The Case for Cultural Humility: Improving Communication Between Racially Non-Concordant Patients and Providers

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Introduction

Though many may assume that improving a patient’s health only consists of diagnostics, treatments, medications, and surgeries, an increasing body of work has identified racial and ethnic inequities as an impactful determinant of health (Cooper et al., 2012, Haider et al., 2015, Lo and Stacey, 2008, Blair et al., 2013, Williams 2012). Contemporary literature in healthcare asserts that culture shapes the way both the patient and provider experience health care, so recent efforts to address racial and ethnic inequity have focused on educating providers about various cultures in order to help them integrate the patient’s culture into their care (Thackrah and Thompsong, 2013, Prasad et al., 2016). Until the late 1990s, most academic literature and medical programs aimed to integrate a patient’s culture into their care through cultural competency programs. Though these efforts may have been well-intentioned, some argue that cultural competency training promotes stereotyping, equates race and ethnicity with culture, and neglects intersecting identities and the fluidity of culture, thereby limiting an open dialogue between the patient and provider, patient autonomy and decision-making, and optimal health care (Kumagai and Lypson, 2009, Kumaș-Tan et al., 2007). Further, cultural competency training instills the idea that providers have enough knowledge of the patient’s culture before the clinical encounter even begins, placing the patient in a more passive role (Tervalon and Murray-Garcia, 1998, Thackrah and Thompson, 2013). Though the cultural competency approach has problems, this method introduced and emphasized the idea that culture affects a person’s healthcare and ultimately paved the way for future programs addressing healthcare inequality.

Many medical institutions have offered cultural competency training for health care providers and medical students that often emphasize quantifiable goals in how to approach and communicate with various cultures (Prasad et al., 2016, Lo and Stacey, 2008). For example, one
pharmacy school offering a cultural competency class indicated in their curriculum that they taught the health and illness behaviors of Middle Eastern, African-American, American Indian, and LatinX patients, then the students were graded on their knowledge of the expected behavior of patients from those communities (Evans, 2006). While cultural competency training is a step in the right direction, this kind of training provides a perspective too narrow to effectively integrate a person’s culture into their health care decision making. Literature on cultural competency fails to define how an individual’s intersecting identities function in medicine and does not acknowledge that the medical field has its own culture (Thackrah and Thompson, 2013). This is a crucial oversight, as the interplay between medical culture and an individual’s culture may greatly influence how a patient and provider communicate. Further, cultural competency approaches lack significant empirical evidence for improved patient outcomes (Thackrah and Thompson, 2013). Even more, this methodology assumes that a person’s culture is a stagnant, rather than a fluid part of their identity that is constantly morphing as they gain new experiences (Thackrah and Thompson, 2013, Lo and Stacy, 2008). The mindset of cultural competency instills the notion in a provider that once they complete cultural competency training, their work to integrate a patient’s culture into their care is essentially complete.

Cultural humility is a more recent approach to address healthcare inequality which teaches providers that through self-reflection and critique, providers can place a patient’s culture into context and acknowledge that culture may change over time and play a different role in each individual’s care (Kumagai and Lypson, 2009, Prasad et al., 2018, Murray-Garcia and Tervalon, 1998). A provider that practices cultural humility must not only think of the patient’s culture, but also continuously reflect on and critique their own practices, beliefs, values, and status (Tervalon and Murray-Garcia, 1998, Kumagai and Lypson, 2009). This requires the physician to practice
the shared decision-making model, which emphasizes a discussion about the treatment plan between the patient and provider rather than the paternalistic model, which places the patient in a passive role with the provider dominating the decision-making process (Tervalon and Murray-Garcia, 1998, Drolet, White, 2012, Brogan et al., 2012). Cultural humility also recognizes that a patient may occupy various cultural spaces, such as work, family, school, religion, social circle, etc., and that all of these cultures are subject to change over time (Yeager and Bauer-Wu, 2013, Lo and Stacey, 2008). However, a provider may not fully comprehend how these cultures and identities interplay to affect a patient’s health experience unless they set aside their dominance over the clinical encounter (Lo and Stacey, 2008). For providers to practice cultural humility, they must give up the traditional role of expert and allow patients to teach them about their unique health experience (Tervalon and Murray-Garcia, 1998).

Pervasive healthcare inequalities among non-Whites throughout history and in the modern U.S. demonstrate the dire need for integrating cultural humility into healthcare. During the mid to late 20th and early 21st century, health care outcomes improved for whites while they stagnated or even declined for many non-white groups, including African-Americans, Native Americans, and Hispanics (Byrd and Clayton, 2003). Studies consistently demonstrate that non-White patients report lower health care satisfaction, less trust in their provider, and less involvement in their health care decision-making (Cooper-Patrick 1999, Doescher 2000, Boulware 2003, Saha 1999). While there are numerous theories attempting to explain the source of this inequality, some argue that institutional racism, a system in which legislative and bureaucratic measures perpetuate racism, serves as the most determining factor in health disparities among different races (Murji, 2007, Williams 2012, Peek et al., 2010, Griffith et al., 2007). Further, socioeconomic status (SES) impacts health outcomes of all races, though low
SES specifically contributes to racial inequality in health care and visa-versa (Williams 2012, Lai et al., 2016).

