

Beyond the Plate: Patterns of Cultural Cuisine Representation in Hospital Menus Across Texas

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ABSTRACT

Diverse cultural representation within menus is crucial within healthcare due to its connection to patient satisfaction, dietary intake, and overall patient health. This study focuses on identifying patterns in the representation of cultural cuisines across hospital menus in urban and suburban Texas counties.

This study collected 32 menus across 21 Texas counties, which were analyzed using a content analysis methodology. The food items within the menus were coded into the following eight categories based on the predominant cultural origin/influence: Hispanic, Asian, European, African, Southern, Mediterranean, Neutral, and Basic. The coded qualitative data were then analyzed for presence, percent composition, frequently occurring items/dishes, and most frequently represented countries.

Findings reveal limited cultural representation through four main patterns: (1) neutral dominance, (2) limited options, (3) emphasis on familiarity, and (4) geographical concentration. The presence of low cultural diversity in hospital menus poses potential concerns over patient health outcomes within Texas, with implications outlining the possible need for dietary policy revisions. These findings can contribute to discussions on cultural competency, patient-centered care, and strategies for improving inclusivity within hospital dietary sectors.

INTRODUCTION

Food is a fundamental component of human life, existing not only for nourishment but also as a powerful component of personal identity. For individuals across the world, cuisines reflect their heritage, traditions, and cultural values. The role of meals becomes especially crucial in the settings of healthcare, where it plays a central role in the patient's health and recovery. Within the United States, hospitalized patients are notably diverse, a trend shaped by the large influx of immigrants throughout history. This is especially evident in states such as Texas, which is composed of 38.7% Whites, 40.3% Hispanics, 13.7% Blacks, and 6.4% Asians ("Quickfacts: Texas," 2024). This establishes the importance for Texas hospitals to provide culturally diverse meals that align with the varied backgrounds of their patient population. Being

successful in this ability to meet the needs of individuals with diverse preferences, values, and traditions is known as cultural competence (Stubbe, 2020).

The adoption of this concept in the framework of healthcare was driven by the 1950s Culture Care theory of Madeleine Leininger, which stressed the necessity of cultural understanding in enabling effective interactions and treatment of patients across different cultural contexts (Kte'pi, 2023). The measure of cultural competence in a healthcare facility can be evaluated through various factors such as patient-provider interactions, medical staff knowledge, and the organization's policies. Among these components, the food services can also serve as a valuable indicator through their meal options that are representative of different heritages. However, the matter of how different cultures are represented and included in the hospital's food options is often not addressed in the discussions of cultural competence.

Using a content analysis methodology, this study aims to address this gap through the collection and analysis of menus across various Texas counties. Ultimately, this research aims to answer the following question: What are the current patterns of cultural cuisine representation in inpatient menus of acute-care hospitals across urban and suburban Texas counties?

LITERATURE REVIEW

Regulation and Administration of Food in Hospitals

The decisions regarding the food served within healthcare are multifaceted, influenced by factors such as regulations and hospital staff. On a state level, agencies such as the Texas Health and Human Services require hospitals to comply with conditions regarding permits, preparation, sanitation, and inspection of the institution's food ("Statutes and Laws," n.d.). This ensures the proper handling and safety of the provided meals. When shifting the focus toward the contents of the food, the federal Centers for Medicare and Medicaid Services (CMS) requires partnered hospitals to meet patients' nutritional requirements in a manner that is aligned with dietary standards ("State Operations Manual," 2024). With an emphasis on safety and nutrition, these federal and state-level regulations largely exclude conditions about the expectations for the inclusion of culturally diverse meals. While there are certain CMS clauses regarding the consideration of patients' cultural background and preferences, it primarily applies to long-term care facilities rather than hospitals in general. That gap is partially addressed through The Joint Commission (TJC), an organization from which many healthcare organizations seek certifications. According to the Joint Commission (2010), hospitals are required to respect the patient's cultural and personal preferences in order to qualify for accreditation. While this condition is not about food specifically, it does establish a broader expectation of cultural sensitivity and patient-centered care that extends to menu designs. As a result of regulatory policies mainly focusing on patient safety and nutrition, the inclusion of cultural preferences in food services is largely influenced by the decisions of the dietary directors, registered dietitians, and nutritionists within the hospital. In recent years, there has been considerable effort to improve cultural understanding among hospital staff through cultural competency training. Evidence from

analysis of systematic reviews suggests that this training has a positive influence on the cultural competence of healthcare professionals (Lee et al, 2025). However, despite the improved cultural understanding of healthcare workers, certain scholars argue that it may not be sufficient by itself in overcoming the current framework of policies that do not incentivize the proper implementation of diverse menus. Minakshi Raj (2024), for instance, emphasizes how the opaque responsibilities of dietary authorities, lack of policy clarity, and the absence of implementative guidance pose practical barriers to the adoption of more culturally diverse menus.

