Chapter 11
Teaching Cultural Humility: Understanding Others by Reflecting on Ourselves

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11.1 Cultural Landscape

The United States has an increasing number of racial and ethnic minorities, as is true of many nations worldwide. The Census Bureau projects that by 2044 more than half of all Americans will belong to a minority group [1]. Illnesses are not defined just by their pathology but also by the larger systems in which they develop and in which they are treated. These systems involve multiple social determinants of health that influence outcomes. One of those determinants is culture. Some have defined culture as an integrated pattern of learned core values, norms, behaviors, beliefs, and customs shared by a specific group of people [2]. Culture shapes how people perceive reality, how they feel and behave, how they understand others, and how they assign meaning to events. It can imply a sense of familiarity with others based on perceived similarities, or a sense of distance based on perceived differences. Culture also defines language, concept framing, the manner in which solutions or treatment are sought, and the methods for defining and measuring success [3].

Health-care institutions must adapt to address the needs of an increasingly diverse patient population as well as an increasingly diverse professional population

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[4]. Academic institutions, accrediting bodies, healthcare policymakers, and governmental agencies have been using strategies such as cultural competence to address diversity and health disparities. The term "competence" implies that there is a defined set of ideas, requirements, or skills that can be learned to comprehend the culture of a patient. The Substance Abuse and Mental Health Services Administration (SAMHSA) in the USA defines cultural competence as the ability to interact effectively with people of different cultures, which will help to ensure that the needs of all community members are addressed [5]. To ensure that this could be implemented broadly, discrete definitions and outcomes were defined. However, this system conveys a false idea that diversity can be condensed into a finite body of knowledge. Even more problematic is the idea that a single person can not only learn but also somehow master this finite body of knowledge.

11.2 Cultural Humility

Cultural humility is a concept created by Tervalon and Garcia [6] to avoid the pitfalls created by trying to "master" culture in health care. Instead, the concept is based on the understanding that providers should instead commit to engage in a continuous process of learning and understanding in which they recognize how their own cultures and assumptions influence the provider–patient relationship and, potentially, patient outcomes. It requires that providers continually engage in self-reflection and self-critique. By embracing their knowledge limitations regarding patients' cultures, providers can create and maintain mutually respectful and dynamic partnerships with patients. This is the beginning of empathy: a recognition of the space between provider and patient attunes the provider to the patient's unique emotional experience of illness and recovery, and the meaning the patient assigns to their experience, which exists in the context of the patient's culture. The provider humbly shares in the patient's uncertainty regarding the care experience, and seeks to develop a greater understanding and connection.

There are the four basic principles of cultural humility, as shown in Table 11.1.

Although cultural humility is relevant across healthcare settings, let us examine a fictional case study of a hospitalized patient in a psychiatric unit to illustrate these principles. During hospitalization, a patient usually interacts with nurses, patient care technicians, phlebotomy technicians, doctors, residents, medical students, family members, friends, custodial staff, administrators, and other members of the hospital team. Many of those individuals will also need to interact with each other to provide care. It is important to consider that not only does the patient have their own set of values, expectations, and multiple cultural roles, but so does each member of that team. This leaves a whole host of possible difficulties in communication and expectations. However, if each person involved in this interaction is able to approach it with receptiveness and an understanding that perceptions will differ, some limitations could be mitigated.

Case Study
You are an orthopedics resident consulting on a patient who has edema and decreased range of motion of the right hand after punching a wall in the psychiatric unit. The patient is a 19-year-old Hispanic male who was admitted for involuntary psychiatric evaluation after being aggressive with police.

Now ask yourself:

- What comes to mind about the patient?
- What comes to mind about his situation?
- How do you expect him to behave when you see him?

Table 11.1 Key principles of cultural humility

Critical self-reflection: • Acknowledgement of personal assumptions and beliefs; thinking about multidimensional cultural identities; examining personal tendencies toward stigma and discrimination
Lifelong learning using patient-focused care: • Using patient-focused interviewing to continuously learn from patients, who are the experts on their own traditions, health beliefs, needs, goals, and values
Recognizing and challenging power imbalances for respectful partnerships: • Addressing provider–patient power imbalances through collaborative partnerships that are developed and maintained, not only with individual patients but also within communities and systems
Institutional accountability: • Undergoing a continuous improvement process in order to foster culturally humble practices