Racism within the medical institution plays a contributing role to racial disparities in patient satisfaction and health outcomes (Williams 2012, Smedley and Smedley, 2005). Racism leads to unfavorable perceptions and thus discriminatory treatment towards certain individuals, and further, that racism permeates institutions and its policies (Williams and Mohammd, 2009). That racism is exhibited by meta-analyses that have found a positive relationship between self-reported chronic conditions and discrimination (Williams and Mohammd, 2009, Price et al., 2013, Gee et al., 2009). Among African-American patients, perceived racism from a provider corresponds to a negative relationship with provider communication and overall respectfulness towards the patient (Hausmann et al., 2011). This racism manifests in decreased patient satisfaction of care, medical adherence, continuation of care, and trust in their provider (Hausmann et al., 2011). While overt racism among physicians may not be as generalized of a problem now as it has been historically, a provider’s lack of cultural integration into a patient’s care due to implicit racism or bias remains a major concern for the medical institution.

Healthcare consistently endures as one of the most hotly debated topics in the U.S., however, there is no consensus on how to address and combat healthcare inequality. Despite a United States history full of racial and ethnic inequities in healthcare, many may still assume that each race and ethnicity will receive the same health outcome if their provider communicates with each patient in the same way. Racial inequalities in health care stem, in part, from ineffective communication between the patient and the provider. Considering this, investigating measures a provider can take to combat this inequity remains as a crucial public health concern. As the second leading cause of death in the United States, cancer affects a significant portion of our
society, though different races and ethnicities experience a cancer diagnosis and treatment differently (Dahe 2012). Taking this into account, how a provider communicates a diagnosis and treatment options should take into consideration an individual’s unique cultural identity. However, a patient and a provider are often different races or ethnicities, i.e. racially non-concordant, which leads to a gap in cultural knowledge and shared experiences of that influence and individual’s perceptions of health and illness (Saha et al., 1999, Persky et al., 2013, Street et al., 2008, 2018, Cooper-Patrick et al., 1999). Though this gap in cultural knowledge greatly impacts effective patient-provider communication, cultural competency glosses over how the role of culture in a person’s healthcare may vary from person to person and even within one individual, thereby limiting the ability of this approach to improve healthcare inequality caused by ineffective communication.

Culture competency ignores cultural complexity, including the simplification of equating race and ethnicity with an individual’s culture. In health care specifically, professionals practicing cultural competency tend to categorize specific cultures, races, and ethnicities into pre-determined risk factors based on assumed beliefs, practices, and behaviors of any given group (Thackrah and Thomspon, 2013). By categorizing patients into cultural groups rather than thinking of each patient as holding a complex identity, providers fail to consider or address how a person’s culture interacts with their race, SES, and social connections (Thackrah and Thompson, 2013). A more comprehensive way for a provider to conceptualize a patient’s culture is a “hybrid habitus” in which a person’s culture functions as a somewhat subconscious influence that works in conjunction with structural forces – such as immigration or parenthood, among many others –, and determines how a patient experiences the medical world (Lo and Stacey, 2008). In line with the effort to consider the relationship between culture and other social
determinants of health, some groups have demonstrated support for the Shared Decision-making Model, also known as Participatory Decision Making, though this school of thought neglects the practical implementation of a system that considers a patient’s culture, both individually and as a community (Lo and Stacey, 2008). Cultural humility, however, offers a lifelong approach for providers to actively consider and incorporate a person’s culture into patient’s care by practicing self-reflection and patient-centered care (Prasad et al., 2016, Tervalon and Murray-Garcia, 1998, Yeager and Bauer-Wu, 2013, Juarez et al., 2006). Considering the central role of patient-provider communication in all of health care and the racial and ethnic demographics of the provider population versus the general population, cultural humility training has the potential to improve communication between racially non-concordant providers and patients, as this methodology encourages an active dialogue between the patient and provider with an explicit emphasis on integrating the patient’s individual culture into their health care.

Contemporary literature surrounding racial inequities in healthcare claims that cultural competency training is essential to improve ineffective communication and poor patient experiences among non-whites in the United States (Tervalon and Murray-Garcia, 1998, Prasad et al., 2016). David Rief (2018), an ICU nurse at Johns Hopkins Hospital, explains why practicing cultural humility rather than cultural competency is necessary for equitable health care. Rief recalled a situation he encountered in the ICU where an Indian male who was the head of his household asked for a DNR/DNI order – a medical code meaning the patient did not want to be intubated or resuscitated in the case that he stopped breathing or his heart stopped –, though he agreed to release the control of his family to his son if he became incapacitated (D. Reif, personal communication, December 14, 2018). The patient’s condition worsened, and he progressed into unconsciousness (D. Reif, personal communication, December 14, 2018). Soon
after this, his son changed the patient’s DNR/DNI order into a Full Code, meaning the medical staff would employ all interventions needed to keep the patient alive. David explained that the medical staff in the ICU generally condemned this action, though for the family and their culture, this was common practice (D. Reif, personal communication, December 14, 2018). Those providing for the patient and his family were unable to put the patient’s culture and their own culture into context to understand how people may experience health differently (D. Reif, personal communication, December 14, 2018). This real case supports the literature claiming that medical staff need cultural humility training to provide the best care for individual patients.