Food Intake and Patient Satisfaction

Within the United States, 20%-50% of patients have malnutrition (Cass & Charlton, 2022). This highlights a rising concern, as malnutrition can contribute to adverse outcomes such as increased risk of complications, prolonged recovery, and longer length of stay at the hospital (Barker et al., 2011). Although food intake is influenced by various factors, patient satisfaction plays a central role. This is supported by a cross-sectional study of 844 inpatients, where a one-point increase in food satisfaction resulted in a 45% decrease in the likelihood of food waste (Hadjimbei et al., 2025). This highlights the importance of improving the food services in order to promote consumption among patients. Numerous studies suggest that the incorporation of culturally diverse food options can help achieve that goal. For instance, the works of professors at Loma Linda University revealed that better meal diversity is one of the factors that elevates patient meal satisfaction (Barros et al., 2025). This suggests that a menu design with options of varying cultures, ingredients, and flavors would score higher on patient satisfaction compared to a homogenous list of options. Possible reasons for this increase in patient satisfaction can include reduced meal fatigue and enhanced ability to select foods that align with personal preferences. Personal preferences play an especially important role among immigrants, who are more familiar and accustomed to the meal characteristics from their own culture. This idea is supported through a study analyzing patient experience in an Australian hospital lacking cultural inclusivity. Conducted by Caitlin Wyman et al. (2025), a certified dietitian, the findings revealed that non-English speaking patients faced hindered food consumption due to the lack of cultural connection with the provided meals. Furthermore, the patients reported feeling like a “minority” due to the lack of culturally familiar options in the Australian-dominated menu (Wyman et al., 2025). This illustrates how a lack of diverse options can alienate individuals from non-dominant cultures, which can reduce feelings of belonging and comfort within the hospital. The feelings of exclusion, combined with the lack of food that meets personal preferences, ultimately cause emotional discomfort and possible reduction in food intake.

Nutritional Benefits of Diverse Menus

The incorporation of cultural foods can also foster health benefits through their nutrient and bioactive composition. Cuisine across various cultures is notably diverse, shaped by different ingredients, preparation methods, and historical influences. This diversity is recognized by Kelly Nemec, a registered dietitian and licensed dietitian nutritionist, who observed high variability in protein sources across different cultures. Mexican cuisine, she notes, is dominated by proteins from pozole, grilled steak,

carnitas, and enchiladas; Chinese cuisine by dumplings, beef, lamb, tofu, and stir-fried chicken; and Indian cuisine by plant-based proteins such as beans and lentils (Nemec, 2020). As a result, the incorporation of diverse cultural foods in hospital menus can encourage the intake of macronutrients from diverse sources. This variability is important as it can help promote the dietary diversity of the patients, which is positively linked to diet quality. An analysis of 3035 patients corroborates this idea through its findings of greater diet diversity being associated with increased consumption of fiber, fruits, and vegetables, as well as a decreased intake of highly processed foods (Russo et al., 2023). This is further supported by an analysis of surveys conducted by the USDA Agricultural Research Service, which revealed a positive relationship between food variety and the ability to obtain a greater range of essential nutrients (Foote et al, 2004). As a result, diverse nutrient intake can help promote the health of the patients and their recovery.

Beyond just nutrition, various traditional dishes have also been found to contain bioactive properties that are beneficial to health. Kimchi, for instance, is a popular traditional side dish in Korea that is created through the fermentation of vegetables and is known to have probiotics that aid digestive and immune health (Park et al., 2014). Thus, the incorporation of traditional regional dishes can not only provide a sense of cultural familiarity and inclusion but also promote the physical health of the patients through their variety and contents.

Gaps in Existing Research and Significance

The existing research discusses the political framework behind hospital food services, as well as potential benefits of diverse menus through the lens of patient satisfaction, food intake, and nutrients. Despite evidence suggesting the influence of menu options on patients' recovery and health, limited research has directly examined the content of hospital menus from the angle of cultural representation. As a result, it remains unclear whether current hospital food services are adequately incorporating culturally diverse options to meet the dietary preferences of the multicultural U.S. population. Using a content analysis methodology, this study aims to address this knowledge gap through the collection and analysis of inpatient menus. By examining the characteristics of the food items and categorizing them in accordance with their cultural influences, this study identifies patterns in how different cultural cuisines are represented within current hospital institutions. Given the high diversity of the Texas population, this state becomes especially relevant for this type of investigation. As a result, this content analysis study aims to address the following question: What are the current patterns of cultural cuisine representation in inpatient menus of acute-care hospitals across urban and suburban Texas counties? It is hypothesized that there will be an overall low to moderate inclusion of cultural groups, with a greater representation of neutral and Hispanic cuisines. By collecting empirical data on the frequencies of the prevalence, composition, and characteristics of cultural representation, this study provides an improved understanding of the hospital dietary decisions and the role of cultural sensitivity. Ultimately, the findings can provide valuable insight into cultural competence among Texas hospitals and the effectiveness of present policies relating to cultural inclusion.

