s body furthers a sense of control over one’s health. The competencies that are hypothesized to comprise CHC thus accrue exponentially (see Bourdieu [1983] 1986:241–42), imparting the concept with a self-perpetuating and self-generating quality. Like fundamental social causes, then, CHC results in the accumulation of advantage, and potentially in the widening of disparities in cultural know-how between those who possess CHC and those who do not. The overall effect is that these skills and attributes, though intrinsically social and relational in their origin, *are perceived to be* individual in their accumulation and expression.<sup>4</sup>

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<sup>4</sup>.Malat et al. (2006) also note that the trend toward consumerism in health care does not take into account that “patients’ sense of empowerment in the medical encounter may not be equally distributed throughout society. The potential for a patient to act as a consumer (e.g., making demands on physicians) may depend on the social position of the patient” (p. 2485).

A second way in which CHC problematizes the fundamental cause perspective is that some of the most striking recent transformations in health care since roughly 1970 are organizational, economic, and sociocultural in nature, in addition to the new knowledge, new risks, and new treatments emphasized by fundamental causes. I argue that as a supplement to the fundamental cause perspective, the CHC concept more fully accounts for how health disparities can be preserved and even widened in times when knowledge, risks, and treatments may be relatively stable, but the *organization* and *culture* of health care provision are changing. These changes include mergers and consolidations that have fueled increasingly pervasive capitation and managed care arrangements, devolving benefits and convoluted coverage rules, and complicated networks of insurers, provider groups, and hospitals.

Over the course of the past four decades, this shifting health care landscape has intensified the demands placed on patients to be knowledgeable about how to maneuver through the health care bureaucracy and to be self-directive about their own care in a time of shortened appointments and heightened gate-keeping. Patients now need a host of distinctively *cultural* skills and competencies to be, in Heimer and Staffen's (1998) words, "savvy organizational players." Patients who possess or acquire and display an enterprising and proactive disposition, a fluency in biomedical concepts and language, bureaucratic know-how, and an interactional agility with authoritative experts are more able to successfully navigate such organizational complexity. The cultural expectations and responsibilities of contemporary patienthood—in terms of self-knowledge, self-surveillance, health promotion, disease management, and the like—have also escalated, at least in the United States.

The changing organizational and sociocultural landscape in U.S. health care also places additional demands and constraints on providers, such as limited clinical time, standards for efficiency, and a scarcity of resources to which they can refer patients for further assistance. Such constraints are likely to curb providers' abilities to work with patients to maximize the CHC available in the clinical encounter (for example, by taking the time to align their interactional style to those most compatible with the patient), as well as to invest in developing the competencies of their patients (more on these points below). As Lutfey and Freese (2005) observed, health care settings with minimal resources and inadequate staffing are least well-positioned to support patients and providers in optimizing the interaction. Compounding the problem, they note that such institutions are more likely, on the one hand, to serve patients who lack significant cultural skills but might benefit most from provider relationships that can foster patient competency. On the other hand, those same institutions also hinder providers from improving their own capacity to help patients become better participants in their own care. The effects of organizational conditions on health care interactions therefore may tend to reproduce existing inequalities in the distribution of CHC and in medical care.

Thus the U.S. medical system can be seen as a set of institutional arrangements that sanctions certain cultural attributes and skills, gives them exchange value, and allows them to function as a form of capital. Cultural health capital works as a form of capital because its constitutive characteristics and competencies are widely (though not universally) shared and viewed positively as assets in clinical interactions. They are increasingly institutionalized



markers of status and legitimacy (Lamont and Lareau 1988), of distinction and deservedness in health care, and therefore they have increasing symbolic power and influence in that arena (Williams 1995). In this context, there is a historically-specific “common sense” and cultural logic about how patients should approach health care and what their duties as patients are. Cultural health capital thus helps to explain how the changing sociocultural and organizational contexts surrounding health care and medical institutions in the United States participate in sorting and stratifying practices (see American Sociological Association 2003), and how power and domination in those contexts are legitimated.