**Racial and ethnic Inequalities**

*Historical Racism in Medicine*

Though there are modern examples of healthcare inequality based on a person’s identity, understanding the historical roots of this inequality enriches our understanding of the current medical institution and offers insight towards addressing healthcare inequality. Historically, the United States has a notorious reputation for perpetuating injustice based on factors such as race, gender, age, religion, immigrant status, and sexuality (Byrd and Clayton, 2001, Trivedi and Ayanian, 2006, Shares and Jaffee, 2015, Kydd and Flemming, 2015, Pitkin Derose *et al.*, 2009). Since the colonization of the Americas, racial inequities have permeated through United States society through education, politics, health care, and numerous other institutions (Byrd and Clayton, 2001). For centuries, non-Whites were deemed inferior races through “empirical” evidence, and these ideas were used to justify racial injustices such as the Atlantic Slave Trade (Byrd and Clayton, 2001, Bhopal, 1998, Krieger, 1987, Smedley and Smedley, 2005). Some may suppose that medical doctors during this time aimed to treat all people equally. On the contrary, many medical school curricula included discriminatory ideas about the inferiority of African-
Americans and supported the idea that health disparities were part of a natural order (Byrd and Clayton, 2001). Further, some physicians believed that any person of color, specifically those that were not Christian, were inferior because they could not have descended from Adam and Eve (Byrd and Clayton, 2001). Though individual physicians contributed to racial inequality in health care, non-Whites also experienced oppression through country-wide inequal access to health care through slavery and lack of citizenship, among others (Byrd and Clayton, 2001).

As early as the 16th century, racial inequality in health care became an institutionalized problem, as many enslaved African-Americans were afforded no legal rights to health care (Byrd and Clayton, 2001). During the Enlightenment and its succeeding years, the idea of freedom from intolerance spread throughout the Western world (Byrd and Clayton, 2001). The concept of Social Darwinism and Eugenics – which deemed certain groups as sub-humans and unfit to reproduce – began not long after the Enlightenment (Byrd and Clayton, 2001, Bhopal, 1998). These ideas of racial inferiority manifested in “negro diseases”, “negro physiological peculiarities” and notions that African-Americans were sexually promiscuous, naturally submissive, and untrustworthy that were generally supported by medical professionals (Byrd and Clayton, 2001, Krieger, 1987, Suite et al., 2007). Further, medical schools in the U.S. maintained high levels of segregation, with white schools dominating the medical institution and a black representation in medical schools as low as 2% until the 1980s, with White and Asian students making up 88% of U.S. M.D. program graduates from 1978-2008 (Byrd and Clayton, 2001, Castillo-Page, 2010). Glaring examples of blatant racial discrimination by the medical institution notably include the Tuskegee experiments, in which poor, illiterate Black men were not given syphilis treatment from the 1930s to the 1970s even though they thought there were being treated (Byrd and Clayton, 2001, Bhopal 1998, Boulware et al., 2003, Suite et al., 2007). Another case
of racial discrimination in health care occurred when numerous Latinas were sterilized without proper consent at USC-LA from 1971-1974 (Suite et al., 2007). These cases illustrate the continuous oppression of non-Whites and their lack of equal healthcare.

Throughout the United States’ history, numerous institutions including healthcare perpetuated the inequality of non-Whites and other marginalized groups. Society rationalized this inequality by deeming these groups as morally and physically inferior, however in the 21st century, oppression of marginalized groups began to present in a more covert way through socioeconomic status, discrimination, health behavior stereotypes, the assumption that the patient adheres to the dominant culture in the U.S., and many others (Williams 2012, Gee, 2007, Kumagai and Lypson, 2009, Kumas-Tan et al., 2007, Byrd and Clayton, 2001, Krieger, 1987, Suite et al., 2007). The oppression of non-Whites in healthcare over hundreds of years may appear as an almost resolved issue, however the only major change in this situation is the means of oppression.

Racial Concordance in Healthcare

Some argue that a new mode of oppression in healthcare is racial non-concordance. Concordance in health care is generally understood as a patient and provider having a shared identity or other connection, including age, sex, race, gender, or another factor (Saha et al., 1999, Persky et al., 2013, Street et al., 2008, 2018, Cooper-Patrick et al., 1999). In recent years, racial concordance has come to the forefront as an indicator of a patient’s experience with their physician and patients are often more likely to have access to and use health care resources when their physician is the same race as they are (Street et al., 2008, Saha et al., 1999). Throughout United States history, immigrants from all over the world have come to the United States, promoting a diverse racial, ethnic, and cultural society. According to the US census bureau
(2017), out of almost 330 million U.S. citizens, 60% of people are non-Hispanic White only, 13% are Black or African American alone, 18% are Hispanic or Latino, and 6% are Asian alone. Currently, there are more non-Hispanic White people in the United States than all other races combined, though projections indicate that by 2045, less than 50% of the United States population will be White (Brookings Institute, 2019). Further, as the white population ages and birth rates decrease, the percentage of non-Hispanic Whites may decrease in the next two decades (US census bureau, 2017). Even more, people identifying as multiracial will be the fastest growing racial category in the next 20 years (US Census Bureau, 2017). Projections also indicate that for the entire population, foreign-born U.S. citizens will increase from 14% to 17% over the next two decades (US Census Bureau, 2017). Considering this, physicians will have an increasingly diversifying patient population with a complex array of health care needs.