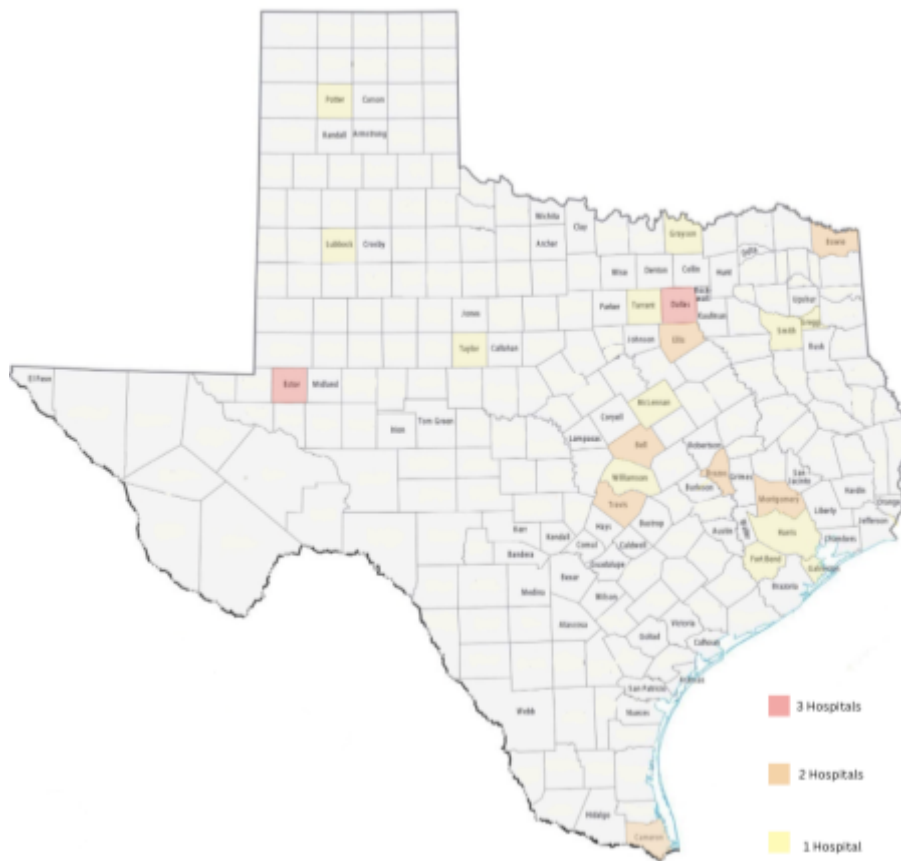
METHODOLOGY

This study aims to identify patterns in the cultural representation of food items within menus of urban and suburban Texas hospitals using a conceptual content analysis methodology. This method was chosen because it allows for the analysis of qualitative information (names of food items) to obtain quantitative data on the presence and frequencies that are central to the goal of identifying patterns in cultural representation within menus. The objects being studied are regular hospital menus that are designed for patients without dietary restrictions. This ensures a more valid representation of cultural cuisine options, as certain therapeutic diets can limit the inclusion of cultural foods through texture and nutritional restrictions. Furthermore, the focus of the study is limited to acute-care hospitals, as they offer inpatient care in which meals are provided throughout the duration of the patient's stay. On average, the length of stay in an acute-care hospital is 4.69 days ("Hospital Average," 2025). As a result, patients within these facilities consume numerous meals during their hospitalization, creating greater significance for this study's findings.

Sampling and Data Collection

Out of all the hospitals that met the criteria ($n=383$), this study randomly selected 139 hospital locations with one to three hospitals per county, depending on the number of acute-care institutions present within the geographic area. Random selection was assured through the utilization of a random number generator that provided an equal chance for each hospital to be selected. In the end, this study was unable to obtain menus for certain hospitals, reducing the sample size to 34 menus. Two menus (5.8%) were identified as outliers and removed from the data pool. The outliers contained fewer than four cultural items in their menu, causing extreme values that would skew the quantitative results of the content analysis. As a result, the final sample consisted of 32 menus with representation from 21 counties. The distribution and number of menus collected across counties can be visually observed in Figure 1. The menus were collected through verbal phone calls with the hospital staff, typically from dietary or kitchen departments, which were then recorded and transcribed for analysis.