## **CHC AND PATIENT ATTRIBUTES: ACCOUNTING FOR DIRECT AND INDIRECT EFFECTS**

Another area of research central to the articulation of cultural health capital focuses on patient characteristics that may facilitate or constrain the full exchange of information between patients and providers. One such patient characteristic is health literacy, defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Ratzan and Parker 2000:vi). As such, health literacy is crucial to basic communication and functioning in the health care environment (Baker et al. 2007; Schillinger et al. 2002, 2004; Williams et al. 1998). Because inadequate health literacy is disproportionately found among poor, immigrant, and racial-ethnic minority Americans (Ad Hoc Committee on Health Literacy 1999; Institute of Medicine 2004), it potentially plays a significant role in generating social disparities in quality of care. Other patient traits that impact patient-provider communication include self-efficacy, mastery, control, and self-esteem (e.g., Bandura 1997, 2004). All of these concepts refer to the “core belief that one has the power to produce desired changes by one’s actions” (Bandura 2004:144), and involve efforts to regulate one’s motivation, thought processes, affective states, actions, and environmental conditions (Bandura 1997).

Cultural health capital obviously has much in common with notions of health literacy and self-efficacy; its constituent elements in fact include these very competencies. But the transactional and interactional lens of CHC adds something more to the discussion, in that it points to the indirect as well as direct, symbolic as well as instrumental ways in which these resources work. By way of example, Stimson and Webb (1975) and Mishler (1984) observed that individuals who phrased their concerns using biomedical concepts and language were more likely to receive attention and treatment from their physicians. This may be due to two related but distinct pathways. First, patients who are health-literate and use the clinical lexicon make themselves more intelligible to providers, facilitating communication and appropriate treatment. That is, these skills are consequential because they equip patients with resources that can directly lead to material benefits in care.

Second, clinicians might interpret such skills as signaling something about the patients themselves (their motivation and competency, for example) that providers are inclined to view favorably and reward. That is, the ability to use biomedical concepts and language can serve as a means of exchange, as a form of CHC, that operates indirectly, by positively influencing providers’ perceptions of patients. Patients and family members who mobilize

CHC to present themselves and their health issues in approval-garnering and medically intelligible ways can generate “cascades” of subsequent interactions and actions—such as more thorough elicitation and evaluation of symptoms, greater information-sharing, and more complete responses to questions and concerns—that may enhance communication and care. In these senses, CHC functions as symbolic capital (Bourdieu 1977), as a form of capital that is accorded positive distinction and approval, and is rewarded as such. It is this dual nature of CHC, as an instrumental *and* symbolic form of capital in the Bourdieusian tradition, that offers a conceptual elaboration of existing notions of health literacy and self-efficacy and the pathways through which they are understood to affect health care interactions.

## CHC AND INTERPERSONAL DYNAMICS: COMPLICATING THE ROLE OF THE PROVIDER

Other research into the patient-provider encounter has identified varying combinations of communication, informational, and interpersonal processes that appear to differentially affect providers’ interactions with their minority patients, as compared to those with white patients. These perspectives postulate that, for a variety of reasons, interpersonal and communication dynamics in the clinical encounter tend to disadvantage minority patients (Balsa and McGuire 2001, 2003; Balsa, McGuire, and Meredith 2005; Cooper et al. 2006; McGuire et al. 2008; Stewart et al. 1999). In particular, the potential links among poor patient-provider communication, providers’ lesser ability to discern and respond appropriately to minority patients’ symptoms and health status, interpersonal dynamics, and disparities in health care quality and outcomes have generated significant scholarly attention.

A number of scholars emphasize providers’ interpersonal skills and responsiveness in the clinical interaction. For example, Stewart and colleagues (Stewart et al. 2007, 1999) hypothesize that “interpersonal processes of care” affect technical processes and outcomes in ways that may disadvantage minority or low-SES groups. They identify three distinct components of interpersonal processes of care: communication, decision-making, and interpersonal style. Similarly, Cooper and colleagues (Cooper et al. 2003, 2006; Cooper, Hill, and Powe 2002; Cooper and Roter 2002) use a relationship-centered paradigm in reviewing and considering the role of such interpersonal aspects of care as communication, partnership, and trust in generating racial-ethnic disparities in health care.

These perspectives on the importance of interpersonal dynamics and affective aspects of health care interactions share with CHC a concern to emphasize the reciprocal influence of patients and providers upon each other. Both the models by Stewart and colleagues and Cooper and colleagues flesh out the role of providers in terms of their skills, attributes, and behaviors that may impact the patient-provider relationship. Thus, these authors highlight the direct and immediate effects of provider skills on enhancing communication and rapport.

But the notion of CHC also brings into clearer view the secondary benefits of provider skills in building patients’ own capacities to facilitate communication.<sup>5</sup> Given its origins in

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<sup>5</sup>.My thanks to Stefan Timmermans for discussions on these issues.

