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CULTURAL CAPITAL IN HEALTHCARE DELIVERY: FROM PATIENT-PROVIDER PERSPECTIVE IN NIGERIA

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ABSTRACT

Healthcare delivery system in Nigeria has been replete with decadence and decay. Overwhelmed persistently by several social inequalities and inequities, the system continues to receive backlashes in spite of spirited efforts by concerned professional groups to revamp it. Healthcare delivery in Nigeria still remains a labor-intensive industry rather than the less complicated, technologically-enhanced one (Obansa, 2013). In addition, healthcare delivery in Nigeria is supplied through a weak conduit (National Strategic Health Development Plan, 2009). Government has been accused of not being sincere in injecting health into the healthcare system. Thus, the growing perception by the public of some concerted efforts at some quarters to create unequal care in the society (Shim, 2010). But a variable that needs to be factored in into this schism could be the influence of cultural capital in patient-provider interaction. This article will essay to explore the multifaceted nature of patient-provider involvement and its ramifications within the context of Bourdieu's conceptual model of cultural capital.

Key Words: Society's symbolic, Cultural capital theory, Cultural capital in healthcare

WHAT IS CULTURAL CAPITAL?

Coined by Pierre Bourdieu, a French sociologist, cultural capital connotes an avalanche of artistic, aesthetic, and innate knowledge held by individuals in a community (Dunt, Hage, and Kelaher, 2010; Khawaja and Mowafi, 2007; Smith-Morris and Epstein, 2014). The concept of cultural capital has also been described and defined as interpersonal competence and shibboleth received via interactions with the society and being able to make and show treasured normative behaviors and knowledge (Vorhies, Davis, Frounferker, and Kaiser, 2012). Bourdieu's idea of cultural capital show that social stratification contributes to social inequities (Ergin, n.d.) and that cultural competence consists of linguistic and cultural elements (Dumais, 2002). As a cultural signal, including such things as attitudes, preferences, formal knowledge, behaviors, goods, and credentials, cultural capital has been used to examine relationships between so many social and health outcomes (Byun, Schofer, and Kim, 2012; Hernandez and Grineski, 2012; McCrone, 2005). Finally, cultural capital, according to (Fismen, Samdal, and Torsheim, 2012) is an embodiment or repertoire of society's symbolic and in-

formational resources that could have an impact on health behaviors.

CULTURAL CAPITAL THEORY

The theory of cultural capital presages that success or failure are both tied to either the possession or lack of cultural capital. For instance, success in education equals possession of cultural capital while failure in education exemplifies absence of such capital (Sullivan, 2002). In addition to the bifocal presentation of cultural capital is the issue of social class. Two fundamental fulcrum of Bourdieu's cultural capital theory are the "field" or the environment and the "habitus" or how the individual perceives the world (Dumais, 2002; Ringenberg, McElwee, and Isreal, 2009). These two factors shape or determine the degree of cultural capital. It is crucial to consider the function of the environment in which the individual resides and how this social ambiance shapes the individual's worldview when analyzing the patient-provider paradigm (the social action) in healthcare delivery system.

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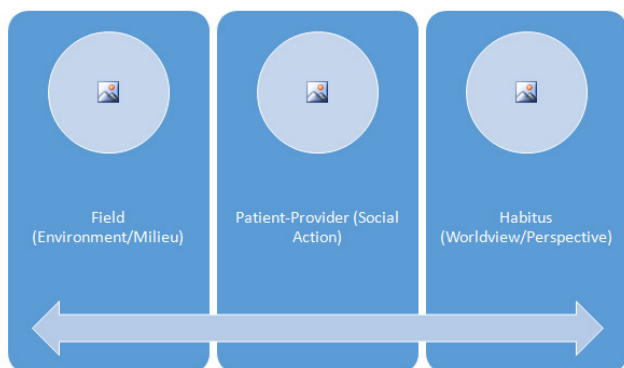


Figure 1: Cultural Capital Components

As Fig. 1 above illustrates, the field or environment, in relation to this discussion, could be explained as the community, city, village, town, state one lives in. On the other hand, the habitus could be described as one’s decision to interact, reveal, and explain every details of one’s health condition with the healthcare provider (nurse, physician, dietician, pharmacist, dentist, etc) for the recipient and giver to make informed healthcare decisions. This decision to interact fluently and openly with the healthcare professional could be guided by the field or environment in which one comes from. Transmitted tradition and received culture could bar an individual, especially those who live in the village or suburbs, not to tell his or her healthcare provider every detail of her health issue. This could result into wrong diagnosis and treatment. But with exposure to city life and interaction with technology and people, there are chances that someone who lives in the city could be more open with the healthcare provider than someone from the village. Thus, the likelihood for good prognosis and treatment.

Cultural capital theory has three core elements or attributes. These three states of cultural capital, as shown in Fig. 2 below, are institutionalized, objectivized, and incorporated (Abel and Frohlich, 2012; Abel, n.d.).