Figure 1: Composition and Distribution of Menu Data Sample



Content Analysis: Coding Categories

After the completion of sampling and data collection, individual menu items were studied and coded into one of the eight categories based on the predominant cultural origin or influence. The primary factors analyzed for each item included: (1) the item's origin, (2) ingredients, (3) preparation methods, and (4) historical influences. The inclusion criteria for these categories are defined below, with the summary and examples found in Table 1.

1. Hispanic. Contained menu items, ingredients, or preparation methods of Mexican, Central American, and Latin American origins. Items, ingredients, or preparation methods that did not originate in these areas, but have a significant and distinct influence from these regions (e.g., Tex-Mex cuisine) were also included.

2. African. Contained menu items, ingredients, or preparation methods of Caribbean and African continental origin, excluding North African countries of Morocco, Algeria, Libya, Tunisia, and Egypt. The listed countries were not coded into this category to reduce overlap with the Mediterranean category.

3. Asian. Contained menu items, ingredients, or preparation methods of Asian continental origin, excluding Russia. Foods from Russia were not coded into this category to avoid overlap with the European category. Items or ingredients that did not originate in Asia but have a significant and distinct influence from these regions were also coded into this category.

4. European. Contained menu items, ingredients, or preparation methods of European continental origin. All Russian items were included in this category, as the European region contains a higher population density, as well as the greater prevalence of major cities and historical events in comparison to the Russian area located in Asia. Items or ingredients that did not originate in Europe, but have a significant and distinct influence on these regions, were also coded into this category.

5. Southern. Contained menu items, ingredients, or preparation methods that are typically associated with the Southern United States. This includes Creole and Cajun Cuisine, which are marked by the fusion of West African, European, and Indigenous traditions.

6. Mediterranean. Contained menu items, ingredients, or preparation methods that have originated or are heavily influenced by the Mediterranean region.

7. Neutral. Items were coded as Neutral if they originated in the United States, with the exception of Southern cuisine. This category also includes items that lacked a distinct cultural influence or have become widely consumed across multiple cultures.

8. Basic. Items were categorized into Basic if they were single-ingredient items that lacked detail on preparation, were manufactured/packaged items, or drinks. In the calculations for data analysis, items of the 'Basic' category were not included as they typically lacked relevance and accuracy.

Category	Inclusion Criteria	Example
Hispanic	Items originating from or strongly influenced by Mexican, Central American, and Latin American cuisines; Includes Tex-Mex	Enchiladas, Quesadillas, Ceviche, Refried Beans.
African	Items originating from Caribbean and African cuisines; Excludes North African countries	Jollof Rice, Egusi Soup, Jamaican Jerk Chicken.
Asian	Items originating from or strongly influenced by Asian cuisines; Excludes Russia	Fried Rice, Hibachi-style dishes, Kung Pao Chicken

European	Items originating from or strongly influenced by European cuisines; Includes Russia	Beef Stroganoff, Pasta Pomodoro, Beef Burgundy
Southern U.S.	Items originating from distinct West African, European, and Indigenous fusion; Includes Soul and Cajun cuisine	Fried Chicken, Barbecue, Biscuits, Chicken-fried Steak.
Mediterranean	Items originating from or strongly influenced by cuisine from the Mediterranean region	Hummus, Lemon-herb Chicken
Neutral	Items with no distinct cultural influence; Items that are globalized and consumed in many cultures; Items originating in the United States, excluding Southern dishes	Hamburgers, Mashed Potatoes, White Rice, Macaroni and Cheese
Basic	Items lacking detail, packaged foods, or beverages	Broccoli, Carrots, Rice Krispies, Cheerios, Milk, Water, Soda

Table 1: Coding Criteria for Cultural Categories

The coding criteria were created for the purpose of ensuring an objective analysis of the menu items and to maintain consistency with the categorization. Consistency was further established through the utilization of a codebook that kept a record of items and their corresponding categories in a clear format. This assisted with the tracking of coded foods and helped guarantee consistent categorization for repeated items. To additionally decrease variability, a standardized process was established for the evaluation of each individual menu option. Visualized through a decision tree in Figure 2, every item followed the same sequence of questions that guided its classification. This limited variance in how different foods were processed during categorization while promoting a consistent application of the coding criteria. Although pilot coding and external review were not implemented, subjective judgement in the coding decision was minimized through a comprehensive review of every dish. This evaluation referenced multiple independent sources, including reports of food historians, articles of culinary journalists, recipes with authors' discussion on the dish's background, and food encyclopedias. A specific cultural category was only assigned in the presence of consistent agreement across the different sources, never based solely on one reference.