Bourdieu's theories of cultural capital, CHC rests upon specific understandings of how it is accumulated, that is, through the embodiment of health care experiences, the cultivated consumption of health-related knowledge, the exercise of self-surveillance, and the like. Through such practices, patients can continually develop the cultural resources to manage and navigate health care. Clinicians inevitably play a role in producing CHC because of their influence in educating patients, shaping the kinds of health care interactions their patients experience, and communicating to patients the kinds of actors they can be. For example, providers can convey particular understandings of the division of responsibility between clinicians and patients for maintaining health, or they can cultivate patients' capacity for self-direction, and in so doing actively contribute to the CHC-building capacity of their patients. As Heimer and Staffen (1998) argued in their study of neonatal intensive care, clinical professionals induced parents' willingness and capacity to optimize their children's health. Lutfey (2005) found that "patient adherence and provider roles ... evolve in tandem" (p. 444), as clinicians not only selectively provided patients and caregivers with the opportunities and tools to be more involved in medical care, but also shaped the circumstances under which such involvement could take place more or less successfully. The CHC concept thus points out that providers not only induce certain kinds of patient behavior, but actually contribute to the capacity to behave in those ways.

Health care professionals may in fact use the cultural competencies patients display as the basis for judging whether further investments in developing their CHC are worthwhile. For example, patients who already show interest in their disease conditions and initiative regarding self-care may inspire more earnest efforts by their clinicians to give them additional information, resources, and skills. Conversely, providers may provide care to those patients who appear passive or neglectful, but without attempting to supplement the tool kit they have to optimize their own care and relationships with health professionals.

Providers, however, are not simply responding to patient attributes, granting or denying them clinical attention and services in some deliberate or even unconsciously biased way. Rather, physicians are imparting to patients medical knowledge, for example, or the ability to self-assess and self-manage symptoms, which is time-consuming interactional work. This is particularly so with patients who possess less knowledge to begin with, and whose initiative and follow-through are difficult to judge. Therefore, in the CHC framework, the compounding of advantageous cultural resources is less (or not only) a matter of bias or provider beliefs than the result of complex interactional processes during the clinical encounter.

To further flesh out the role of providers along this dimension, I consider CHC alongside another body of research on patient-provider encounters. A number of scholars have hypothesized that stereotypes and beliefs held by the provider about certain groups of patients act in complicated ways to produce clinically unwarranted disparities in health services (Burgess et al. 2006; Malat 2006; Malat and Hamilton 2006; Malat et al. 2006; Tait, Chibnall, and Kalauokalani 2009; van Ryn et al. 2006; van Ryn and Burke 2000). For example, Van Ryn and Fu (2003) argue that even among well-intentioned providers, a patient's race-ethnicity can activate ubiquitous and unconscious social cognition processes that can result in the generation of racial-ethnic inequalities in health care. A provider's

beliefs about race-ethnicity may shape, for example, her or his interpretations of health-related information, or interpersonal behaviors toward the patient (that in turn impact the patient's acceptance of advice and self-management).

The concept of CHC supplements these social cognition models; both view providers' behaviors as impacting patients' cognitive and affective factors, like self-efficacy, attitude, and feelings of competency (van Ryn and Fu 2003). Moreover, provider beliefs triggered by patient race-ethnicity or socioeconomic status can compound those activated by patient behaviors or displays of CHC. Since access to and acquisition of clinically valuable cultural resources are often shaped by social hierarchy, the distribution of CHC often follows racial and socioeconomic lines, reinforcing providers' existing beliefs about minority patients, and, in turn, providers' interpretations of health-related information and interpersonal behaviors. Anspach (1993), for example, observed that physicians and staff in the neonatal intensive care unit extrapolated from parents' behaviors, comments, and actions, judgments about their "medical sophistication" (i.e., their educational attainment) and "moral sophistication" (i.e., their social class). Based on these judgments, nursery staff then actively shaped and constrained the opportunities for parental participation in decision-making.