Before a health provider has even met a patient, assumptions are made. Any information that a provider has about the patient, such as age, address, race, ethnicity, previous diagnoses, or chief complaint, can begin to paint a picture about the patient in the provider's mind, even before an encounter begins. Cultural humility begins here. Providers should be aware that their own culture, assumptions, past experiences, and beliefs can influence provider–patient relationships and might affect treatment outcomes. Also, the provider should recognize the potential influence of prior interactions between the patient and other providers. For example, how a consult or note is written can reflect the assumptions of another provider and their interaction with the patient and the team. In a similar fashion, the interactions and opinions discussed among providers can also influence rapport, assessment, and treatment decisions. Being aware of these factors may reduce the risk of making biased or inaccurate conclusions during the assessment and creation of a treatment plan. It can also have a significant impact on the ability of a provider to empathize with a patient and to maintain quality of care as a fundamental priority.

Case Study, Continued

You enter the nursing station and look into the window of the seclusion room to observe the patient. You see a young, well-groomed Hispanic male, thin but not gaunt, with multiple tattoos including two full sleeves and full neck coverage. He is pacing the room, talking to himself angrily. A psychiatry resident approaches you and states that the patient is very angry and just punched the wall. He says the patient was a "frequent flyer" for drug abuse in the children's unit. The patient was always disrespectful and aggressive. As per records, the patient was brought in today by law enforcement after becoming aggressive with his father.

You have the patient brought to the exam room by a member of staff who must remain per unit rules. The patient looks at you and says, "I don't [expletive] need your help." He refuses to look you in the eye and is cradling his right hand. Reflexively you take a step back. The patient suddenly explodes and states "What?! So you think I'm just some druggie too!" You ask the patient to calm down and explain that you just want to get to know him and examine his hand.

He explains that he was treated like a criminal by the police, without reason. Since he arrived at the hospital, the staff have talked to him as if he was still a child and assumed he was "high." He was received by a group of staff as if they were prepared to restrain him. Frustrated, he then lightly punched the wall.

There are tears streaming down the patient's face. You do not interrupt. Given the pause, the patient continues. He is frustrated because he has worked hard to change his life. He reports that after his last admission two years ago, he was sent to a rehab program and actually completed it, for the first time. He has been sober since that time and now even works as a peer specialist while he pursues an undergraduate degree. This is the first time the patient has been home since his recovery.

Here the orthopedics resident may take into consideration all the information gained prior to the meeting, but in the room, they engage in a more open, patient-focused interview. This type of interview was one of the four main concepts comprising cultural humility. The resident expresses empathy and uses reflective listening. The resident allows the patient to express his view of the situation at his own pace. This is a less controlling, less authoritative manner of interviewing, which attempts to create an environment that demonstrates respect for the patient. In this instance, the patient begins to indicate a more complex story than what may have been anticipated by the patient's history and presentation.

Tervalon and Murray-Garcia [6] highlight how unique each person is: a composite of multiple cultural roles. For example, we know that the patient in the case study identifies as male, Hispanic, a son, student, peer specialist, and recovering drug addict. He may also be a part of a certain religious community, a resident of a

certain town, an immigrant from another country, a father or a spouse, a victim of violence, someone with some other chronic medical condition, and so on. Given all these intersections of roles, only the patient can be the true guide on who he is and how his identity affects his current illness. Humility is essential in this process. The provider should make attempts to cede control to the patient and be willing to learn from them in order to have effective health promotion and therapeutic strategies. They have to understand that the patient is a full partner in the therapeutic alliance. This applies not only to individual patients but also to communities and specific populations that providers target or work with to prevent, improve, or treat any kind of medical illness affecting them.

Case Study Continued

The patient allows you to complete a full exam and develop a treatment plan. You go to communicate the treatment plan with the psychiatry resident, and also discuss the case with him and explore the rapport issues you have noticed. The resident points out that he has known the patient for years, even if the patient does not remember him. The patient has gang tattoos, multiple arrests and has even hurt staff members who have tried to help him. Now, as a chief resident, he feels responsible for the safety of his staff and he feels uncomfortable giving him the opportunity to hurt another staff member or patient. You point out that you did not see any indication of gang-like tattoos on the patient. In fact, during your physical exam, you and the patient discussed that he had multiple cover-ups to reflect who he is now. You explain to your colleague that the patient noted how much he regretted getting those tattoos, as they reflected on someone he is not. The resident, having grown up in a nearby community, is surprised to learn all of this. He recognized those older tattoos from gangs in his community and understands how hard leaving the gangs can be.