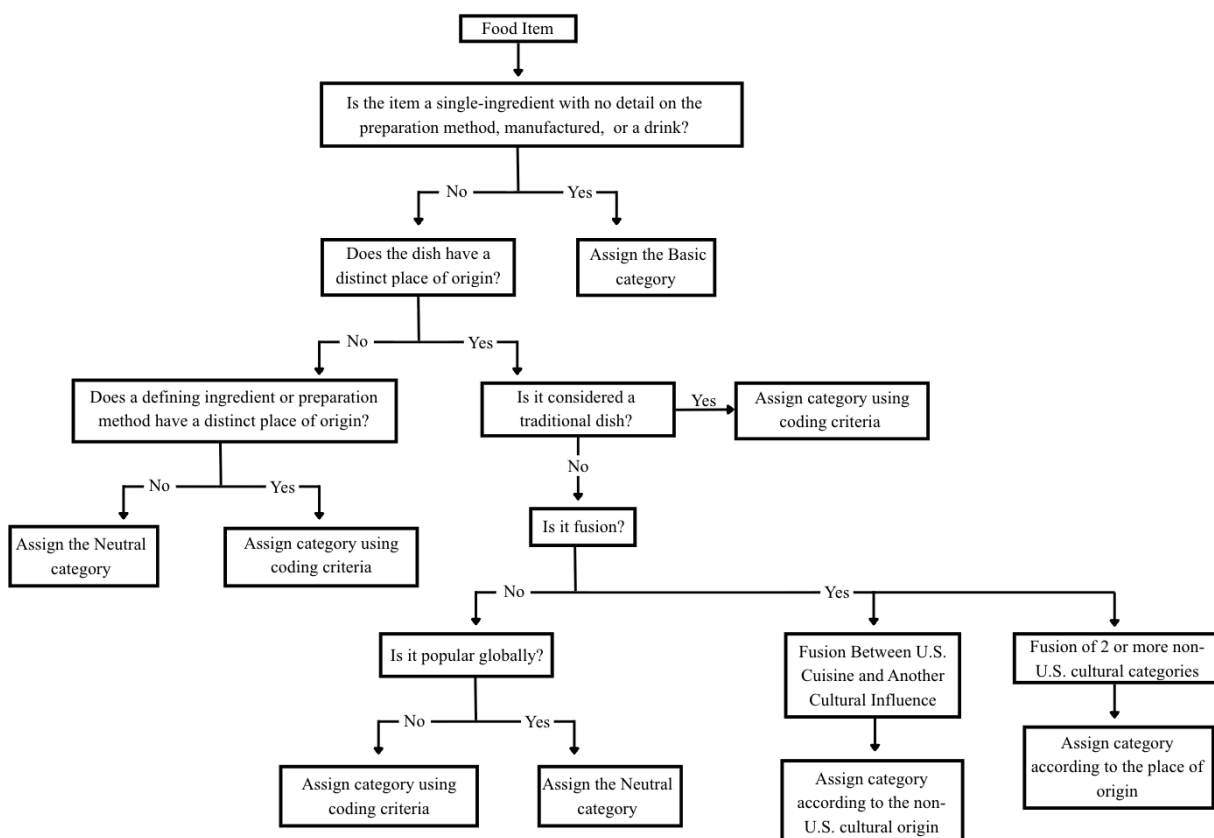


Figure 3: Decision-Tree for the Food Categorization Process

For fusion dishes combining elements of U.S. cuisine and another culture, the item was coded according to the non-U.S. influence. This decision was established to ensure the effort to incorporate elements of foreign cuisine into the Texas menu options was captured, even if the item was not traditional. For dishes fusing two non-U.S. cultures that fell under the same cultural category (e.g., Chinese and Japanese), the item was categorized accordingly (e.g., Asian). On the other hand, if the dish was a fusion of two non-U.S. cuisines from different cultural categories (e.g., French and Vietnamese), they were coded according to the place of origin (e.g., French-Vietnamese banh mi would be under the Asian category due to its origin in Vietnam). All instances of a fusion dish were marked on the data collection sheet for subsequent data analysis.

Following the categorization of every menu item, the data were then analyzed for: (1) presence, (2) percent composition in relation to the whole menu, (3) most frequently occurring items/dishes, (4) the percent composition of traditional and fusion items, and (5) most frequently represented countries.

RESULTS:

The presence (≥ 1 item) of each cultural category across 32 menus can be observed in Figure 3. The order of presence from highest to lowest was as follows: Neutral (n=32, 100%), Southern (n=26, 81.25%), European (n=23, 71.87%), Hispanic (n=20, 62.5%), Asian (n= 16, 50%), Mediterranean (n=4, 12.5%), African (n=1, 3.13%). On average, the majority of items within the menus were Neutral (69.05%), followed by Southern (9.1%), European (9.01%), Hispanic (7.68%), Asian (3.84%), Mediterranean (1.09%), and African (0.3%). This average distribution of items within a menu can be visualized through Figure 3.

