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

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Abstract: This paper is a literature review of articles published from 1992 to 2002 in the *American Journal of Health Education* using critical race theory as a lens of analysis of culture differences in healthcare.

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

In this illustration taken from the article titled, "The Life and Death of Mrs. Mildred, An Elderly Black Woman," it is apparent that social and economic differences exist between individuals in healthcare settings. The Civil Rights movement of the 1960's targeted various disciplines, including healthcare and healthcare education for reform. Governmental initiative H.R. 3250, Titles I through Title V, entitled Health Care Fairness Act of 1999 (as cited in Dingell, 2002), addresses issues of healthcare and research for minorities, data collection relating to race and ethnicity, medical and provider education regarding race and ethnicity, and other standards developed by the Office of Civil Rights.

The United States of America is an ethnically diverse country, representing numerous racial, ethnic, and cultural groups. Rutledge (2001) states that, "with the changing cultural makeup of many communities, a heightened understanding of the issues, challenges and opportunities faced by minorities is a must for everyone, especially for those who provide services" (p. 314). Because of these issues of race, ethnicity and equity in healthcare, we believe it is important that critical race theory (CRT) concepts be used to critique cultural competency in healthcare and healthcare education. CRT is a lens of analysis that views the world from the perspective of the underprivileged. The purpose of this paper is to analyze the literature published in the *American Journal of Health Education* using CRT as a lens. The first section of this paper explains critical race theory, followed by the method used, and concludes with a discussion of the findings and implications for the future.

Understanding Critical Race Theory

"The CRT movement is a collection of activists and scholars interested in studying and transforming the relationship between race, racism and power" (Delgado & Stefancic, 2002, p. 2). Critical race theorists attempt to inject the cultural viewpoints of people of color, derived from a common history of oppression, into their efforts to reconstruct a society crumbling under the burden of racial hegemony (Barnes, 1990). CRT investigates the assumptions behind the call for equal rights and seeks to re-evaluate and transform stagnant notions of equality, which serve to hide important differences of power between groups. It goes beyond traditional civil rights and ethnic discourses to place these relationships in economical, historical, social, and group contexts. CRT originated in the mid-1970s, when Derrick Bell (an African-American), and Alan Freedman (a White), Richard Delgado (a White Hispanic) and others began to challenge the "subtler forms of racism that were gaining ground" (Delgado & Stefancic, 2001, p. 3-4) following the early success of the Civil Rights movement. CRT was brought out of academia and into the public consciousness in 1993, after the controversy over President Clinton's nomination and withdrawal of Lani Guinier to be the first Black woman to head the Civil Rights division of the Department of Justice (Guinier, 2002).

Initially, CRT began as a critique of legal studies and subsequently spread to other disciplines since the CRT conference in 1989 took place in Madison, Wisconsin (Delgado & Stefanicic, 2001; Ladson-Billings, 1999; Roithmayr, 1999). This was a meeting that Harris (2002) identifies as one of the first CRT conferences. As a result, a growing number of scholars made race a central focus of their research and analysis (Ladson-Billings & Tate, 1995; Rubin, 1996; Taylor, 1999; Wing, 1996). In addition, other movements have splintered off CRT including a Latino critical theory. The LatCrit theory has been described as a close relative of CRT, which highlights Latina/o concerns and voices in legal discourses and social policies (Valdes, 2002). Despite the array of intellectual traditions and diverse disciplinary backgrounds of critical race theorists concur that a) racism is endemic to American life, b) CRT must confront history and pursue a contextual and historical analysis of social issues, c) CRT draws from the experiences of those being oppressed, and d) storytelling (voice) is often employed (Barnes, 1990).

Race and ethnicity among minorities affects the opportunity for access to healthcare and healthcare outcomes (Mayberry, 1999). Although much progress has been made since the Civil Rights movement, racial bias still echoes within healthcare, and the struggle for equity still continues. Addressing health issues has become increasingly important to public policy in the effort to change the health outcomes of Blacks, Hispanics and other minority Americans. Race and ethnicity are seen as fluid social constructs that have changed over time (Waters, 2000) and have no genetic or biological bias (Krieger, 2000). Figures from the 2000 U.S. Census Bureau reveals that minority groups such as Hispanics/Latinos, African Americans, Asians and Native Americans will compromise more than half of the U.S. population in 2050 (Estes, 2001).

Race is a social construct that has no basis in biology (Gregory & Sanjek, 1994) and is associated with a set of physical characteristics, which are perceived by others in ways that determine one's social power and privilege (Giroux, 1997). However, Webster's Dictionary (1991), defines race as a class or kind of people unified by communities of interests, habits, or characteristics. The goal of CRT is to reshape power relationships, as "power, access, status, credibility, and normality are all manifestations of privilege," (Rocco &West, 1998, p. 173).

Method

To examine cultural differences in healthcare through the CRT lens, we chose the *American Journal of Health Education*, which was first published in 1977, focuses on general health education, and does not focus on any one specific discipline within healthcare. The journal was originally named *Health Education* (January 1977 to December 1990), was renamed the *Journal of Health Education* (January 1991 to December 2000), and has again been renamed to the *American Journal of Health Education* (January 2001 to the present). Although the journal was available to review dating back to 1977, we reviewed the last ten years of articles published between January 1992 and August 2002 based on the assumption that CRT was firmly established by then due to the developments in the 1970's and 1980's. For this review, articles are defined to include literature reviews, research based and theoretical based publications. This did not include any book reviews, debates, editorials or rejoinders.