In addition to supplementing social cognition models, the concept of CHC also helps to flesh out and elaborate how some of their causal pathways operate. Social cognition models begin with patient social status, which triggers provider beliefs, which then cascades into multiple causal links between and among patient and provider beliefs, interpretations, and behaviors, culminating in differential treatment. However, the concept of CHC offers an explanation for what actually occurs in each of these links: that the acquisition, mobilization, transmission, and exchange of critical cultural resources shapes and constitutes many of the interactional sequences, the give-and-take and back-and-forth of the clinical encounter. Thus differential care can result not only because providers' beliefs about patients' race-ethnicity or socioeconomic status are triggered, but also because patients and clinicians alike are caught up in complicated, interactive processes. These processes are composed of often habitual actions and reactions by both patients and professionals that are based in largely implicit styles of thought, approaches to situations, and definitions of valued cultural assets.<sup>6</sup>

Moreover, by equipping individuals with some degree of agency, I argue that CHC, though highly influenced by racial and class inequalities, is not wholly determined by them. Cultural health capital thus has a conceptual edge over social cognition models, in that it retains its explanatory power across multiple kinds of scenarios, from clinical interactions involving minority or low-SES patients who buck expectations, to those in which provider stereotypes are initially triggered but then dissipate, to those where racial or class discordance is not an issue, but things go badly nonetheless. It is to these issues that I turn to last.

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<sup>6</sup>It may be that provider judgments of patients' deservedness, and in turn CHC, is less relevant as more clinicians understand that many diseases are beyond patients' control, and as treatments proliferate for diseases that no longer rely on patient behavioral changes alone to control. However, there is ample evidence that, even for such conditions, providers still hold negative beliefs about minority and low-SES patients that affect decision-making about treatment (e.g., Bogart et al. 2001; Feldman et al. 1997; van Ryn et al. 2006; van Ryn and Burke 2000). Thus, the availability of treatment and a better understanding of the complexity of disease causation and progression do not appear to diminish the triggering of providers' beliefs and subsequent impacts on differential treatment.

## CHC AND CONVERSATION ANALYSES OF CLINICAL DISCOURSE: ACCOUNTING FOR THE SYSTEMATIC YET VARIABLE INFLUENCE OF SOCIAL STATUS

An accounting of the systematic yet variable relationship between social status and health care interactions fruitfully builds upon a final body of scholarship with a somewhat different angle: patient-provider communication. Conversation analyses of medical discourse (Fisher 1986; Fisher and Todd 1983; Heritage and Maynard 2006; Maynard 1991, 2003; West 1984) aim for a close analysis of the conversation that occurs in the clinical encounter, given that much of what providers and patients do when they meet is to talk. These analyses reveal not only the overall structure, component activities, and distinct sequences of clinical discourse, but also important elements of the interaction order of the clinic and the strategies by which the encounter is jointly constructed. This research shows that the interaction order of the clinic is in certain ways unique, less flexible and more authoritative than that of the everyday world (Maynard 1991). Particularly relevant for this article is conversation analysis's insistence that, "rather than simply being imposed ... asymmetry is interactively *achieved*" (Maynard 1991:449, emphasis added). In other words, communication "is the very means by which participants *enact* patterns of authority, distinctions of class, discursive formation, and other institutional features that form the social surround" (Maynard 1991:456, emphasis added). The larger point here is that the outcomes of an interaction cannot be simply assumed from the relative structural positions of its participants; instead, social power and inequality are realized, that is, made real, through the interaction itself.

The conceptual tools we use to understand disparities in patient-provider interactions must therefore account for some variability in the relationship between social status and interactional dynamics in the clinic, while at the same time elucidating its generally hierarchical and asymmetrical interaction order. Cultural health capital is able to do both. On the one hand, its distribution and acquisition are strongly tied to social stratification; on the other, CHC imparts to its holders some measure of agency. It is not always inevitable that minority and low-SES patients have low CHC, or the converse. Displays of CHC can run counter to providers' previously held beliefs about their patients and offset status-associated disadvantages, complicating when and how clinicians' stereotypes get triggered. As most health professionals well know, there are always instances of patients who, despite being afforded every advantage, "drop the ball," while others, despite significant obstacles, "rise to the occasion." Thus, CHC provides a more complicated picture of the relationship between standard markers of social status and health care interactions.

Much like conversation analysis's ability to reveal how asymmetry is accomplished (or not) through talk, CHC helps to highlight the work that cultural resources—in the form of verbal and nonverbal cues, vocabulary, styles of dress, mannerisms, demonstrations of rational and calculating dispositions—do in health care interactions. These cultural resources serve as a means of exchange in patient-provider encounters, but as conversation analysts observe, they do so in an institutional context in which dominant participants have some power to define the kinds of activities, resources, and behaviors that carry value, that constitute cultural health capital. By postulating some possible patterns of exchange of CHC and the differing

conditions under which they might occur, we can conceptualize how unequal treatment is both systematically yet variably realized.