Figure 3: Presence of Cultural Categories (≥ 1 item)

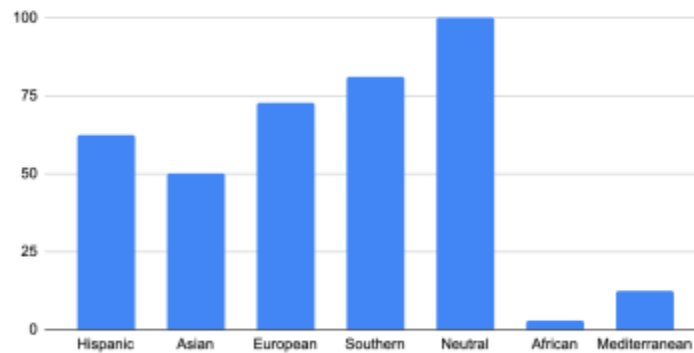
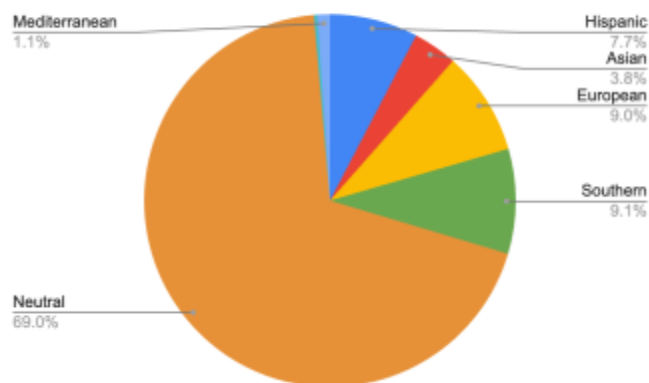


Figure 4: Average Menu Composition by Cultural Category



Hispanic

Hispanic cuisine appeared on 20 menus, with a total of 52 items. The most frequently occurring items were: quesadillas (n=11, 21.15%) and enchiladas (n=6, 11.54%). Rice dishes, such as Spanish Rice and Cilantro Rice, were the third most frequent item (n=5, 9.62%). The majority of Hispanic items were traditional (82.7%), with the remaining being Hispanic-American fusion (17.3%). Traditional Mexican items composed 76.92% of all Hispanic items and 93.02% of all traditional Hispanic items.

Asian

Asian cuisine appeared on 16 menus, with a total of 23 items. The most frequently occurring items were: Pepper Steak (n=3, 13.04%), Teriyaki Dishes (e.g., Teriyaki Chicken, Teriyaki Grain Bowl) (n=3, 13.04%), and Rice dishes (e.g., Jasmine Rice, Fried Rice) (N=3, 13.04%). The majority of Asian items were traditional (69.57%), with the remaining being Chinese-American (17.39%). Three items (13.04%) were placed in an ambiguous category, as they lacked distinct traditional/fusion characteristics due to a lack of insight into the dish. Among traditional dishes, the majority of items were Chinese (31.25%) and Japanese (18.75%). With all Asian items in consideration, Chinese composed 21.74%, and Japanese 13.04%. For fusion dishes, 100% were Chinese-American.

European

European cuisine appeared in 23 menus, with a total of 57 items. The three most frequently occurring items were: Beef/Vegetable Lasagna (n=8, 14.03%), Pasta (e.g., Pasta pomodoro, Pasta with Marinara) (n=6, 10.53%), and Meatballs (e.g., Swedish Meatballs, Italian Style Meatballs) (n=5, 8.77%). The majority of European items were traditional (82.46%), with the remaining being European-American fusion (17.54%). Among traditional dishes, the majority of items were Italian (48.94%) and French (19.15%). With all European items in consideration, Italy composed 40.35% and France 15.79%. Among fusion dishes, 90% were Italian-American and 10% were French-American.

Southern

Southern cuisine appeared on 26 menus, with a total of 54 items. The most frequently occurring dishes were: Fried dishes (e.g., Chicken fried steak, Fried Chicken, Fried Catfish) (n=10, 18.51%), Barbecue (e.g., Grilled Barbecue Chicken, Carolina Barbecue Pork) (n=9, 16.67%), Southwest dishes (e.g., Southwest Chicken, Southwest Roast Turkey) (n=9, 16.67%), Biscuits (n=6, 11.11%), Brisket (n=5, 9.26%), and Grits (n=5, 9.26%).

