J Canc Educ (2016) 31:813–815
DOI 10.1007/s13187-015-0878-0

“A Word can become a Seed”: A Lesson Learned about Cultural Humility

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Published online: 8 July 2015
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Abstract Culturally competent cancer care approaches are necessary to effectively engage ethnic and racial minorities. This reflection shares personal insights on this subject gained throughout my journey from a young immigrant to a medical and public health student in the USA. The death of a friend prompted me to explore what I had deemed as my family’s taboo subjects: discussing illness, cancer, and death in the family. However, I eventually realized that it was I who perceived it as taboo subjects. When I inquired earnestly about their health beliefs and values and asked questions in a way that respected those beliefs and values, my family was quite willing to talk about these uncomfortable topics. Subsequent encounters with minority patients and the process of synthesizing this reflection helped me recognize that the way I successfully addressed what I had erroneously assumed to be taboo subjects embodied the idea of cultural humility and can also be applied to issues with other minority patients and families. This recognition will not only make me a better physician but also allow me to become a strong advocate of cultural humility, especially in cancer care and education.

On July 10, 2001, my parents brought my younger brother and me to the USA from South Korea so that we could have a better life. Uprooting everything and moving to the USA was a tremendous undertaking, but my family’s placing the well-being of the younger generation above all made it possible. However, despite my parents’ best intentions, our new life in America was unbearable. The language and cultural barriers seemed insurmountable to my 13-year-old self. Gritting my teeth, I became determined to overcome these barriers. I memorized a Korean-English dictionary, read *Arthur*, watched *Sesame Street*, and listened to NPR. I saw the result of my efforts when one day, after 6 months of studying, I tuned into NPR and actually understood the words, “From NPR News, this is ‘All Things Considered.’”

Over time, my knowledge of English and American culture strengthened. Being a child of two worlds, I aspired to become a diplomat, a liaison between worlds. Studying political science in college—perhaps in part due to my status as an ethnic immigrant—taught me that what genuinely piqued my interest was the topic of racial and ethnic disparity. I learned that disparity in political power, socioeconomic status, and education can create dichotomous worlds, even within the same country. And it was evident that any type of disparity led to the deterioration of the mental and physical well-being of one of those worlds. Learning this, I wished to be a liaison between these worlds and work to protect the well-being of both. With this mindset, I embarked upon a MD and MPH dual degree path. With zeal, I raced through the first 2 years of medical school. As I started my third year, however, my race was abruptly halted and my worldview was turned upside down when one of my housemates was fatally shot in the house by armed burglars. Having lost someone with whom I had shared meals, memories, dreams, and home, I began an introspective journey into what life and death meant to me. In doing so, I remembered that this was not the first time I had experienced the death of someone I knew.

My grandfather had passed away when I was eight from gastric cancer, but I was never told very much about it. In my experience, illness, cancer, and death seemed to be more or less taboo subjects in my family. However, during my introspective journey, I eventually dared to ask my family why

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they avoided talking about these topics. They either responded that they did not feel such information was important or cited the Korean proverb, "A word can become a seed." Indeed, Koreans believe strongly that words are seeds that can bloom into reality. Thus, it was reasonable for my family to fear that speaking about illness and death in the family will make them come true. To overcome this barrier to an open discussion, I appealed to my family's value of placing the well-being of the younger generation above all by emphasizing how an open discussion about illness and death in the family could help the younger generation prevent or survive illness and death. To address their fear that talking about illness and death would make them come true, I reasoned that talking about prevention and promoting the well-being of the younger generation can then equally come true. In this framework, my family became more willing to discuss illness and death in the family, especially the untimely death of my grandfather.

Evidently, he had many of the classic risk factors for gastric cancer: a diet high in salty, pickled foods and dried fish, possible past history of chronic gastric inflammation, and an extensive family history of gastric cancer [1]. While his diet was consistent with an East Asian diet, our family history of gastric cancer took me by surprise. My parents and relatives all knew of this, yet no one talked about it or took preventive measures. My grandfather not once sought preventive or even regular medical care until it was too late. He died soon after imaging studies revealed metastatic gastric cancer.

Synthesizing this narrative from bits and pieces of stories I gathered from my family, I realized it was actually I who perceived illness and death as taboo topics within the family. Just because my family did not discuss these issues did not mean that they were off-limits. When I inquired earnestly into their cultural beliefs and subsequently framed my question in a culturally competent way, my family was quite willing to discuss these things. Thanks to further encounters with minority patients and the process of synthesizing this reflection, I learned that the manner in which I broke down what I had perceived to be a cultural taboo embodied the idea of cultural humility and can also be applied to other cultures [2].

Healthcare providers in the USA may assume that a minority patient's hesitance or unwillingness to discuss certain health information is due to a cultural idiosyncrasy or taboo and do not inquire further. In some cases, providers may have a false sense of security in their knowledge of different cultures and make generalized assumptions or stereotypes about a certain culture. As presented in this reflection, I have also made assumptions about my own family initially. However, it is critical that providers inquire about culturally shaped health values, beliefs, and behavior instead of making assumptions. In other words, it may benefit providers to embrace the idea of cultural humility versus cultural competency. Cultural competency implies that culture is a fixed and finite body of knowledge that one can master. On the other hand, cultural humility encourages a lifelong commitment to self-evaluation and self-critique on a provider's knowledge of culture [2]. In fact, racial and ethnic minorities in the USA tend to appreciate a provider's attempt to understand and accommodate them [3]. While they respect healthcare providers, they are also afraid that their language barrier and cultural beliefs will not be understood or appreciated by the providers [4]. Thus, a provider's cultural humility—earnestly inquiring into their culture without assuming or generalizing—will be sincerely appreciated by minority patients and families.

Over the next decade, as racial and ethnic minorities come to comprise more than 50 % of the US population, minorities, as a group, will become the majority [5]. This change in demographic characteristics further underscores the importance of cultural humility in healthcare. Cultural humility is especially important in cancer care and education, for providers, patients, and families must thoroughly discuss diagnosis, prognosis, treatment options, the use of complementary and alternative medicine, support systems, insurance options, and sometimes end-of-life decisions [6–11].

In closing, I can personally testify that cultural humility has now led to my family avoiding risk factors for gastric cancer and seeking preventive screenings. The idea of cultural humility has changed my perspective on how to respect and treat minority patients, but I also believe that it can benefit other healthcare students, trainees, and providers by strengthening curricula on racial and ethnic disparities that are currently being developed by entities such as the Society of General Internal Medicine Health Disparities Task Force [12]. Ultimately, my humble hope is that speaking about cultural humility, especially in cancer care and education, will make it come true for us all.

Acknowledgments I wish to express my sincere gratitude to Dr. Patricia Mullan for her brilliant insights and continuous encouragement.

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