Beyond Cultural Competence: Applying Humility to Clinical Settings

Linda M. Hunt

In recent years, the concept of "culture" has captured the imagination of a broad cross section of health care providers and policy makers. An increasingly diverse and multicultural society is inspiring health care providers to strive to develop cultural sensitivity and cultural competence. Virtually every health profession has made cultural competency a part of its curriculum, and many health care institutions are requiring cultural sensitivity training for personnel (American Medical Association, 1999). Such programs are generally designed to sensitize health providers to the special needs and vulnerabilities of different populations, with the goal of providing accessible and appropriate care to all.

The emphasis in this movement has clearly been focused on members of "underserved" and "underrepresented" racial and ethnic minority groups. Developing the cultural competence of health professionals is intended to minimize cultural barriers to health care and make health services more "user friendly" to culturally diverse subgroups, and thereby help to reduce their disproportionate burden of poor health. Health providers are encouraged to explore the traditional cultural concepts and practices of such patients, and to develop culturally appropriate models for clinical interactions, treatment protocols, and health education efforts (Carrillo, Green, and Betancourt, 1999).

Despite widespread popularity, cultural competency remains a vaguely defined goal, with no explicit criteria established for its accomplishment or assessment. This lack may in part be due to the elusive nature of its central construct: culture.

Linda M. Hunt, "Beyond Cultural Competence: Applying Humility to Clinical Settings," from *The Park Ridge Center Bulletin*, issue 24, 3–4.

Defining Culture

Definitions of "culture" are multiple, broad, and notably ambiguous. While there is no agreed-upon definition of culture, the classic definition by E. B. Tylor in 1871 is widely cited in anthropology textbooks: "Culture . . . is that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society" (Tylor, 1871:1). Most definitions of culture emphasize that it is complex and dynamic, comprised of the shared solutions to problems faced by the group. These solutions include technologies, beliefs, and behaviors.

Culture does not determine behavior, but affords group members a repertoire of ideas and possible actions, providing the framework through which they understand themselves, their environment, and their experiences. Culture is a complex set of relationships, responses, and interpretations that must be understood, not as a body of discrete traits, but as an integrated system of orientations and practices generated within a specific socioeconomic context. Culture is ever changing and always being revised within the dynamic context of its enactment.

Culture is neither a blueprint nor an identity; individuals choose between various cultural options, and in our multicultural society, many times choose widely between the options offered by a variety of cultural traditions. It is not possible to predict the beliefs and behaviors of individuals based on their race, ethnicity, or national origin (O'Connor, 1996). Individuals' group membership cannot be assumed to indicate their culture because those who share a group label may variously enact culture.

In its zeal to encourage respect for cultural difference, the cultural competency movement has sometimes lost sight of these important features of the concept of culture. Instead it has too often represented culture as a decontextualized set of traits providing a template for the perceptions and behaviors of group members. A burgeoning literature on cultural diversity presents the reader with veritable laundry lists of traditional beliefs and practices ostensibly characteristic of particular ethnic groups. This approach encourages the questionable notion that immigrants and certain ethnic and racial minorities are particularly driven by traditionalism (Hunt, Schneider, and Comer, 2004). The emphasis in this genre is on difference, pitting the exotic and esoteric against mainstream or conventional beliefs that remain unnamed and unexplored.

The misconception, common in clinical settings, that culture can be

understood as a set of discrete traits, has led some mistakenly to treat culture as an explanatory variable, subject to prediction and control. In such applications, specific ethnic cultures are represented as a codified body of characteristics that can be identified and then either modified or manipulated to facilitate clinical goals (Santiago-Irizarry, 1996).

Paradoxically, in such approaches, what originated in a desire to promote respect for individual differences may instead promote stereotyping and essentializing (Carillo, Green, and Betancourt, 1999). This process of reifying presumed difference may have the unintended consequence of bolstering a sense of group boundaries (Santiago-Irizarry, 1996). It may also reinforce the belief that culture can be diagnosed and treated, that exotic or unfamiliar beliefs and behaviors of members of already disempowered subgroups should be controlled and adjusted to resemble norms of the dominant group.

Cultural Humility

Such pitfalls may be avoided by more subtly integrating the concept of culture with the clinical agenda. The starting point for such an approach would not be an examination of the patient's belief system, but careful consideration by health care providers of the assumptions and beliefs that are embedded in their own understandings and goals in the clinical encounter (O'Connor, 1996). Training for cultural competency, with its emphasis on promoting understanding of the "cultural" client, has often neglected consideration of the providers' worldview. In the alternative approach, rather than learning to identify and respond to sets of culturally specific traits, the culturally competent provider would be taught to develop what might be called cultural humility.

Cultural humility has been described by Melanie Tervalon and Jann Murray-Garcia as a lifelong process of self-reflection and self-critique. Cultural humility does not require mastery of lists of "different" or peculiar beliefs and behaviors supposedly pertaining to certain groups of patients. Rather, the provider is encouraged to develop a respectful partnership with each patient through patient-focused interviewing, exploring similarities and differences between his own and each patient's priorities, goals, and capacities. In this model, the most serious barrier to culturally appropriate care is not a lack of knowledge of the details of any given cultural orientation, but the provider's failure to develop self-awareness and a respectful attitude toward diverse points of view.

Effectively exploring cultural issues in the clinic should begin with recognition that "cultural difference" refers to a relationship between two perspectives. Identifying difference requires contrasting two orientations: the provider's and the patient's. Culturally competent providers develop skills for exploring the existence and importance of differences in the basic assumptions, expectations, and goals they and their patients bring to any clinical interaction. This kind of reflexive attentiveness should not be limited only to those people who are perceived to be culturally "other," but can be useful in any clinical encounter.

The ideal conclusion of this kind of cross-cultural exploration would be to develop an approach to managing clinical problems based on negotiation between the two perspectives. Due to institutional, time, and other pragmatic limitations of the clinical setting, as well as social, economic, and other practical restrictions faced by patients, the ideal of reaching a negotiated plan of action may not be feasible. Still, following the principle of cultural humility, a culturally competent provider should be open and flexible enough to be able to identify the presence and importance of differences between her orientation and that of each patient, and to explore compromises that would be acceptable to both. This strategy does not call for the health care provider to become an expert in cultural minutiae, nor to act as a minister or an herbalist. Ideally, being appropriately cognizant of and responsive to cultural issues should not be thought of as reaching a "competency," so much as engaging in an ongoing process of honing and applying skills for self-awareness and for respectful recognition of the unique perspective each patient brings to the clinical encounter.

References

American Medical Association. 1999. *Cultural Competency Compendium*. Chicago: American Medical Association.

Carrillo, J. E., A. R. Green, and J. R. Betancourt. 1999. Cross-cultural primary care: A patient-based approach. [see comment]. *Annals of Internal Medicine* 130(10):829–834.

Hunt, L. M., S. Schneider, and B. Comer. 2004. Should "acculturation" be a variable in health research? A critical review of research on US Hispanics. *Soc.Sci.Med.* 59(5):973–986.

O'Connor, B. B. 1996. Promoting cultural competence in HIV/AIDS care. *Journal of the Association of Nurses in AIDS Care* 7 (Suppl 1):41–53.

Santiago-Irizarry, Vilma. 1996. Culture as cure. *Cultural Anthropology* 11(1):3–24.

Tervalon, M., and J. Murray-Garcia. 1998. Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. [Review] [32 refs]. *Journal of Health Care for the Poor & Underserved* 9(2):117–125.

Tylor, Edward B. 1871. *Primitive Culture: Researches into the Development of Mythology, Philosophy, Religion, Art and Custom*. London: John Murray.