Neutral

Neutral cuisine appeared in all of the menus (n=32), with 496 items. As shown in Figure 3, that is the only category out of the seven that is present 100% in the menus across the sample. The most frequently occurring dishes were: Sandwiches (e.g., Chicken Salad Sandwich, Tuna Salad Sandwich, Ham Sandwich) (n=66, 13.31%), Burgers (e.g., Hamburgers, Cheeseburgers, All-American Burgers) (n=29, 5.85%), Soups (e.g., Chicken Noodle Soup, Tomato Soup, Hearty Vegetable Soup) (n=27, 5.44%), Mashed Potatoes (n=17, 3.43%), Meatloaf (n=13, 2.62%), and Chicken Tenders/Strips (n=11, 2.22%).

African and Mediterranean

African cuisine appeared in 1 menu, with a total of 1 item. Mediterranean cuisine appeared in 4 menus with 5 items in total. As illustrated in Figure 3, their presence was significantly less than the other cultural categories. The insufficient number of items limited the extent of data analysis for this category.

DISCUSSION:

This study examined the cultural characteristics of menu items to identify patterns in cultural cuisine representation across Texas acute-care hospitals using a content analysis methodology on 32 menus sampled across 21 counties. The data findings reveal patterns summarized under four categories: (1) neutral dominance, (2) limited options, (3) emphasis on familiarity, and (4) geographical concentration.

Neutral Dominance

Neutral cuisine appeared on all menus and held a dominant role in many aspects of the data analysis results. Results summarized in Figure 4 clearly show this trend with the percentage breakdown of a typical menu by each cultural category. On average, neutral items composed nearly 70% of the menu, while other categories constituted approximately 9% or lower. The strong majority of neutral cuisine suggests that the hospitals strive for the broadest possible appeal rather than providing meals that align with distinct cultural identities. This pattern may be incentivized by functionality, as these options have a greater chance of being consumed by a wide range of patients. In addition to dominating the menu composition, the neutral category also contained the most frequently appearing items: sandwiches and burgers. Because these items are generally easier to mass-produce, require less effort, and necessitate a lower skill level for production, this may indicate the importance of efficiency in the kitchen workplace. This emphasis on efficiency can serve as a potential justification for the lack of culturally diverse menu options, given that their preparation methods are more complex.

Limited Options

While Neutral was the dominant category, various other groups were also widely present. Hispanic, European, and Southern all had a relatively consistent presence across menus at 62.5%, 72.72%, and 81.25%, respectively. While less prominent, Asian cuisine did appear on half of the menus as well. However, despite their presence, the number of items offered from these categories was significantly less than their neutral counterparts. This resulted in the very uneven distribution of items by category, as seen in Figure 3. On average, Hispanic items made up only 7.68% of the menu, European at 9.01%, Southern at 9.1%, and Asian at 3.84%. This large discrepancy between the percentage of hospitals that include these cuisines and the average percentage of the menu that these cuisines represent illustrates that cultural items are not provided as consistent meal options. Instead, they are rare occurrences that serve more as special occasions rather than standardized choices. This indicates that cultural foods are still not recognized as a necessary component of menus.

Emphasis on Familiarity

Across Hispanic, European, and Asian categories, there was a consistent dominance of traditional foods (ranging 69%-83%) over fusion, which typically accounted for 17% of the items. Some of the most popular traditional items were quesadillas and lasagnas. Although these items do have a distinct cultural heritage tied to a specific region, they have become increasingly commercialized, popularized, and consumed by people of other cultures within the United States. Thus, many individuals are familiar with the names and ingredients of these dishes. As a result, this inclusion of more familiar traditional meals over lesser-known foods depicts the hospital's prioritization of easily identifiable and widely recognized cultural items. Consequently, this suggests that items that have entered the American mainstream diet are more likely to be selected for inclusion in hospital menus rather than more authentic counterparts. This works to further support the trend found through neutral dominance, which is the goal of achieving the broadest possible appeal. This approach can foster obstacles to providing more authentic meals that would better align with the cultural background of the patients.

Geographical Concentration

Across menus that included Hispanic, European, and Asian categories, there was a consistent concentration of items from specific countries. Data findings showed that 77% of Hispanic dishes were Mexican, 56% of European dishes were Italian and French, and 50% of Asian dishes were Chinese and Japanese. This trend indicates that within cultural categories, hospitals tend to include items from a narrow selection of cuisines that are more globally recognized, as opposed to focusing on the incorporation of greater variety. The reasoning can stem from the repeated trend in broadening appeal through the selection of cultural options that align with the mainstream diet of the United States. A consequence of such practices emerges through the minimal representation or complete absence of cuisine

from many countries that are less familiar to an American audience. This approach can foster a false appearance of cultural diversity and contribute to the failure of menus to provide meals that align with patient dietary preferences stemming from different countries.