First, different elements of CHC may have different exchange values in different situations. Certain dispositions might be an asset in the outpatient clinic but not in the emergency room, or some skills may be advantageous in health care institutions serving middle-class, privately-insured populations, but not so in resource-poor county hospitals.

Second, CHC may have different exchange values when held by different individuals. That is, the ability of CHC to enhance clinical relationships may differ for patients of varying races and SES. Research indicates that economic and health returns to income and education are lower for people of color. Blacks, for example, are less able to convert their economic resources into residential quality (Massey, Condran, and Denton 1987; Villemez 1980), or their educational assets into income and wealth (Oliver and Shapiro 1997) or years of healthy life (Crimmins and Saito 2001). In much the same way, non-whites and the poor may be less able to convert the cultural resources and skills that they have into health care advantages. It is plausible, for instance, that some clinicians may hold preconceived notions that poor people lack sophisticated interactional skills and therefore do not recognize them even if such patients exhibit them, diminishing the potential effect that CHC displays could have. That is, as many scholars (Burgess et al. 2006; van Ryn and Burke 2000; van Ryn and Fu 2003) have found, providers may reflect and respond to patients on the basis of expectations rather than actual experience. Or, as Malat (2006) has suggested, non-white and poor patients may be less effective at activating and communicating the resources and skills they have. Or patients might feel unable to use the cultural resources that they in fact possess because of providers' status (Williams et al. 2007) or their interpersonal behaviors. Or providers may assign different meanings to the same behavior depending on the race or social class of the patient (Kunda 1999; Kunda and Sherman-Williams 1993; Lepore and Brown 1997). For example, asking questions about recommended treatment might be interpreted as minority patients' challenging medical expertise versus white patients' legitimate attempts to collect information (Burgess et al. 2006). In any of these scenarios, more CHC assets would be required to "overcome" the greater social disadvantages of minority and low socioeconomic status (in comparison to their white and higher-SES counterparts) in order to materially influence the care they receive.

There is also a dynamic, interactional, and cumulative aspect to the deployment and reception of CHC that can result in variable exchange rates for different groups. Johnson and colleagues (2004) found that providers were more likely to communicate in a verbally dominant manner with their African American patients than their white counterparts. In turn, African Americans who perceive they are being discriminated against in their medical care may react by being more skeptical of providers and less accommodating (Schnittker, Pescosolido, and Croghan 2005). Physicians in turn may respond by being less aggressive in diagnosis and treatment (Bloche 2001; Lutfey 2001) or, on the contrary, overly forceful in their recommendations. Conversely, a patient and provider might be so well-matched that they "hit it off," with growing good faith, mutual respect, and common understanding as the interaction progresses. In the processual give-and-take, back-and-forth of the clinical encounter, then, patients' and health professionals' habitual styles,

dispositions, and strategies of action (Swidler 1986) may reciprocally influence each other to result in systematically and cumulatively higher or lower deployment and exchange value of cultural health capital.

On the other hand, it is also plausible that patients of disadvantaged racial and socioeconomic groups may experience a higher return on the CHC they deploy, precisely because providers do not expect them to possess it. Krupat and colleagues (1999), for example, found that lower-SES cancer patients experienced greater benefit (in the form of more diagnostic testing) from assertive behavior than their higher-SES peers.<sup>7</sup> Lachman and Weaver (1998) concluded that perceived control had a stronger positive influence on health among those with fewer economic resources than their more resource-rich counterparts.

Finally, CHC may also have different exchange values because different providers may respond differently to varying kinds of cultural health capital. Although U.S. health professionals may have more or less similar perceptions of what counts as CHC, some patient attributes or skills may resonate better—and be more valuable sources of CHC—with some clinicians than with others. For example, older clinicians may be acculturated to more deferential patient roles, while recently trained clinicians may prefer relatively proactive patients. Practitioners often signal their views on the appropriate division of labor and responsibility for health care between themselves and their patients. Those patients who have the sensitivity to “read” their providers and understand what kind of interpersonal style he or she may favor, and who have the cultural agility to flexibly present themselves in varying ways, then have a greater likelihood of converting their cultural resources into care-related advantages. Finally, providers may adjust their own interactional styles to better match the needs and inclinations of their patients. All this requires sophisticated cultural skills and the tools to engage in complex interactional work on the part of both patients and providers alike. Thus the actual mobilization and efficacy of CHC represents an interactional accomplishment, “greasing the wheels” of the interaction, allowing for a more jointly “orchestrated” encounter and greater patient-provider compatibility.