Despite the increasing diversity in the United States, the racial distribution of medical doctors still does not reflect the United States population. According to the Henry J Kaiser Family foundation, in 2017, 59% of M.D. program graduates were white, 20% were Asian, 6% were black, and 5% were Hispanic. Racial and ethnic demographics among Doctor of Osteopathic Medicine students show even less diversity than M.D. programs (American Association of Colleges of Osteopathic Medicine, 2019). During the 2017-2018 school year, 59% of D.O. students were White, non-Hispanic, 21% were Asian, 5.0% were Hispanic, and 3.1% were Black (American Association of Colleges of Osteopathic Medicine, 2019). Blacks, Hispanics, and other marginalized groups are glaringly underrepresented in both M.D. and D.O. programs, though a rapidly diversifying United States under 18 population may contribute to physician racial and ethnic distribution that more closely mirrors the U.S. population (US Census Bureau, 2017).
Though the United States is rapidly becoming a more culturally, racially, and ethnically diverse country, Whites will still be the largest racial group for at least the next two and a half decades (Brookings Institute, 2019). Until the White population in the United States becomes closer to the population of other races and ethnicities, many patients will continue to be racially non-concordant with their provider. Further, while race and ethnicity are often important aspects of a person’s culture, these components of a person cannot be equated (Daher, 2012, Naeem, 2003). However, measuring racial non-concordance between patients and providers offers a simpler though reductionist view of patients’ cultures to demonstrate the need for cultural humility.

Considering the racial demographics of physicians and the general population, non-whites are more likely than whites to have a racially non-concordant provider (Malat 2001). Some studies have demonstrated that patients prefer a racially concordant provider and even report better care compared to non-racially concordant providers, possibly due to language and cultural similarities (Saha et al., 2003, Garcia 2003, Saha 2000). Interestingly, primary care providers often spend more time with racially concordant patients (Oliver et al., 2001, Cooper, 2003). Those few extra minutes may give patients crucial time to ask questions and clarify any concerns they may have about their treatment. Compared to White patients, African-American patients often have providers that are more verbally dominant and facilitate less patient-centered communication (Johnson et al., 2004). However, more recent research found that only one-third patients had positive health outcomes with patient-provider race concordance while one-third demonstrated no difference in health outcomes, and the remaining studies demonstrated mixed health outcomes (Meghan et al., 2009). While racial concordance may play a role in a patient’s
health care experience, the heterogeneity in studies on this topic indicates that the medical field should seek other avenues to address health care inequality.

Although the United States is swiftly becoming a more diverse country, marginalized groups still face immense inequality in health care. In one nation-wide study on primary care visits, Hispanics were less likely than non-Hispanic Whites to be screened for tobacco use, and in another national study on primary care visits, Hispanics were less likely than non-Hispanic Whites to be counseled on smoking cessation (Jamal et al., 2012, Danesh et al., 2014). These racial disparities in health care are indicative of a larger, institutional problem, including health policies and structure, politics, and a physician’s behavior (Fiscella and Sanders, 2016). They further assert that equitable healthcare means that both providers and the healthcare system actively acknowledge individual needs of patients (Fiscella and Sanders, 2016). Though there is lacking evidence that providers exhibit racial biases towards patients in primary care decision making, recent literature indicates that when patients need to make major decisions, such as receiving surgery for a tumor removal or end of life care, racial biases are more likely to influence clinical decision-making (Blair et al., 2013, Cooper et al., 2012, Green et al., 2007, Haider et al., 2015, Schulman et al., 1999, Penner et al., 2016). Considering cancer care often requires a complex treatment plan with extensive information required from the patient, racial or ethnic biases among providers may seep into crucial decisions for racially non-concordant patients (Gross et al., 2008, Esnaola and Ford, 2012, Penner et al., 2016). Taking this into account, patient experiences with cancer offer a useful example of why cultural humility is needed to improve racially non-concordant patient-provider communication.

Cancer care inequalities

The Role of Race and Ethnicity in Cancer Care
According to the National Cancer Institute, in 2018 an estimated 1,735,350 people were diagnosed with cancer, and 609,640 people died from cancer in the United States alone (National Cancer Institute, 2015). Considering that cancer affects such as an extensive percentage of the United States population, understanding cancer prevention, diagnosis, and treatment and how people perceive those health experiences persists as a major public health concern. Even when accounting for any genetic differences, many racial and ethnic groups experience significant disparities in cancer care treatment, and for some cancers, racial disparities may even be widening (Lai et al., 2016, Gross et al., 2008, Penner et al., 2016). The National Cancer Institute reported that Black women have an almost two times higher chance to develop aggressive, triple negative breast cancer (National Cancer Institute, 2017). Another startling example of cancer-related racial inequity is that although Black women have a lower prevalence of breast cancer than White women in the U.S., they have a higher rate of breast cancer related death (Williams, 2012). Even more, Spanish-speaking Hispanics are less likely to be screened for cancer English-speaking Hispanics or White non-Hispanics (National Cancer Institute, 2017). Further, American and Alaskan natives and Asian and Pacific Islanders have higher liver cancer rates than any other racial or ethnic group (National Cancer Institute, 2017). These statistics highlight that racial and ethnic disparities in cancer care are undeniable, however efforts to combat this issue have proved largely unsuccessful (Gross et al., 2008).

