Towards Engagement, Conversation, and Cultural Humility

When I grew up, an upper middle class teenager in a suburban San Antonio high school, I was taught that we live in a colorblind society. I was taught by many an educator that good people, people who aren’t racist, just don’t see color; we only see individual people. If you had asked me in high school about the importance of cultural competence, I might have responded that it is not important because only individuals are important. College on the other hand exposed me to an academic, left-wing activist, cultural revolution. I lived in cooperative housing in the liberal enclave of Texas, and in well-meaning workshops with titles like, “confronting our white privilege,” my friends and colleagues emphasized that everyone is a racist, and highlighted the discrimination that is alive and well in America today. In college, my high school education seemed naïve. But since starting medical school I’ve come to realize that my later experiences were naïve in a different way. Not only did my friends and colleagues’ emphasis on fundamental difference too often result in feelings of guilt, helplessness, divisiveness and alienation, but also they often took place without input from the disenfranchised people they were designed to empower.

An understanding of cultural differences necessitates a heightened awareness of the historical and cultural forces that contribute to disparities. But cultural awareness in medicine also requires a mindfulness of something my high school civics teacher understood: a person cannot be perfectly reduced to her race, class or gender. While each of these understandings is aimed at a greater respect and sensitivity in multicultural society, each is missing something vital: an engagement and a conversation. To care for the sick in our ever-diversifying world will require a sensitivity to the endemic inequalities in our society. It will also require a respect for individuals as such, and above all a commitment to communication and conversation. Making space in the clinical encounter for conversation will require a rethinking of the meaning of cultural competence, a hefty dose of humility, and a firm commitment to listening with an eye toward what we can learn from those we seek to serve.

The idea that we live in a colorblind society amounted to a denial of the realities of racism. If we are blind to inequality and injustice we cannot fight them. What’s worse, sometimes our inability to see color can be hurtful. Seeing injustice, discrimination, and inequality where it exists is crucial. Not mistaking the normativity of whiteness for a colorblind society is critical. But an excessive attention to what divides us can be just as harmful as a denial of it. As Kwame Appiah puts it, “the foreignness of foreigners, the strangeness of strangers: these things are real enough. It’s just that we’ve been encouraged, not least by well meaning intellectuals, to exaggerate their significance by an order of magnitude.”1 His solution is simple, “conversation.”

An attention to conversation can help us rethink the meaning of cultural competence. As California physicians Melanie Tervalon and Jann Murray-Garcia point out, “cultural competence in clinical practice is best defined not by a discrete endpoint but as a commitment and active engagement in a lifelong process that individuals enter

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1 Kwame Anthony Appiah, Cosmopolitanism: Ethics in a World of Strangers (W. W. Norton, 2006), xxi
into on an ongoing basis with patient, communities, colleagues, and with themselves.”² True cultural awareness in medicine can only succeed in the spirit of engagement. Without an emphasis on engaged conversation, an educational curriculum that focuses on competence in the limited and traditional sense can actually function as an impediment to effective and empathetic patient care and work against the patients it is designed to serve. The paper describes the case of a Latino patient moaning in pain whose nurse had learned in a cultural competency course in school that Hispanic patients, “over-express the pain they are feeling.”³ To emphasize the importance of engagement and conversation, Tervalon and Murray-Garcia prefer a very different term, cultural humility.

Cultural humility. At first glance it seems a foreign concept for physicians. And, not surprisingly, in the ten years since the publication of their article, the term cultural humility has not been widely embraced. Though the past thirty years have witnessed an encouraging trend emphasizing cultural awareness in medical curricula, with the social movements of the sixties and seventies being followed in the nineties by mandates that cultural awareness be a part of every medical student’s education, there is still a significant amount of resistance. It is my belief that a resistance to the implied mandate of humility is at the core of the pushback. My own awareness of this resistance came on my first day of POM II when our professor brashly informed us that we wouldn’t be doing any of that cultural competency nonsense because, “This is Texas.” When I hotly pointed out that living in a state as diverse as Texas meant we needed more cultural awareness, not less, he responded that although he had some sympathy for immigrants, he still felt that they needed to learn English like his ancestors did. For this reason I missed out on the majority of didactic cultural competency training in our curriculum, but the brazenness of my professor convinced me that under his veneer of confidence was fear.

The gap I experienced in the classroom was equally manifest on the wards where I quickly witnessed first hand the language barrier that had so frightened my professor. Our OB/Gyn service has a high percentage of Mexican-American and Mexican patients. Many of these patients speak only Spanish and this was the case with Lupe Gonzales,⁴ a Latina woman in her early thirties in labor with her third child. Mrs. Gonzalez became my patient one evening late in my shift after my resident barked the fiat, “Go in there and get that baby out because I don’t want to talk about her at board change.”

She had given birth to her first baby vaginally. For the second birth she had been given a cesarean section after pushing more than her allotted amount of time, but with this baby she hoped for a vaginal birth. Her labor was progressing well, but when it came time to push, the baby wouldn’t come. I was gowned and gloved and standing between her legs in what seemed to me to be a sterile cell of preparedness, (“You have to be ready if you’re going to deliver this baby. The baby could come at any time!”) when my resident walked in put both hands in her patient’s vagina and began yelling in English: “Push my fingers out! If you keep pushing like that I don’t care if you push for three hours, we’re going to cut you.” At this point Mrs. Gonzales started crying. Somewhat

³ Ibid., 119
⁴ Names have been changed to protect confidentiality.
less than perceptive, my resident demanded, “Why are you crying?” And then, “Is your epidural wearing off?” And then, this time to the translator, “Ask her if the epidural is wearing off.” The question was translated, but Mrs. Gonzales shook her head no. Her anesthesia was, of course, fine.

My Spanish is limited, but after spending some time between undergrad and medical school at a birth center on the border, I knew enough to understand what she was saying through tears. She was saying, “I’m afraid.” Afraid myself I waited until the resident left to query in my limited Spanish “What are you afraid of?”

“I’m afraid I can’t do it.”

To me this story represents a good example of cultural incompetence even though it was not by any lack of specific knowledge about Latina culture that we failed Mrs. Gonzales. Our Spanish could have been better, and its true, we failed her in part because we could not understand her. But mostly we failed her because we were unwilling to listen to her. We were unwilling to make a space in the fast paced and sterile world of the hospital ward for her to tell us her story. Arthur Kleinman was right when he said that for patients in pain, the ability to tell their story is therapeutic. And Arthur Frank was right when he said that both articulating and witnessing the stories of people who are suffering with an eye toward our mutual vulnerability is a fundamental moral act. But it is a therapy and a morality that can only occur if we act with the humility necessary to allow the stories to manifest.

William Carlos Williams wrote of the act of witnessing these stories, “The poem springs from the half-spoken words of such patients as the physician sees from day to day….Humbly he presents himself before it and by long practice he begins to interpret the manner of its speech. In that the secret lies. This, in the end, comes perhaps to be the occupation of the physician after a lifetime of careful listening.” It is in this spirit that we as clinicians should serve our patients, with a great respect for difference, with an understanding of what unites us, and with an enduring humility.