Here the psychiatry resident is trying to act with competence with regard to the patient. He has experience with this patient in the past, as well as with this community, and so felt he was acting in the most effective and professional way. He had not reflected on how his assumptions could be incorrectly impacting his current interactions with the patient. Extensive knowledge of the community and cultural background we serve is valuable, but without continuous self-reflection, we run the risk of settling into a false sense of security.

Cultural stereotyping often leads to miscommunication and gaps in patient care. This interaction also highlights how our own personal background may affect the interaction with the patient. The resident grew up in a nearby community and thus has an opinion based on those interactions outside the hospital system. This provider already has predefined views about the patient as a cause of the negative experiences in his community, as well as negative actions against his co-workers. Comas-Dias

and Jacobsen discussed how the cultural background of both the clinician and patient influenced the therapeutic relationship [7]. They defined interethnic transference as the patient's response to an ethno-culturally different clinician, and interethnic countertransference as the way an ethno-culturally different clinician may respond to a patient. Given the opportunity to examine how his own experiences and multiple cultural roles, traditions, and perceptions affect his interactions with the patient, this resident may have developed a deeper empathic connection with him.

Case Study Continued

The psychiatry resident speaks with the patient and apologizes for his assumptions. The patient also apologizes, after realizing that his behavior in the past, as well as his angry effect on arrival, may have also played a role. The patient expresses that he has spent a lot of time trying to be a better person and that returning to the same situation with the same result was difficult. He reports that his father was physically and emotionally abusive to him growing up and that his minor sister still lives at home. He returned home to see if she was doing well, but was upset about how his father was treating her. With that information, the team is able to gather appropriate resources for the patient and optimize his treatment plan with his input, rather than without it.

After the patient is discharged, the case is reviewed in an interdisciplinary staff meeting. Among the attendees is the administrative director of the unit, who has been working collaboratively with colleagues and administration to improve their cultural competence training. The director mentions this case to the Chief Medical Officer (CMO) of the hospital and suggests that they incorporate the learned lessons from this experience into their plan to improve cultural competence training. The CMO agrees and proposes it during the administration's next Quality Improvement Committee meeting.

11.3 Teaching Cultural Humility

The fourth tenet of cultural humility outlined by Tervalon et al. is that institutions must be held accountable to improve their procedures and foster humble practices. By providing training and addressing cultural misunderstandings, we can reduce healthcare disparities [8]. However, the idea of teaching others to be humble poses several difficulties. The concept is a paradigm shift for many providers and involves a constant process of practicing the principles discussed above. Cultural competence is usually taught through courses about normative or traditional values of various cultures, or through personal histories or interactions with representatives from

Table 11.2 Institutional standards for culturally responsive care

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Cultural Formulation Interview	1. Cultural definition of the problem 2. Cultural perceptions of cause, context, and support 3. Cultural factors affecting self-coping and past help-seeking 4. Cultural factors affecting current help-seeking
Substance Abuse and Mental Health Services Administration (SAMHSA) Culturally and Linguistically Appropriate Services (CLAS) Requirements	1. Defining values and principles with demonstrated behaviors 2. Attitudes, policies, and structures that enable effective work across culture 3. Valuing diversity 4. Conducting self-assessment 5. Managing the dynamic of difference 6. Acquiring and institutionalizing cultural knowledge 7. Adapting to diversity and the cultural context of the communities the organizations serve
Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements	1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds 2. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation 3. Residents must have the opportunity to participate in inter-professional quality improvement activities. This should include activities aimed at reducing healthcare disparities

particular populations. These experiences can be very helpful in developing providers' awareness of how culture impacts patients' experiences and their care. However, there is a risk that these courses may place the focus on how those communities differ from providers' own traditions and beliefs. This sense of "other" can disengage and separate providers from the patients and communities they serve, rather than bringing them closer together. This gap may become wider as miscommunications feed those perceptions and interactions.

At least three major entities governing care provision and education have set standards related to culturally responsive care (Table 11.2). The American Psychiatric Association, in its Diagnostic and Statistical Manual of Psychiatric Disorders, 4th edition (DSM-IV), introduced the Outline for Cultural Formulation as a framework for including information about the cultural factors that influence an individual's mental disorder and the social and cultural context in which it occurs [9]. In the DSM-5, the Cultural Formulation Interview (CFI) guideline was introduced as a systematic tool to help clinicians and researchers ask questions about race, religion, and culture in a non-judgmental way [10]. It consists of a 16-question interview guide, an informant module, and 12 supplementary modules that expand on each domain of assessment.