Studying racial disparities in healthcare is complicated, because race and socioeconomic status (SES) are often closely linked (Williams 2012). While SES does interplay with race to affect a patient’s health, research indicates that racial and ethnic disparities exist even when adjusting for SES (Williams 2012, Gross et al., 2008, Lai et al., 2018). In a study on Black and White patients in the United States diagnosed with breast, lung, colorectal, and prostate cancer, only 64% of Black
patients received early stage surgical resection, whereas 78.5% of Whites received this treatment (Gross et al., 2008). Interestingly, there was only a 2% difference in Black and White patients with breast cancer receiving adjuvant chemotherapy, indicating that racial and ethnic disparities may vary depending on the type of treatment or procedure (Gross et al., 2008). Disparities in cancer care between Blacks and Whites may be affected by the type of cancer, cost, bias, access to care, and socially or culturally informed health practices and beliefs (Gross et al., 2008). However, other studies indicate that even when Black and White patients with stage 1 or 2 non-small cell lung cancer have the same insurance and SES, Black patients are less likely to receive the recommended surgery (Byers et al., 1999, Singh et al., 2003). While SES may play a role in cancer care disparities, sociological factors such as provider-patient communication and a patient’s culture may present a more effective target for improving racial and ethnic inequities in cancer (Newman et al., 2006).

Complex emotional and social experiences surrounding cancer contribute to inequities in cancer care among different races, ethnicities, and cultural groups (Daher, 2012). Much of a patient’s suffering caused by cancer is due to various cultural stigmas and taboos about this illness. As a result of cancer myths and stigma, some patients may not practice preventative measures – such as a screening or yearly checkup –, engage in behaviors linked to increased cancer risk, or not seek social support or proper care after a cancer diagnosis (Daher, 2012). Individuals in Middle Eastern communities often believe that cancer is not preventable, that the treatment is worse than the disease, and that cancer is always fatal (Daher, 2012). Stigma surrounding female reproductive organs may increase negative perception surrounding gynecological cancers in Middle Eastern women, and even discourage them from discussing concerns with their provider (Daher, 2009). In many cases, a patient’s culture influences their risk and perception of cancer and its treatment,
emphasizing the need for providers to consider and integrate a patient’s culture into their healthcare.

In numerous cultures, religion plays an influential role in determining beliefs and behaviors (Naeem, 2003, Yehya and Dutta, 2010). Recent studies have tied religion or spirituality to cancer care decision-making specifically (Tam et al., 2003 Jones et al., 2009, Sheppard et al., 2010). Religion or spirituality influences medical decision-making, preventative care and medical compliance, and may produce patient beliefs that conflict with medical interventions. However, a patient’s religion or spirituality has also been linked with increased social support, lower stress levels, and even lower cancer mortality (Koenig, 2004). Interestingly, in African American patients specifically, spirituality can strengthen the patient’s trust in the physician’s decision making and positive outcomes of the treatment plan (Mead et al., 2013). Providers should discuss a patient’s religion or spirituality with them if they are receptive to this idea, because religion can affect decision making, how a patient understands their illness, and provide a coping mechanism for difficult diagnoses and treatments (Puchalski, 2001). This specifically includes listening to a patient’s spiritual history, considering how a patient’s religious and spiritual wellbeing influences their health, and integrating religious leaders when appropriate and needed (Puchalski, 2001).

The role of family and community in a person’s life may vary widely across cultures, and in some cases, a patient’s social and familial ties may influence their cancer care decision-making (Georgas, 2003, Taylor et al., 2004). Often times a family member or friend can act as an advocate, caretaker, interpreter, advisor, or coach in a patient’s care, though in other cases they may could dissuade patients from receiving the recommended treatment. Hispanic breast cancer patients who reported that their spouse was influential in their decision to receive a mastectomy were less likely to receive surgery than patients who reported no or little influence from their
spouse in decision making (Hawley et al. 2008). A meta-analysis of Chinese-American breast
cancer patients found that women were less likely to undergo breast-conserving surgery rather
than modified radical mastectomy even when this procedure was unnecessary, because their
community viewed breast conserving surgery as vain and less effective (Mead et al., 2013). In
Middle Eastern countries, patients are often less concerned about their individual autonomy and
place more value in their family’s wellbeing (Daher, 2012). In some cases, families may cut off a
relative with cancer due to the financial burden or stigma (Daher, 2012). In other cases, a family
may take on end of life care for the patient rather than using hospice care or a nursing home
(Daher, 2012). In these situations, providers must practice open communication with both the
patient and their family to find the best treatment option based on their needs (Daher, 2012). An
approach that emphasizes patient-provider communication is the shared decision-making model.
Considering that until the late 20th and early 21st century many providers practiced the
paternalistic model, providers may need to learn the shared decision-making model before
delving into cultural humility (Charles, Gafni, and Whelan, 1997, Drolet, White, 2012, Brogan et
al., 2018)

**Shared Decision-Making Model as a Prerequisite for Cultural Humility**

**The Shared Decision-Making Model versus the Paternalistic Model**

Before cultural humility can be implemented, the medical institution must undergo a
cultural shift from a more paternalistic, provider-centered model to patient-centered care, also
known as the shared decision-making model. The paternalistic model generally involves a
physician overriding the wishes of a patient or making a decision without the patient’s consent
(Drolet, White, 2012). In contrast, the shared decision-making model involves a dialogue in
which the provider explains treatment options for the patient, and the patient decides what is best for them considering their values, culture, religion, financial circumstances, and other important factors in their life (Brogan et al., 2018). The shared decision-making model emphasizes the relationship between the provider and patient, as well as any family member or friend accompanying them (Charles, Gafni, and Whelan, 1997). This model also prioritizes both the patient and provider actively engaging in decision-making, information sharing, and mutual agreement about the treatment plan (Charles, Gafni, and Whelan, 1997).

