CULTURAL HUMILITY VERSUS CULTURAL COMPETENCE: A CRITICAL DISTINCTION IN DEFINING PHYSICIAN TRAINING OUTCOMES IN MULTICULTURAL EDUCATION

MELANIE TERVALON, MD, MPH
Children's Hospital Oakland
JANN MURRAY-GARCÍA, MD, MPH
University of California, San Francisco

Abstract: Researchers and program developers in medical education presently face the challenge of implementing and evaluating curricula that teach medical students and house staff how to effectively and respectfully deliver health care to the increasingly diverse populations of the United States. Inherent in this challenge is clearly defining educational and training outcomes consistent with this imperative. The traditional notion of competence in clinical training as a detached mastery of a theoretically finite body of knowledge may not be appropriate for this area of physician education. Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.

Key words: Medical education, minority populations, multicultural, racism, underserved populations.

The increasing cultural, racial, and ethnic diversity of the United States compels medical educators to train physicians who will skillfully and respectfully negotiate the implications of this diversity in their clinical practice. Simultaneously, increasing attention is being paid to nonfinancial barriers that operate at the level of the physician/patient dynamic. This dynamic is often compromised by various sociocultural mismatches between patients and providers, including providers' lack of knowledge regarding patients'

Received December 13, 1996; revised June 26, 1997; accepted June 26, 1997.

health beliefs and life experiences, and providers' unintentional and intentional processes of racism, classism, homophobia, and sexism.[1-3]

Several recent national mandates calling for innovative approaches to multicultural training of physicians have emerged from various sources. The Pew Health Professions Commission, specifically seeking to give direction to health professions education for the twenty-first century, stated that "cultural sensitivity must be a part of the educational experiences that touches the life of every student."[4] The Institute of Medicine defines *optimal primary care* as including "an understanding of the cultural, nutritional and belief systems of patients and communities that may assist or hinder effective health care delivery."[5]

The necessity for multicultural medical education provides researchers and program developers with the challenge of defining and measuring training outcomes and proving that chosen instructional strategies do indeed produce these outcomes. However, in the laudable urgency to implement and evaluate programs that aim to produce cultural competence, one dimension to be avoided is the pitfall of narrowly defining competence in medical training and practice in its traditional sense: an easily demonstrable mastery of a finite body of knowledge, an endpoint evidenced largely by comparative quantitative assessments (i.e., MCATs, pre- and postexams, board certification exams).

Rather, cultural competence in clinical practice is best defined not by a discrete endpoint but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves (L. Brown, MPH, Oakland health advocate, personal communication, March 18, 1994). This training outcome, perhaps better described as cultural humility versus cultural competence, actually dovetails several educational initiatives in U.S. physician workforce training as we approach the twenty-first century.[4-7] It is a process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners.[1,2,7] It is a process that requires humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care.[8,9] And it is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities on behalf of individual patients and communities in the context of community-based clinical and advocacy training models.[4,6,7]

Self-reflection and the Lifelong Learner Model

Increasing trainees' knowledge of health beliefs and practices is critically important. For instance, the Cambodian child who comes in with the linear marks of "coining," a Southeast Asian healing practice, should not be mistaken for the victim of parental child abuse.

To be avoided, however, is the false sense of security in one's training evidenced by the following actual case from our experience: An African American nurse is caring for a middle-aged Latina woman several hours after the patient

had undergone surgery. A Latino physician on a consult service approached the bedside and, noting the moaning patient, commented to the nurse that the patient appeared to be in a great deal of postoperative pain. The nurse summarily dismissed his perception, informing him that she took a course in nursing school in cross-cultural medicine and "knew" that Hispanic patients overexpress "the pain they are feeling." The Latino physician had a difficult time influencing the perspective of this nurse, who focused on her self-proclaimed cultural expertise.

This nurse's notion of her own expertise actually stereotyped the patient's experience, ignored clues (the moaning) to the patient's present reality, and disregarded the potential resource of a colleague who might (albeit not necessarily) be able to contribute some relevant cultural insight. The equating of cultural competence with simply having completed a past series of training sessions is an inadequate and potentially harmful model of professional development, as evidenced by this case.

In no way are we discounting the value of knowing as much as possible about the health care practices of the communities we serve. Rather, it is imperative that there be a simultaneous process of self-reflection (realistic and ongoing self-appraisal) and commitment to a lifelong learning process. In this way, trainees are ideally flexible and humble enough to let go of the false sense of security that stereotyping brings. They are flexible and humble enough to assess anew the cultural dimensions of the experiences of each patient. And finally, they are flexible and humble enough *to say that they do not know when they truly do not know* and to search for and access resources that might enhance immeasurably the care of the patient as well as their future clinical practice.