On an organizational level, the Substance Abuse and Mental Health Services Administration (SAMHSA) has outlined how administrators can create institutional frameworks for culturally responsive care delivery, policy and procedure development and administrative practices based on Culturally and Linguistically Appropriate Services (CLAS) [11] (see Table 11.2).

Similarly, the Accreditation Council for Graduate Medical Education (ACGME) set the expectation that residents in all medical specialties must show sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation [12]. Training programs must ensure that their curricula prepare residents to practice in a culturally sensitive way. Teaching a set of ideas about different cultures may be straightforward, but training providers to cultivate lifelong learning and self-reflection requires teaching principles for providers to use within their process of developing skills in this lifelong practice. How do we instill these values into an approach that trainees can utilize when in the field? Below we describe examples of some existing teaching models.

11.3.1 Existing Teaching Models

A literature and internet search revealed four training courses or curricula. The *QIAN* (humbleness) curriculum was presented by Chang, Simon and Dong [13]. This model curriculum is based on the works of Chinese philosophers, Chinese cultural values, and contemporary Chinese immigrant experiences throughout the world. It includes the importance of self-*Q*uestioning and critique, bi-directional cultural *I*mmersion, mutually *A*ctive listening, and the flexibility of *N*egotiation. The model focuses on enhancing patient-oriented communication skills and "aims to trigger the reflective minds of both healthcare professionals and patients regardless of cultural or ethnic labels." They also note how this applies to health research within communities, as this approach generates mutual trust, learning, and respect beyond the scope of the research.

In 2012, Jefferson College developed a course titled "Teaching Cultural Humility and Competence: A Multi-Disciplinary Course for Public Health and Health Services Students" [14], provided for master of public health, medical doctor and master of public health, occupational therapy, doctor in pharmacy, and physical therapy students. The course was divided into three themes: (1) diversity, health disparities, and cultural competence; (2) self-reflection: values, beliefs, and behavior; and (3) application to practice. The course was intentionally multidisciplinary in order to develop cultural responsiveness across organizations.

In "Bridging the Gap: A Curriculum to Teach Residents Cultural Humility," Juarez et al. created a yearlong diversity curriculum for second-year family medicine residents [15]. The curriculum included panel presentations, home visits, book discussions, video discussions, relationship-centered interview teaching, simulated patients, using art, exposure to the culture of local seniors, and self-reflection. They

evaluated the effect of the curriculum through trained observations of simulated patients with residents. Residents were more likely to seek a patient's perspective and to include the patient in decision-making after the training. The residents indicated high satisfaction with the learning activities and found the self-reflection exercises to be the most meaningful. The group highlighted three elements that lead to success: (1) grant-funded staff members who worked full time on the project, (2) protected time in the schedule, and (3) structured learning sessions. Lastly, faculty facilitators remained sensitive to resident experience and modeled humility when working with the learners.

The Auburn University School of Nursing found that when they began to partner with a local low-income public housing provider, their students found it difficult and stressful. They postulated that this was largely due to the divergence in the backgrounds of the students versus the patient population. In response to this challenge, they created a reflective journaling program [16]. The aim of this was to embrace cultural humility by developing the student's critical thinking, self-understanding, and self-reflection. They began in their first semester and continued throughout their training. The program found that early journaling allowed the students to recognize cultural differences. Later this grew into understanding how these differences were linked to healthcare disparities and how important culture is in the teaching of clients.

11.3.2 Teaching Methods

Common themes and methods from the training programs described above suggest a few essential components and considerations for a comprehensive course on cultural humility (see Table 11.3).

First, cultural humility training should be included in the core curriculum of training programs and have dedicated staff and protected time devoted to the topic. Education in cultural humility should follow the developmental trajectory of the learners and expand across the span of their training. In the initial stages of training, the focus should be on identifying the trainees' cultural background, encouraging

Table 11.3 Cultural humility curricular suggestions

• Protected time and committed educators
• Continuity across training
• Tools to foster self-reflection
• Use of both real and simulated examples
• Multidisciplinary training using facilitated discussions

self-reflection, and developing an understanding of core concepts. Tools such as journaling can help trainees to be critical of their experiences and perceptions. Following this period of introspection, trainees should learn how to incorporate cultural considerations into the assessment and treatment plan. This includes learning how to provide education about medications and engage in shared decision-making with patients around medication choices in a way that seeks to understand the patient's beliefs regarding medication treatment. Use of real or simulated clinical encounters with patients of diverse backgrounds can help develop and evaluate trainees' attitudes and skills. Lastly, as much as possible, training should be provided in multidisciplinary settings. Training across disciplines creates organizational change, and also allows participants to reflect on how cultural background affects how people may interact in the group dynamics of patient care.