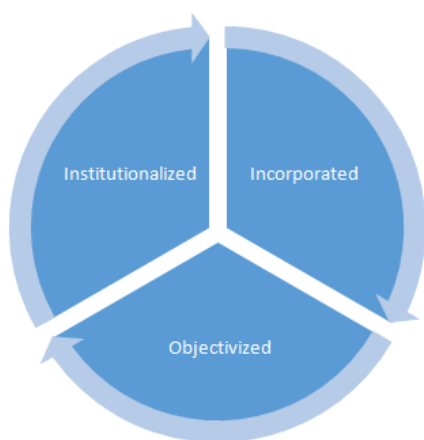


Figure 2: Subcategories of Cultural Capital

Incorporated cultural capital is invisible, personally acquired or learned, and associated with the innate biological traits of the individual. In other words, incorporated cultural capital comprises all the stored skills and knowledge of the individual that can be acquired through the culture. The other subcategories, objectivized and institutionalized are equally linked to the incorporated cultural capital. By objectivized cultural capital we mean things that represent knowledge and has been accumulated over time in a culture or society such as a book. Finally, institutionalized cultural capital simply means the formal recognition or acknowledgement of the cognitive skills and pragmatic competence exemplified through the acquisition of a college degree. Since Bourdieu, there has been criticisms about the empiricism of Bourdieu’s theory of cultural production (Dumais, 2002; Holt, 1997). All these trilaterally related states of cultural capital could help healthcare and public health practitioners develop clinical and population health programs.

DISCUSSION

Patient-centered care is all about the patient and the patient’s healthcare needs (Epstein and Street, 2011; Reynolds. 2009). To have a successful outcome while attending to the patient and his needs, there should be an understanding of the patient’s cultural knowledge, skills, needs, values and preferences (Dubbin, Chang and Shim, 2013) and a built trust between the patient and the healthcare professional. This trust enhances openness on the patients’ part and confidentiality and ability to deliver best care on the healthcare professional’s part. This dual-patriate deal reinforces patients’ empowerment. But empowerment cannot occur in a vacuum. An interaction to enable understanding of the patients’ perspectives and the environment that shapes the patient’s worldview must occur. Full exchange of information and understanding of the information being exchanged determines the individual’s health outcome (Shim, 2010). In other words, during clinical encounters, both the patient and the clinicians are expected to possess this package called cultural health capital.

Healthcare literacy, knowledge and understanding of medical resources could enhance health outcomes and increase patient-provider interaction. Given the dictates of cultural capital, individuals who are less educated could be prone to subjugation by the dominant culture and may have a low-level medical assistance or care (Vikram, Vanneman, and Desai, 2012). The educated population have greater propensity to navigate the ever changing healthcare system, especially in the developed worlds. Understanding of several cultural products such as eating habits, educational levels, verbal skills, acts as forms of capital to patient-practitioner conversation (Dubbin, Chang and Shim, 2013). Furthermore, building this bridge of understanding may involve living between

two tracks from the patient perspective. For example, one may be trapped between choosing a lived experience embodied in what has been transmitted or passed on from parental knowledge and skills and the culture of the healthcare system as explained by the nurses, pharmacists, physician, and other healthcare professionals (Smith-Morris and Epstein, 2014). In Nigeria, for instance, physicians have been perceived to have the notion that they know what is best for the patient and, therefore, limiting the patient's input in his or her care (Udonwa and Ogbonna, 2012). The above notion could foreclose seamless interaction between the physician and the patient and may not provide room for understanding of the cultural capital. Moreover, 95% of patient's treatment are decided by the physician with less patient involvement (Onotai and Ibekwe, 2012).

Healthcare literacy should be broadened to include understanding of the patient's field and habitus by healthcare professionals. Acquiring this knowledge-based competency by nurses, doctors, dentists, pharmacists, and other allied healthcare workers may enhance health promoting behaviors among patients (Abel, n.d.). Health literacy may be approached as a dual mechanism that might result into health gain. In this sense, the patient and the provider works towards understanding each other's environment and worldview. Healthcare workers, especially in a diverse culture like Nigeria, may begin to decipher whether handing out brochures, leaflets, promotional pamphlets, using the internet suits the patient's learned environment and habitus. As herculean and utopian as this may be, the goal may be working towards a net gain for all players.

Presently, the healthcare delivery system in Nigeria is doctor-centered. In other words, the physician makes the diagnosis and treatment with little or no patient involvement. So, the doctors bring into the medical practice their cultural capital via their field and habitus. Abiola, Udofia, and Abdullahi (2014) has described this as paternalistic or asymmetric relationship between doctors and patients. This physician paternalism has been replicated in Brazil, a developing country like Nigeria, where the focus of medical students is not on the interactional skills or humanistic attitudes rather on biomedical subjects (Ribeiro, Krupat, and Amaral, 2007). The paternalistic physician behavior has been described as being beneficial to the patient because the doctor pays attention to holistic medicine (Israel, 2014). Doctor-patient relationship in some Nigerian hospitals have been described as dialogical and transactional with a mention of understanding the field and habitus of the patient (Adegbite and Odeunmi, 2006).

CONCLUSION

This article builds on existing literature to buttress the importance of cultural capital in healthcare promotion and patient-

provider interaction in Nigeria. Given the backdrop of events in the healthcare system in Nigeria, time is of the essence to finding practical panaceas to the ailing industry. One of such solutions may be using cultural capital in fostering better partnership between patients and healthcare professionals. The debate in relation to cultural capital in health promotion may portray two divergent perspectives of the impact of this variable on health outcomes. Future research may establish whether promoting cultural capital could improve health for all and strengthen patient-provider partnership in the Nigerian healthcare landscape.

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