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Training, Communication, and Competence: The Making of Health Care Professionals

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The role of medical anthropology in tackling the problems and challenges at the intersections of public health, medicine, and technology was addressed during the 2009 Society for Medical Anthropology Conference at Yale University in an interdisciplinary panel session entitled Training, Communication, and Competence: The Making of Health Care Professionals.

The discipline of medical anthropology is not very formalized in the health setting. Although medical anthropologists work across a number of health organizations, including schools of public health, at the Centers for Disease Control (CDC†), and at non-governmental organizations (NGOs), there is an emerging demand for an influential applied medical anthropology that contributes both pragmatically and theoretically to the health care field.

The role of anthropology at the intersections of public health, medicine, and technology was addressed during the 2009 Society for Medical Anthropology Conference at Yale University in September. In a conference session entitled Training, Communication, and Competence: The Making of Health Care Professionals, health professional career issues, including training and education, medical entrepreneurship, and the maintenance of clinical relationships with patients were examined. The presentations encompassed macro approaches to institutional reform in training, education, and health care delivery, as well as micro studies of practitioner-patient interaction. Seemingly disparate methodological, disciplinary, and theoretical orientations were united to assess the increasing relevance of medically oriented anthropology in addressing the challenges of health care delivery, health education, and training.

Margaret Bentley, a professor of public health at the University of North Carolina, Chapel Hill, spoke about the increasing "epidemic of global health" in universities, noting a doubling of global health majors within the past three years. Despite this expansion of the field, a common discipline

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†Abbreviations: CDC, Centers for Disease Control; NGO, non-governmental organization.

of global health continues to be developed. In September, the Association of Schools of Public Health (ASPH) and the University of Minnesota hosted a Global Health Core Competency Development Consensus Conference with the initiative to explore "workforce needs, practice settings, and to identify core constructs, competency domains, and a preliminary global health competency model"[1]. Given the current variability in training, Bentley believes medical anthropology is uniquely suited to inform training in global health because of its offerings in the way of interdisciplinary methods and team-based applied field experience.

Anthropologists Carl Kendall of Tulane University and Laetitia Atlani of Université de Paris X Nanterre have seen medical anthropologists examine models of health strictly within a clinical experience. Understanding of the social determinants of epidemiology, methodological issues of population health, and survey research is crucial. However, training individuals through a more formalized program (currently in development in Europe) will allow anthropologists to better understand context, explain complex models, humanize aggregate statistics, and articulate methods of the multidimensional "social field" of health outside of the clinical experience.

The social field of health, however, as Robert Like of the University of Medicine and Dentistry of New Jersey explained, shares an uncomfortable interface with clinical medicine. Recent efforts by the New Jersey Board of Examiners to incorporate cultural competency legislation have been robustly criticized. Evaluations of six-hour training sessions on cultural competency training have revealed health professionals' frustration with the health care system's inability to deal with "culturally different" individuals. In fact, the majority of health professionals who were required to complete the training believe cultural competency to be an area of study that is a "waste of time."

This opposition to cross-cultural education and the value of "cultural competence" training also has been a topic of great debate among anthropologists and health researchers. Despite the ubiquitous use of the term among research and health professionals, cultural competency is a term that cannot be defined precisely enough to operationalize.

In "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It," Arthur Kleinman and Peter Benson asserted that the static notion of culture in the medical field "suggests that a culture can be reduced to a technical skill for which clinicians can be trained to develop expertise" [1]. T.S. Harvey, a linguistic and medical anthropologist at the University of California, Riverside, expounded on Kleinman's opposition to competence as an acquired "technical skill" [1] and suggested reconceptualizing the approach to competence as communication. Although Kleinman's explanatory models approach [2] provides a health care professional with what to ask the patient, Harvey pulls from Dell Hymes' communicative competence [3] to understand how to ask it. Harvey recommended viewing competence as a "sociolinguistic acquisition … like a foreign language" where competencies are rule-governed and communication and speech events are formulaic.

Harvey also noted that the "onus of cultural competency" is too often placed on the practitioner. Inevitably, there is an asymmetry in every clinical encounter, whereby the "would-be patient" is perpetually considered the "passive receptor." Patients also share a stake in their health and, as such, should be taught communicative competence as well.

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[1]The Global Health Core Competency Development Consensus Conference was held September 24-25, 2009, at the University of Minnesota. The preliminary objective of the conference was to explore workforce needs, practice settings, etc., and to identify core constructs, competency domains, and a preliminary global health competency model.

stake in their health and, as such, should be taught communicative competence as well.

The role of the patient is made ever more complex by the power relationship that exists in the patient-provider context. Through ethnographic research, Sylvie Fainzang, director of research in the Inserm (Cermes), examines how doctors and patients lie. She argues that lying, in the context of secrecy, is an indication of a power relationship [4]. Fainzaing's further research on the relationship between doctors and patients has yielded additional information on how patients learn about their diagnoses and how they will react to these diagnoses. Though a clinical encounter between a doctor and patient is expected to be one of informed consent, doctors often judge patients upon their ability to "intellectually understand" [4] and assess who is "psychologically ready" [4] to bear the information. This leads to manipulated, misinformed, and "resigned consent" [4]. This sort of social training of obligation of a subject to medical authority provides the patient with the choice either to conform or overthrow the rules as defined by society.

Collectively, this interdisciplinary panel worked to inform the discussion on how medical anthropology can address training, communication, and competence at the intersections of medicine, public health, and education. By reviewing health professionals' growing interest in public health, training in health education and competence, and the patient-provider relationship, medical anthropology can be seen as both relevant and necessary to addressing the challenges faced by the medical and health community today.

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