While many physicians are transitioning towards the shared decision-making model, some still adhere to the paternalistic model. In the article Selective Paternalism, Drolet and White (2012) argue that the shared decision-making model poses multiple limitations including patient’s lack of health literacy, patient denial, time limitations, as well as the notion that an agreement for the patient’s treatment plan will always be reached. Further, they point out that respecting all patient requests may lead to performing medically futile treatments that give the patient false hope and waste valuable medical resources (Drolet and White, 2012). They go on to claim that due to the highly complex nature of patient beliefs and values, consistently using the shared decision-making model may limit the role of the physician (Drolet and White, 2012). Expanding on that notion, they assert that physicians have enough training and expertise to make decisions for the patient if need be (Drolet and White, 2012). Though these are valid concerns, many providers advocate for the shared decision-making model, and research indicates that this model improves patient satisfaction and outcomes when compared to the paternalistic model (Charles, Gafni, and Whelan 1997, Sepucha and Mulley, 2009, Brogan et al., 2018)
An extensive body of research supports the efficacy of the shared decision-making model in improving the patient’s health care experience (Hawley et al., 2009, Mead et al., 2013, Charles, Gafni, and Whelan 1997, Sepucha and Mulley, 2009, Brogan et al., 2018). Patients show improved quality of life, illness coping, and medication adherence when their provider used the shared decision-making model compared with providers who used the paternalistic model. However, patients from different cultures may have distinct concerns regarding their treatment plan (Hawley et al., 2009). African-American, Whites, and low and high acculturated Latinas with non-metastatic breast cancer, all groups were more likely to choose to receive a mastectomy when they were more involved in the decision-making (Hawley et al., 2009). One meta-analysis on shared decision making in cancer care found that non-White women were less likely to be satisfied with their decision-making role than their white counterparts (Mead et al., 2013). Further, Latinas with low acculturation demonstrated the lowest satisfaction in their decision making among all non-White women when compared to White women (Mead et al., 2013). This meta-analysis determined that level of acculturation, English language proficiency, religion, and preconceived notions about the patient role and their illness prevent effective communication between the patient and provider (Mead et al., 2013). These studies underline the need for providers to promote an active dialogue with patients to develop a treatment plan that satisfies both groups.

Though the shared decision-making model is a step towards patient-centered care, this model does not delve deep enough into the complexities of patient culture and identity. Patients across cultures demonstrate vast differences in decision-making preferences, including type of communication, level of information given, and what kind of decisions they are comfortable making (Mead et al., 2013). Meta-analyses showed that among women with cancer, non-Whites
reported lower satisfaction with their provider compared to Whites, even when their provider practiced the shared decision-making model (Mead et al., 2013). Further, a provider that practices the shared decision-making model without an understanding of the patient’s culture may damage the patient-provider relationship (Mead et al., 2013). Meta-analyses further revealed that Chinese-American women with cancer felt that when their provider presented them with multiple options and asked them for their preferences, they were demonstrating incompetency and a lack of authority (Mead et al., 2013). These examples elucidate that providing patient care which integrates their culture may be more complex than simply following the shared decision-making model, stressing the need for a more comprehensive model.

The Case for Cultural Humility

Cultural Competency versus Cultural Humility

Many medical institutions have aimed to address the increasingly diverse U.S. patient population through various forms of cultural and diversity training (Tervalon and Murray-Garcia, 1998). Cultural competency training teaches medical professionals about beliefs and practices of specific cultures, and once completed, deems them proficient to more effectively treat those patients (Tervalon and Murray-Garcia, 1998). While advocates for cultural competency have attempted to address the lack of patient-centered care in cultural competency by pairing it with the shared decision-making model, recent literature indicates that providers using this model still stereotype their patients and that race may play a key role in negative patient-provider relationships (Saha et al., 2008, Tervalon and Murray-Garcia, 1998, Peek et al., 2011). Cultural humility, however, promotes patient-centered medical interviews, recognizes the diversity within each culture, and acknowledges that each patient may occupy numerous cultural and social spaces that influence how they experience health and illness (Thackrah and Thompson, 2013,
Tervalon and Murray-Garcia, 1998). The downfalls of cultural competency have been illustrated by studies indicating limited improvement in patient outcomes even if cultural competency training improves provider knowledge of numerous cultures (Lie et al., 2011, King 1996, Green et al., 2002, Wyszewanski and Green, 2000).