The conceptualization of social, interactional, cognitive, and dispositional resources as forms of CHC, then, explicitly accommodates differential exchange rates that can vary by patient characteristics, provider preferences, institutional settings, and changing definitions of responsible behavior over time. Despite the variable exchange value of different forms of CHC, however, CHC as a general, functional entity should maintain an overall consistent relationship both to social conditions and social status from which it arises, and to the ability to optimize the clinical encounters in which it manifests. In this way, the concept of cultural health capital helps to elucidate the durable connections between social relations of power and the quality of health care interactions.

## CONCLUSION

In sum, I argue that cultural health capital provides a way to understand how features of patient-provider interactions—such as interpersonal rapport, exchange of information,

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<sup>7</sup>See note 1.

empathy, and trust—are accomplished or undone, based upon the repertoire of specialized cultural resources that patients bring to the health care encounter, in combination with providers' fostering of and receptiveness to those resources. That is, CHC constitutes a collective interactional achievement of clinical encounters, the mutual outcome of how patients, caregivers, and providers (and their gatekeepers) engage with one another. Cultural health capital offers a framework that helps to account for the emergent, cumulative, and reciprocal nature that often characterizes medical interactions. Sometimes patients and providers might simply hit it off, or, conversely, get off on the wrong foot. Or, over the course of the medical encounter, a clinician might change her initial judgments about the patient, the patient might find some way to make a fresh connection with the provider, or things may start to unravel. CHC provides a way to make sense of how this actually happens.

In this concerted sociological view, cultural health capital contests individualistic notions of culture, and instead takes up Bourdieu's conception of culture as a shifting, emergent set of resources that are critical to the pursuit of social privilege, the maintenance of stratification, and the exercise of power. Importantly, CHC—following Bourdieu's notion of habitus—is mobilized in largely unconscious, habitual schemes of perception, thought, and action that are embodied through experience and socialization and deeply stratified. CHC forefronts the fluid yet durably structured relationships between health professionals and gatekeepers, and patients.

Moreover, cultural health capital links the micro-interactional level of the provider-patient encounter to the macro-structural level of broad social hierarchies and distribution of resources. The concept of CHC seeks to direct our attention “upstream,” to the modes of accumulation, transmission, and exchange of this form of capital, and to the durable social arrangements and patterns of status, privilege, and advantage in which the “market” for CHC is embedded. The CHC concept also aims to direct our attention “downstream,” by helping to elaborate the multiple fluid relationships among patient social status, provider attributes, organizational settings, and clinical care. Conceptualized as a means of exchange, cultural health capital's rates of return may vary according to who has it, how it is deployed, where it is deployed, who is on the receiving end, and the emergent interactions which ensue. Race, class, and other markers of social status are seen as replicated in, or as refracted by, the specific forms and effects of cultural health capital.<sup>8</sup>

The concept of cultural health capital thus elucidates, on the one hand, some of the ways in which macro-structural inequalities in social status and power manifest in micro-interactions through shaping what confers advantage and how advantage is itself generated and regenerated in those situations. On the other hand, CHC also offers a potential account of some ways in which micro-interactional dynamics may produce macro-structural inequalities and exacerbate them over time. In short, this article argues that the concept

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<sup>8</sup>The dispositions, skills, and competencies that act as CHC also have potential relevance and explanatory utility for disease management, self-care, and health promotion that occur outside the clinic. Familiarity with medical knowledge, an instrumental attitude toward one's body, and a belief in the value of self-discipline are just some of the theorized elements of CHC that allow one to consider one's bodily condition and destiny as manipulable and controllable. But for the purposes of more precisely explicating CHC, I chose to focus on its role in health care interactions and the dynamics of unequal treatment.



of CHC offers a coherent perspective for thinking about, in the context of health care, the two long-standing sociological questions I opened with—namely, how social structural inequality manifests in clinical encounters, and how interaction-level phenomena accrete to produce systemic disparities in care. In this effort, the notion of CHC can act as a sensitizing concept that alerts researchers to a range of patient-provider interaction-related variables and phenomena that might be potentially important in stratifying care, and, in turn, disease risks and outcomes. In this respect, the notion of cultural health capital provides added theoretical traction in the endeavor to explicate and concretize the fundamental relationships among material conditions, social position, and health status, but in ways that also acknowledge the interplay of social structure with agency in daily life.

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