In a related manner, an isolated increase in knowledge without a consequent change in attitude and behavior is of questionable value. In fact, existing literature documenting a lack of cultural competence in clinical practice most reflects not a lack of knowledge but rather the need for a change in practitioners' self-awareness and a change in their attitudes toward diverse patients.[10-13] These data indicate that the prescription of clinical resources from prevention services to potentially life-saving procedures is often differential, dependent on the race or ethnicity of the patient. For example, a study in a university emergency department showed that Latinos were half as likely as white patients to receive analgesia for the same, usually very painful, long-bone fractures, regardless of the linguistic capability or insurance status of the patient.[10] A follow-up study in the same institution showed no difference in physicians' assessment of the level of pain experienced by white and Latino patients experiencing the same, isolated injury.[11] Another study showed that while African Americans are twice as likely to go blind from progressive ophthalmologic diseases such as glaucoma, they are half as likely to receive sight-saving procedures.[12] Such disturbing evidence[13] from the medical profession is a sobering reflection of the parallel reality and tragic costs of racism that persist in American society and that potentially influence every physician.

Clearly, program developers and researchers cannot, in our cultural competency training, simply stimulate a detached, intellectual practice of describing "the other" in the tradition of descriptive medical anthropology. At the heart of this education process should be the provision of intellectual and practical leadership that engages physician trainees in an ongoing, courageous, and honest process of self-critique and self-awareness. Guiding trainees to identify and examine their own patterns of unintentional and intentional racism, classism, and homophobia is essential.[1,2,14]

One way to initiate such a constructive process is to have trainees think consciously about their own, often ill-defined and multidimensional cultural identities and backgrounds.[2] In leading trainees into this process of cultivating self-awareness and awareness of the perspectives of others, trainers and program planners have used the following pedagogical approaches with success: small-group discussions; personal journals; availability of constructive professional role models from cultural groups and from the trainee's groups; and videotaping and feedback, including directed introspection of residents' interactions with patients.[1-3,15,16] Recognition and respect for others' cultural priorities and practices is facilitated by such initial and ongoing processes that engender self-knowledge.

At the same time and by the same process of self-reflection, awakening trainees to the incredible position of power physicians potentially hold over all patients, particularly the poor, is critical.[2,9,17] Especially in the context of race, ethnicity, class, linguistic capability, and sexual orientation, physicians must be taught to repeatedly identify and remedy the inappropriate exploitation of this power imbalance in the establishment of treatment priorities and health promotion activities.

Again, humility, and not so much the discrete mastery traditionally implied by the static notion of competence, captures most accurately what researchers need to model and hold programs accountable for evaluating in trainees under the broad scope of multicultural training in medical education.

Patient-focused interviewing and care

Embodied in the physician who practices cultural humility is the patient-focused or language-focused interviewing process.[8,9,18,19] Studies of patient-physician communication have shown a strong bias on the part of physicians against patient-initiated questions and agendas, with physicians in one study initiating over 90 percent of the questions.[19,20] Another study[21] demonstrated that although poor and minority patients wanted as much information regarding their conditions as did other patients, they received less information regarding their conditions, less positive or reinforcing speech, and less talk overall.[9,21]

Patient-focused interviewing uses a less controlling, less authoritative style that signals to the patient that the practitioner values what the patient's agenda and perspectives are, both biomedical and nonbiomedical. With these

communication skills, perhaps along with other specifically cross-cultural interaction techniques,[3,22,23] physicians potentially create an atmosphere that enables and does not obstruct the patient's telling of his or her own illness or wellness story. This eliminates the need for a complete mastery of every group's health beliefs and other concerns because the patient in the ideal scenario is encouraged to communicate how little or how much culture has to do with that particular clinical encounter.

For example, Ridley[14] describes the uniqueness of a patient by detailing the patient's "conjoint membership in eight cultural roles:" as a Mexican American, male, father, husband, Catholic, mechanic, night-school student, and resident of East Los Angeles. Only the patient is uniquely qualified to help the physician understand the intersection of race, ethnicity, religion, class, and so on in forming his (the patient's) identity and to clarify the relevance and impact of this intersection on the present illness or wellness experience. Relevant and effective prevention, health promotion, and therapeutic strategies can then be developed that take into account the patient's life priorities, health beliefs, and life stressors. Humility is a prerequisite in this process, as the physician relinquishes the role of *expert* to the patient, becoming the *student* of the patient with a conviction and explicit expression of the patient's potential to be a capable and full partner in the therapeutic alliance.

Community-based care and advocacy

There is increasing consensus that a substantial portion of physicians' clinical training needs to occur in community sites.[4,6,24-26] It is argued that training needs to happen in arenas where most physicians will eventually practice, away from the university-based, largely tertiary medical center. Part of this training directive includes a population-based approach to health promotion and disease prevention that works toward the optimal health of communities; that is, health in its broadest sense of physical, mental, and social well-being. Evans[24] states that "surely a small part of each physician's responsibility should extend beyond the care of individual patients to the advocacy for changes in the community's policies and practices that influence determinants of health, causes of disease, and the effectiveness of health services."