Case Studies in Cultural Humility

The book The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures by Anne Fadiman (1997) exemplifies why cultural humility provides a more useful strategy for providers than cultural competency. In this true story, Lia Lee, a Hmong immigrant from Laos, began experiencing life-threatening seizures, but her doctors and her family held a contrasting understanding of her disease and how it should be treated (Fadiman, 1997, 21-22). This disconnect in how each group understood the etiology and consequences of Lia’s disease was compounded by the fact that many Hmong refugees believed that American doctors ate the organs of Hmong patients, packaged the bodies of deceased Hmong into food, and took too much blood from patients (Fadiman, 1997, 32). Neil Ernst and Peggy Philp, Lia’s primary pediatricians, remember their relationship with her Hmong parents as having:

A layer of Saran Wrap or something between us, and they were on one side of it and we were on the other side of it. And we were reaching and reaching and we could kind of get into their area, but we couldn’t touch them. So we really couldn’t accomplish what we were trying to do, which was take care of Lia. (Fadiman, 1997, 48).

Lia’s doctors’ unknowing disrespect of Hmong culture despite reading numerous books and articles about Hmong cultural norms and the constant change of medications with minimal resolution of Lia’s symptoms resulted in Lia’s parents and the Merced Hmong community developing a sense of mistrust towards her doctors and the medical institution.
Lia’s case offers a compelling example of many doctors’ inadequate skill set in practicing cross-cultural medicine. Dan Murphy is quoted as saying that her doctors, “had spent hundreds of hours dissecting cadavers and could distinguish at a glance the ligament of Hesselbach and the ligament of Treitz, but none of them had had a single hour of instruction in cross-cultural medicine” (Fadiman, 1997, 61). Due to a medical education bereft of cultural humility training, Lia’s doctors failed to realize that many medical procedures that other patients accepted as routine were taboo in Hmong culture. From a perspective of cultural competency, a doctor with basic knowledge of Southeast Asian culture learned in the 1970s would have been “sufficient” for treating a Hmong patient. Cultural humility, however, emphasizes a “critical consciousness” that accustoms providers to setting aside their personal beliefs and listening to the needs of each patient and steers them away from cultural check lists (Kumagai and Lypson, 2009).

The case of Lia Lee provides a critical example of why cultural humility training is needed for medical professionals. In Lia’s case, most of the medical staff caring for her consistently offended her family and community by disregarding the differences in how Hmong culture perceived epilepsy (Fadiman, 1997). If a doctor with cultural competency training was assigned to Lia’s case, they would have assumed that their course provided enough information to understand and treat any Hmong patient (Kumagai and Lypson, 2009). However, Hmong culture, like most cultures, could change from year to year, community to community, and person to person. In contrast to a provider with cultural competency training, a provider with cultural humility training would assume that they have limited knowledge of Hmong culture and allow the patient to explain how their culture influences their healthcare experience (Kumagai and Lypson, 2009). If Lia’s doctors had been trained in cultural humility, the reciprocated mistrust of Lia’s family and her doctors may have been prevented by a continuous dialogue.
concerning the treatment plan, thereby promoting better health outcomes for the patient and less stress for those taking care of Lia.

For Lia’s case and for cross cultural medicine in general, Fadiman suggests implementing Arthur Kleinman’s 8 question\(^1\) Explanatory Model as a tool to bridge the critical gap in how the patient and provider understand the illness in question (Fadiman, 1997, 260-261). In practice, using Kleinman’s Explanatory Model or modified versions of his model may help medical professionals take a patient’s understanding of their illness into greater account (Hsieh, Hsu, and Wang, 2016). If the patient does not agree with how the doctor explains the illness, they may choose to disregard treatment recommendations or blame their doctor if they do not improve or worsen (Hsieh, Hsu, and Wang, 2016). However, if a provider understands how a patient perceives and experiences their illness, they can attempt to dispel stigma and even make compromises with the patient’s treatment plain to improve satisfaction and effectiveness of care (Hsieh, Hsu, and Wang, 2016). Kleinman’s explanatory model readily fits into cultural humility, as it does not assume the provider fully understands the patient’s culture or identity and allows the patient and provider to have a dialogue concerning the treatment plan.

When discussing Lia’s case with Fadiman, Kleinman also suggested that her providers should have used a cultural broker who understands both the patient’s culture and biomedical culture who can mediate the clinical encounter to help the patient and provider agree upon a treatment plan (Fadiman, 1997, 261). Though often times interpreters or bilingual nurses act as cultural brokers, speaking the same language does not mean that the interpreter understands the

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\(^1\) Arthur Kleinman’s 8 questions are: 1. What do you call the problem? 2. What do you think has caused the problem? 3. Why do you think it started when it did? 4. What do you think the sickness does? How does it work? 5. How severe is the sickness? Will it have a short or long course? 6. What kind of treatment do you think it should receive? What are the most important results you hope she receives from the treatment? 7. What are the chief problems the sickness has caused? 8. What do you fear most about the sickness?
patient’s culture or how to effectively communicate complex medical ideas (Singh, Mckay, and Singh, 1999, Lo and Nguyen, 2018). Racial and ethnic concordance does not necessarily confer a shared experience considering that gender, class, immigration status, level of education, and other factors also influence a patient’s perspective on health and illness (Lo and Stacey, 2008, Lo and Nguyen, 2008). Cultural brokers act as more than an interpreter, as they are knowledgeable about the dominant culture as well as the patient’s culture and can inform the provider of a patient’s cultural taboos or conceptions about health and illness (Singh, Mckay, and Singh, 1999, Lo and Nguyen, 2018). Using cultural brokers in patient encounters readily fits into practicing cultural humility, as it rests on the notion that the patient and cultural broker teach the provider about the patient’s health experience, thus improving upon the provider’s limited knowledge of a patient’s culture and identity.