For the intent of this paper, the analysis will be based on these criteria emerging from the tenets of CRT: (a) race must be central to the consideration or interpretation of the research problem, (b) the research must be grounded in the experience of the underprivileged seeking equity in healthcare, (c) ethnicity and (d) voice.

We created a table with two descriptors, which were race, ethnicity and equity in healthcare with headings listed as year, volume, and page number. We each conducted a hand search in the journal indexes looking for titles and recorded the results on separate tables. We did this independently to reduce the risk of being influenced to include or exclude any titles. After completing our list, we correlated our results. If there were any differences of inclusion or exclusion of titles, we reviewed them together. We agreed upon 40 titles using our descriptors and we computed the number of titles and listed them by year and according to race, ethnicity and equity in healthcare. Some noteworthy differences are that no titles were found between the years 2000 and 2002.

In our second step, we read the abstracts from the forty articles to verify that all were related to race, ethnicity and equity in healthcare. The forty abstracts were reviewed independently and we correlated our results: only fourteen abstracts were chosen. On another table, we listed the fourteen abstracts by page number so we could easily access the articles.

In our third step, we used a Thematic Analysis, as described by Boyatzis (1998), to categorize the articles by the inclusion or exclusion of race/ethnicity and equity/voice in healthcare. The standards used to evaluate the articles were based on our criteria: a) race or ethnicity must be central to the consideration or interpretation of the research problem, or b) the research must be grounded in the experience of the underprivileged seeking equity and voice in healthcare. Our matrix included the following degrees of classification: Radical view (present and meets criteria), liberal view (small incremental changes – no drastic steps), minimally mentioned (used as a characteristic in the article) and absent (not present). This review process identified twelve articles that correlated with the descriptors that related to race, ethnicity, equity and voice in healthcare.

Findings and Discussion

The results of our Thematic Analysis showed that during the past ten years, the *American Journal of Health Education* published articles relating to race, ethnicity, equity and voice in healthcare. Although the twelve articles varied in degrees of classification, the articles discussed issues pertaining to the principles of CRT. The themes are cultural differences, access, health disparity, and healthcare education. We discovered that desparities in healthcare exist and varied

among cultures. Healthcare institutions and healthcare professionals must bridge the gaps that still exist between individuals to provide fair, equal and impartial care.

Cultural Differences

Cultural differences are differences between cultures that vary according to traditon, custom and practices that define an individual's and communities' beliefs (Glasgow, 1985). These differences and beliefs impact how various people from different cultural backgrounds view healthcare. For example, Southeast Asian refugees have to adapt to a new environment and are reluctuant to seek out social services because of suspicions about care and traditional use of alternative medicine. On the other hand, Russian refugees have higher expectations of healthcare based on their prior experiences with socialized medicine (Wei & Spigner, 1994).

Access

When we think of access to healthcare, we *think* of people with health insurance coverage, who know how and when to seek medical attention and in what form (private physician instead of emergency services). On the other hand, we think of those without health insurance who don't utilize preventive healthcare because of social and economic factors. For example, African Americans are percieved as "being products of a dysfunctional culture of their own making" (Spigner, 1994, p. 213).Therefore, the traditions and practices of this dysfunctional culture contribute to the health problems of African Americans (Spigner, 1994). On the other hand Cross (et al., 1989 as cited in (Denboba, Bragdon, Epstein, Garthright, & McCann Goldman, 1998) maintains that African Americans have limited access to political and economic systems that plan and adminster health services (Denboba et.al., 1998).

Health Disparity

Health disparities are differences in the time spent trying to get healthcare, information about healthcare being available but not known by different groups, quality or availability of insurance, transportation, and other factors that act as deterrents. These deterrents are often culturally specific being visible to some and invisible to others. The development of cultural competence among healthcare professionals is one mechanism used to decrease disparity (Denboba, et.al., 1998). Another tactic is for underserved communities, rural or urban, to develop health promotion cooperatives (Wagner, 1994).

Healthcare Education

Health education is a way to disseminate information about the trends and issues in healthcare. It is also a way to instruct the medical community and the general public about the prevention, diagnosis and treatment of symptoms, conditions and disease. For example, healthcare professionals need to design educational programs for specific populations like Hispanics (Pinzon & Perez, 1997), Mexican Americans (Stauber, 1994), African Americans (Chng & Fridinger, 1994) and racial and ethic descriptors (Lacey, 1992).

Implications for the Future

Critical race theory awareness can be achieved through education. We encourage the *American Journal of Health Educati*on to continue promoting articles relating to race, ethnicity, equity and voice in healthcare. Although we sometimes have distorted and limited views of other people's culture and history, we must find ways to achieve cultural competency at all levels throughout our community and around the world. Cultural competency is defined "as a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross

cultural situations" (Cross et.al, 1989). The Joint Commission on Accreditation of Healthcare Organizations (2002) states

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

The healthcare industry must continue to address issues of race, ethnicity and equity through cultural competency. Knowing something about different cultures, beliefs, values and traditions are essential to overcome cultural gaps in the healthcare setting. Although, no one can be expected to know everything about every culture, we should learn something about the most common patterns of the populations we typically encounter. We must keep in mind the fact that there are variations both within each group and among individuals. As adult educators and healthcare professionals, we must continually nourish the awareness and understanding of the cultural differences and needs of our patients, peers and students.

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