One training methodology that has not being explored as a means to teach cultural humility, but may support group learning regarding culture, is Visual Thinking Strategies (VTS) [17]. This training uses facilitated discussions of visual art, music, and writing to activate transformational learning. For example, a group will move through a curated set of paintings. The discussion may start with objective descriptions and grow to navigate the emotions elicited by the art. In these discussions, art acts as a canvas of multiple meanings that can be unpacked in a group setting. Reflection on the artwork helps develop the capacity of trainees to introspect and communicate [18]. The art also acts as an equalizing tool in multidisciplinary training groups, as there is no "expert" or hierarchy when it comes to personal reactions to works of art. Listening to the reactions of others and approaching their opinions with respect further develops the desired humble stance. With a trained moderator, participants can be taught to navigate discussions of very difficult, conflictual, and even traumatic themes in a safe space. Incorporation of these types of programs in medical schools has been shown to increase empathy, awareness, and team building [19]. This methodology might be effective in stimulating discussions around culture, for example, by examining ethno-culturally distinct works of art. VTS could create a learning environment in which cultural humility becomes an intrinsic part of providers' discourse, fostering respect, and empathy in healthcare settings and in larger contexts.

11.3.3 Future Directions in Teaching Cultural Humility: Structural Competence

Further, systematic studies are needed to evaluate the effectiveness of cultural humility teaching techniques. It is also important to assess how these methodologies might impact efforts to reduce health disparities and address inequality in health care. Cultural humility is a concept that strives to minimize cultural stereotyping and empower the patient in clinical encounters as a means to achieve health equity. However, some experts on stigma and inequality argue that cultural humility (narrowly defined) does not address the systemic socioeconomic and political

conditions that produce inequalities in health care in the first place [20]. The emphasis on cultural competence in medical education has been used to imply that by having the trained ability to identify cross-cultural expressions of illness and health, providers can counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation, or other markers of difference. However, this implication does not take into account that marginalization and health inequity are systemic issues that go well beyond a provider–patient encounter in a hospital or clinic room.

Health inequity results from financial, legal, political, and ethical decisions with which medicine must actively engage if it wishes to help its patients clinically. For example, in the case discussed above, we have not considered the socioeconomic and political factors that predisposed, potentiated, or influenced this patient's mental illness, delinquent activity, barriers in access to care, etc. Expanding cultural humility to recognize systemic power imbalances that go beyond the patient–provider encounter can serve as the basis for health-care professionals to engage in a process of further involvement in addressing the social determinants of their patients' health. Metzl and Hansen propose re-articulating cultural presentations in structural terms in order to effectively address health inequity. They propose that this is necessary to counteract the common notion of culture in clinical settings, as familiarity with the values of different ethnic or demographic groups, without recognition of the deep ways in which complex cultural structures and systemic constructs of privilege and oppression produce inequalities and create barriers to inclusion [21]. There are three US psychiatry residency programs that have developed curricula to teach structural competency: New York University, Yale, and University of California, Los Angeles [22]. These training programs help residents understand patients' experiences of illness in the context of structural factors such as unstable housing and violence, teaching them to address these factors at institutional levels by working with community and government agencies. Residents are involved in projects such as diversion of people with mental illness from forensic to clinical settings, testifying to legislatures on the association between housing availability and mental health, or developing community connectivity and collaboration with community leaders. One thing that may be taught or modeled in these programs is patience with the slow pace of change, while maintaining effort to address structural inequities.

11.4 Conclusion

Cultural humility can be a valuable tool to improve the quality of patient care and also to reduce health disparities. The principles of self-reflection, patient-focused care, and addressing power imbalances can foster a higher level of empathy among clinicians so that they can go beyond demonstrating interest in their patients and share decision-making with them. Cultural humility should be taught as a skill that requires continuous study and practice over time, rather than a definite set of rules

or instructions to follow. It is fundamental to provide dedicated time for this learning process and to go beyond didactic lectures, incorporating methods to stimulate critical thinking and conflict resolution in multidisciplinary group discussions, and allowing experiential learning through examples of real cultural interactions and clinical scenarios.

We note that the construct of cultural humility is not without limitations, as it does not directly address the larger social, economic, and political structures at play beyond direct person-to-person encounters. Teaching providers how to effectively address social determinants of health is an integral partner to cultural humility. At the core of these discussions is the potential of empathy to empower patients, improve outcomes, and promote equality.

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