Implications

The findings from this content analysis revealed a strong dominance of neutral items, the low availability of cultural options, and a focus on mainstream traditional foods plus popularized cultural cuisines. In contrast with the initial hypothesis, Hispanic cuisine did not comprise a significant portion of the menu items despite making up 40.3% of the Texas population. These patterns depict the lack of cultural diversity in the current dietary services across Texas hospitals. This ultimately fosters serious discussions regarding patient health implications. As observed through the findings of Hadjimbei et al. (2025) and Wyman et al. (2025), existing research suggests that reduced patient satisfaction and lower cultural familiarity can lead to reduced food intake. The observed findings of limited variety among Texas hospital food options suggest that current dietary practices may contribute to reduced satisfaction, feelings of isolation, and reduced food consumption among patients. This inadequate food intake can have serious health consequences, including increased risk of malnutrition and longer recovery time. With the health of people at risk, this creates urgency to address the causes and obstacles to effective inclusion of diverse cultures.

A potential area of focus can be directed towards the current political framework regulating the menu options offered at hospitals in Texas. Some scholars, such as Minakshi Raj (2024), have highlighted the lack of clarity and authority within policies as contributors to the effective implementation of culturally diverse menus. Seeing how there are no comprehensive requirements directed toward the inclusion of different cuisines in Texas hospitals, the critiques on policies appear to be relevant to this discussion. While additional studies would need to be conducted to directly evaluate the effectiveness of current dietary policies, this study suggests a potential need for policymakers and hospital administrators to revise or establish new policies/regulations on the adoption of more culturally diverse options in inpatient menus.

Limitations

There are limitations to the research design and findings of this content analysis study. The data were based on a total of 32 menus across 21 counties in Texas. Because the urban and suburban counties of Texas contain hundreds of acute-care hospitals in total, this sample size is relatively small, which reduces the generalizability of the research conclusions. This is attributed to the reduced likelihood of this study capturing data from diverse hospitals: different neighborhoods, healthcare systems, and institutional sizes. As a result, the findings of this research may not fully represent the diverse hospital practices present in Texas. Furthermore, the small sample size also increases the influence of each individual menu on the overall results. Menus with high or low cultural diversity had a greater impact on increasing or decreasing the overall data. This reduces confidence in the findings reflecting true patterns of hospital practices.

In addition, the majority (96%) of the data was collected through verbal phone calls, in which only a portion of the hospital menu could be collected (typically items for 1 to 3 days), rather than the collection of the full menu rotation, which typically lasts a week, two weeks, or one month. As a result, the data may not fully represent the cultural offerings of the hospitals, and certain cultural items could have been overlooked. This had the potential to create data that underestimates the cultural inclusivity of sampled hospitals, which limits its true representation.

Furthermore, there is also the possibility of subjectivity and bias present in the content analysis, as the categorization of qualitative data was based on the research and interpretation of a single researcher. Inter-coder reliability was not possible to measure due to the absence of multiple coders, making subjectivity and bias difficult to detect.

Lastly, this study tracked the presence of items but did not account for the number of times each item was offered. Thus, items that appeared more than once were counted the same as items that appeared only one time. This caused representation to be underestimated for frequent items and overestimated for one-time items. Ultimately, this limited the practical accuracy of the patterns this study reflects.

CONCLUSION

Hospitals within Texas serve a diverse population, marked by a variety of identities and cultural backgrounds. Through a content analysis study tracking the presence of different cultural groups, this study revealed a pattern of neutral dominance, limited options, emphasis on popularized dishes, and geographical cultural concentration within the food menus of sampled Texas hospitals. These findings contribute to the current field of health, food, and cultural competency by providing empirical data on how cultural cuisines are represented within hospital food services, an area that has not received any direct examination prior. While previous research has focused on the political framework and benefits regarding patient satisfaction, food intake, and nutritional composition of culturally diverse meals, this study works to address a knowledge gap by directly examining the contents of 32 hospital menus randomly selected across Texas. The identified patterns reveal deficiencies in the incorporation of cultural cuisine into healthcare, highlighting the possible failure of Texas hospitals in the studied sample to meet the needs of their diverse patient population. However, various limitations reduced the accuracy and generalizability of the data findings. This creates the necessity for a replicated study in order to validate or challenge the results. These new studies can incorporate a bigger sample size in order to provide a more accurate and comprehensive representation of hospital dietary services. Furthermore, these inquiries can also include a multitude of researchers to reduce bias during the content analysis section. Lastly, future research can also conduct longitudinal studies by analyzing numerous rotations of hospital menus to examine changes or continuities in patterns of cultural cuisine representation. This information is crucial for a better understanding of hospital menu decisions and is essential to discussions on cultural competency in healthcare.

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