Competency in advocacy is actually mandated by the American Academy of Pediatrics as a skill to be acquired during pediatric residency. This professional skill is to be taught by way of "structured educational experiences that prepare residents for their future role as advocates for the health of all children . . . with particular attention to underserved populations."[6]

It is hoped that community-based care and advocacy training would go beyond working with community physicians and even beyond training in legislative advocacy to include systematically and methodically immersing trainees in mutually beneficial, nonpaternalistic, and respectful working relationships with community members and organizations. Experiencing with the community the factors at play in defining health priorities, research

activities, and community-informed advocacy activities requires that the physician trainee recognize that foci of expertise with regard to health can indeed reside outside of the academic medical center and even outside of the practice of Western medicine. Competence, thus, again becomes best illustrated by humility, as physician trainees learn to identify, believe in, and build on the assets and adaptive strengths of communities and their often disenfranchised members. Requiring ongoing self-reflection and a parallel notion of patient-(community-) focused interactions, the possibility then exists for planning, practice, and advocacy in community health work in which physicians and physician trainees are both effective students of and partners with the community.

Institutional consistency

The same processes expected to affect change in physician trainees should simultaneously exist in the institutions whose agenda is to develop cultural competence through educational programs. Self-reflection and self-critique at the institutional level is required, encompassing honest, thorough, and ongoing responses to the following questions: What is the demographic profile of the faculty? Is the faculty composition inclusive of members from diverse cultural, racial, ethnic, and sexual orientation backgrounds? Are faculty members required to undergo multicultural training as are the youngest students of the profession? Does the institutional ethos support inclusion and respectful, substantive discussions of the clinical implications of difference? What institutional processes contradict or obstruct the lessons taught and learned in a multicultural curriculum (i.e., if it is taught that practitioners should not use children or other family members as translators, does the institution provide an accessible alternative?)? What is the history of the health care institution with the surrounding community? And what present model of relationship between the institution and the community is seen by trainees?

Time-limited and explicit educational goals are one dimension of demonstrated institutional cultural competence. For instance, developing a written plan of faculty recruitment and/or curricular development to be in place by a designated date could be a point to which the community and/or other external entities hold the institution publicly accountable with regard to issues of race, ethnicity, language, culture, sexual orientation, and class in health care.

Summary of the challenge to medical education researchers

The emphasis on demonstration of process as opposed to endpoint is not meant to imply that training outcomes in cultural competence programs cannot be measured or monitored. Capturing the characteristic of cultural humility in individuals and institutions is possible, especially with mixed methodologies that use qualitative methods (including participant observation, key informant interviews, trainees' journals, and mechanisms for com-

munity feedback)[27-30] and action research models[31,32] to complement traditional quantitative assessments (pre- and postknowledge tests, patient and trainee surveys)[27-30] of program effectiveness. A potentially valuable measure is the documentation of an active, ongoing institutional process that includes training, established recruitment and retention processes, identifiable and funded personnel to facilitate the meeting of program goals, and dynamic feedback loops between the institution and its employees and between the institution and patients and/or other members from the surrounding community.

This is not to say that the measurement of individuals' or institutions' cultural competence is a well-developed area of research. Witness this present discussion on defining training outcomes. Indeed, the definition and measurement of program effectiveness in producing cultural competence is a relatively new arena of inquiry in need of careful and attentive intellectual leadership. Nonetheless, acknowledging the necessity for creativity in a program's development and evaluation stages will help avoid the pitfall of adopting the status quo in documenting clinical competence.

Conclusion

In this critically important dialogue of defining training outcomes, it is proposed that the notion of cultural humility be distinguished from that of cultural competence. Cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and nonpaternalistic partnerships with communities on behalf of individuals and defined populations.

Acknowledgments

This work was supported by grants from the California Wellness Foundation, the Federal Office of Minority Health (DHHS), the East Bay Neonatology Foundation, and the Bay Area Physicians for Human Rights.

REFERENCES

1. Borkan JM, Neher J. A developmental model of ethnosensitivity in family practice training. Fam Med 1991 Mar-Apr;23(3):212-17.
2. Pinderhughes E. Understanding race, ethnicity and power: The key to efficacy in clinical practice. New York: Free Press, 1989.
3. Kavanagh K, Kennedy P. Promoting cultural diversity: Strategies for health care professionals. Newbury Park, CA: Sage, 1992.
4. Pew Health Professions Commission. Critical challenges: Revitalizing the health professions for the twenty-first tentury. San Francisco: UCSF Center for the Health Professions, 1995.
5. Committee on the Future of Primary Care. Institute of Medicine: Defining primary care: An interim report. Washington, DC: National Academy Press, 1994.