_Cultural Humility Training for Medical Professionals and in Medical School_

Though many medical schools now offer cultural competency training, one study found that one in five residents felt unprepared to address key components in cross-cultural medicine including mistrust, incorporating interpreters, how the patient perceives the illness, discussing treatment plans, determining influential religious and cultural beliefs, and decision-making difficulties (Weissman and Betancourt, 2005). Further, these difficulties led to medical non-compliance, longer visits, needless labs and diagnostics, lower patient satisfaction and outcomes, and a longer process for obtaining consent (Weissman and Betancourt, 2005). Interestingly, most residents in this study indicated that they received no training on cross-cultural medicine past medical school, and even more alarming, one in ten students never received training or evaluation of their patient-provider communication skills (Weissman and Betancourt, 2005).

Considering that among recent medical school graduates only 20-25% feel prepared to practice
cross-cultural medicine (Weissman and Betancourt, 2005), requiring cultural humility training that teaches providers to learn about a patient’s culture and identity from the patient themself rather than learning expected health behaviors stereotypical of each race and culture may improve providers’ feeling of preparedness to actively and consistently engage with a patient’s culture.

While medical students, residents, and health providers obviously need more applicable and effective training to improve their skills treating an increasingly diverse patient population, developing a curriculum to efficiently achieve this goal poses a difficult task. Through small-group discussions, written reflection, accessible, culturally diverse mentors, and videotaping and analyzing patient-provider interactions, providers and medical school students may develop skills in self-awareness and reflection (Tervalon and Murray-Garcia, 1998). David Reif (2018) suggests that medical staff talk to patients outside of the medical institution – such as community centers and schools – to investigate where the breakdown in communication occurs between patients and providers (D. Reif, personal communication, December 14, 2018). Reif claims that by engaging with their community outside of the medical institution, providers glean a greater understanding of the numerous cultural and social spaces a patient may occupy, and further, how those intersecting identities shape their perceptions of health and illness. The medical field must ardently pursue a more diverse faculty and require cultural diversity training for both students and providers to expose health professionals to a wider array of cultures and perspectives, particularly considering that in a study of more than three thousand residents, almost one third of residents reported limited role models or mentors for cross-cultural medicine (Tervalon and Murray-Garcia, 1998).
Though these solutions will improve healthcare inequities and inadequate cross-cultural practice, current literature indicates that the culture of biomedicine, a medical ideology predicing that each disease and symptom can be explained by facts and logic with strict homogeneity for each patient, may prevent providers from accepting or integrating cultural humility into patient care (Carpenter-Song, et al., 2007). Cultural humility requires that providers question their own preconceived notions of medicine and health in order to allow the patient to teach the provider about their medical experience, though this directly conflicts with the culture of biomedicine. In many cases, such as Lia Lee’s seizures, the patient or patient’s family and the provider often hold disparate explanatory models for the illness, which may lead to poorer patient satisfaction and medical outcomes (Patchar, 1994). To address the discrepancy between biomedical and patient explanatory models, providers should discourage medically harmful cultural practices in a tactful and respectful way and discuss other traditional or cultural healing techniques that could be used instead or alongside biomedical treatments. Providers should not aim to prevent non-harmful traditional healing, but instead discuss how traditional medicine and biomedicine can work in tandem (Patchar, 2009). By implementing cultural humility’s tenet of self-reflection and critique, providers can care for the patient without erasing their culture while simultaneously treating them with biomedical interventions.

While requiring cultural humility training for all current medical professionals and students remains ideal, implementing a program of this scope may face numerous obstacles. In David Reif’s efforts to implement cultural humility training at John’s Hopkins, administrators often placed their concern predominantly in financial profits rather than patient care (D. Reif, personal communication, December 14, 2018). Another issue he found was that medical professionals were already strained for time and resources, so in most cases he was only afforded
one hour for training (D. Reif, personal communication, December 14, 2018). Though these issues may slow the implementation of cultural humility training in medical institutions, the benefits of improving patient care and the provider’s experience with culturally diverse patients outweighs the effort and cost of training. If a provider’s ability to effectively communicate with patients improves, then the healthcare inequalities perpetuated by ineffective patient-provider communication may improve as well.

Conclusion

As our country rapidly diversifies, offering healthcare that effectively treats a wide-array of patient needs poses a significant challenge, though one our country must strive to meet. Considering the impact of health on people’s every day lives and the varying cultural perceptions surrounding health and illness, finding an effective way for providers to address and integrate a person’s culture into their treatment is crucial in providing optimal care. Further, patients that are racially non-concordant with their provider may be more likely to occupy different cultural spaces from their provider, leading to an even larger disconnect in how they understand their illness. Though each aspect of a patient’s life – such as SES, religion, race, country of origin, gender, etc., – plays a role in their health experience, a provider cannot assume that those identities have the same effect on every patient and further, the role of those identities in perceptions of health and illness may shift over time among both individuals and communities. Considering this, cultural humility presents a more comprehensive, life-long methodology for integrating a patient’s cultural needs into their healthcare compared to the canonical cultural competency, and therefore serves as an effective solution to improving the healthcare among racially non-concordant patients and providers.
Citations


(https://www.aacom.org/reports-programs-initiatives/aacom-reports).


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