6. Accreditation Council for Graduate Medical Education. Proposed guidelines and recommendations for the 1996-1997 academic year. Pediatric Review Committee, 1995. Washington, DC: U.S. Department of Health and Human Services.
7. Tresolini C, Pew-Fetzer Task Force. Health professions education and relationship-centered care. San Francisco: Pew Health Professions Commission, 1994.
8. Smith RC, Hoppe RB. The patient's story: Integrating the patient- and physician-centered approaches to interviewing. Ann Intern Med 1991 Sep 15;115(6):470-77.
9. Ventres W, Gordon P. Communication strategies in caring for the underserved. J Health Care Poor Underserved 1990 Winter;1(3):305-14.
10. Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. JAMA 1993 Mar 24-31;269(12):1537-39.
11. Todd KH, Lee T, Hoffman JR. The effect of ethnicity on physician estimates of pain severity in patients with isolated extremity trauma. JAMA 1994 Mar 23-30;271(12):925-28.
12. Javitt J, McBean A, Nicholson G et al. Undertreatment of glaucoma among Black Americans. N Engl J Med 1991 Nov; 825(20): 1418-1422.
13. Friedman E. Money isn't everything. Nonfinancial barriers to access. JAMA 1994 May 18;271(19):1535-38.
14. Ridley C. Overcoming unintentional racism in counseling and therapy. Thousand Oaks, CA: Sage, 1995.
15. Sabnani H, Ponterotto J, Borodovsky L. White racial identity development and cross-cultural counselor training: A stage model. Counseling Psychologist 1991 Jan;19(1):76-102.
16. Tatum BD. Talking about race, learning about racism: The application of racial identity development theory in the classroom. Harv Educ Rev 1992 Spring;62(1):1-24.
17. Watzkin H, Britt T. Processing narratives of self-destructive behavior in routine medical encounters: Health promotion, disease prevention, and the discourse of health care. Soc Sci Med 1993 May;36(9):1121-36.
18. Mishler EG, Clark JA, Ingelfinger J, et al. The language of attentive patient care: A comparison of two medical interviews. J Gen Intern Med 1989 Jul-Aug;4(4):325-35.
19. Beckman HB, Frankel RM. The effect of physician behavior on the collection of data. Ann Intern Med 1984 Nov;101(5):692-96.
20. Platt FW, McMath JC. Clinical hypocompetence: The interview. Ann Intern Med 1979 Dec;91(6):898-902.
21. Hall JA, Roter DL, Katz NR. Meta-analysis of correlates of provider behavior in medical encounters. Med Care 1988 Jul;26(7):657-75.
22. Berlin EA, Fowkes WC Jr. A teaching framework for cross-cultural health care: Application in family practice. West J Med 1983 Dec;139(6):934-38.
23. Kleinman A. Patients and healers in the context of culture: An exploration of the borderline between anthropology, medicine, and psychiatry. Berkeley: University of California Press, 1980.
24. Evans JR. The "health of the public" approach to medical education. Acad Med 1992 Nov;67(11):719-23.
25. Wright RA. Community-oriented primary care: The cornerstone of health care reform. JAMA 1993 May 19;269(19):2544-47.
26. DeWitt TG, Starr S. Educating pediatric residents in community settings. Curr Opin Pediatr 1995 Oct;7(5):489-93.
27. Jayawickramarajah PT. How to evaluate educational programmes in the health professions. Med Teach 1992;14(2-3):159-66.
28. Walker M. Analysing qualitative data: Ethnography and the evaluation of medical education. Med Educ 1989 Nov;23(6):498-503.
29. Bushy A. Ethnocultural sensitivity and measurement of consumer satisfaction. J Nurs Care Qual 1995 Jan;9(2):16-25.
30. Leppert PC, Partner SF, Thompson A. Learning from the community about barriers to health care. Obstet Gynecol 1996 Jan;87(1):140-41.

31. Borrero M, Schensul J, Garcia R. Research based training for organizational change. Urban Anthro 1982;11(1):129-53.
32. Greenwood D, Whyte WF, Harkavy I. Participatory action research as a process and as a goal. Human Rel 1993 Feb;46(2):175-92.

DR. TERVALON is currently Senior Director, Office of the President at The California Endowment, 21650 Oxnard Street, Suite 1200, Woodland Hills, CA 91367, and former Director of the Multicultural Curriculum Program (MCCP) at Children's Hospital, Oakland, California. DR. MURRAY-GARCÍA is a former Fellow at the Institute for Health Policy Studies at the University of California, San Francisco, and the former Research Associate with the MCCP.