

CULTURAL HUMILITY

A GUIDE FOR MEDICAL PRACTITIONERS

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INTRODUCTION

PURPOSE & BACKGROUND

This document is intended to serve as a brief guide to how medical students and other medical practitioners can work to practice cultural humility, and how cultural awareness can enhance doctor-patient relationships.



This project was made possible through the support of an American Medical Women's Association (AMWA) and American Women's Hospitals Service (AWHS) Overseas Assistance Grant as well as through the support of Mayo Clinic Alix School of Medicine AZ. With this assistance, I was able to spend four weeks in Quetzaltenango (Xela), Guatemala at the Pop Wuj language

school. The Pop Wuj language school has a strong emphasis on community involvement. By providing affordable medical services, clean stoves, and nutrition education to children and families, they are taking a wholistic approach to health.

IMPORTANCE

Cultural humility begins with acknowledging our own limitations and biases. Once we establish a learning mindset, curiosity and respect pulls us into a new way of interacting with others. When we acknowledge that learning is an ongoing process requiring both flexibility and self-challenge, we cultivate lifelong learning habits. This is the foundation for responsible work with medically underserved patients, especially those from different cultures. As medical providers, it is our responsibility to commit to ongoing learning about those we are partnering with in their health.

As someone working with medically underserved patients, it is vital to become familiar with the challenges of providing care in resource-limited settings, understand common medical problems seen in these settings, and work to better understand cultural beliefs and hesitations surrounding western medicine. It is also the responsibility of healthcare providers to continually seek to learn more about the cultures and the individuals we serve.

When considering all the inequities of the world and problems within most healthcare systems, the barriers to change can feel daunting and insurmountable. However, I believe that by working one step at a time to create change and focusing on one patient encounter at a time, we can collectively improve the system.

LIMITATIONS

My hope is that this resource will help to lay the groundwork for others who want to practice cultural humility by sharing lessons from my experiences working with patients from different cultures at home in the USA and abroad. This guide is compiled using many wonderful resources, though the reflections are my own and as they are from only one perspective, are naturally limited.

It is important to point out that through cultural humility, we cannot place the burden of education on another person. It is vital that we seek to educate ourselves about the history and cultures of other places and other groups. By building our understanding of historical contexts, we can better understand where others are coming from. This can be accomplished in many ways, from watching documentaries to reading novels from authors of other backgrounds that tell diverse stories, there are nearly unlimited ways to expand our worldviews. Even as we build our cultural understanding, remember that everyone is unique. I encourage medical providers to enter each encounter with a patient curious about the individual in-front of them as each person has a unique set of experiences, beliefs, and desires.

GUATEMALA

As the birthplace of this project, please see below for an extremely condensed version of Guatemala's history from the UN's Ministry of Foreign Affairs website:

The History of Guatemala begins with the arrival of its first inhabitants approximately between 12,000 BC and 18,000 BC. Civilization developed and flourished during the Pre-Columbian era with little contact with other cultures outside the Mesoamerican area. The Mayan civilization dominated the region for about 2000 years before the arrival of the Spaniards who arrived in the early part of the 16th century, and although most of the great Maya cities in the lowlands of Peté, The northern part of the country, had already been abandoned since 1000 AD. The central highland states were still flourishing until the arrival of the Spanish conquistador Pedro de Alvarado, who subjected these states from 1523. Guatemala was a Spanish colony for almost 300 years, before its independence on September 15, 1821; After a brief period of political uncertainty, it became part of the Mexican empire and later belonged to a federation called United Provinces of Central America, until the federation disintegrated with a civil war between 1838-1840. Since then, Guatemala's history has been divided between periods of democratic governments and periods of civil war and military juntas. Guatemala emerged from a 36-year war following the signing of the peace accords in 1996.



Photo of Indigenous Mayan women from Trama Textiles. "Trama Textiles is a 100% worker owned and run cooperative. Their mission is to create work for fair wages for the women of Guatemala, to support their families and communities, and to preserve and develop cultural traditions by maintaining textile arts and their histories. Weaving is a century-old Maya art which remains a fundamental part of Maya identity today. Across Guatemala, each Maya town has its own unique traje (traditional dress) which distinguishes it from another."

According to the 1999 report written by the U.N. backed Commission for Historical Clarification titled *Guatemala: Memory of Silence*: "With the outbreak of the internal armed confrontation in 1962, Guatemala entered a tragic and devastating stage of its history, with enormous human, material and moral cost." The commission itself documented 42,275 victims of human rights violations and acts of violence (including arbitrary execution and forced disappearances). The commission further estimated that the number of persons killed or disappeared as a result of the confrontation reached over 200,000 with eighty-three percent of fully identified victims being Mayan. The report also concluded that 93 percent of human rights violations perpetrated during the conflict were carried out by state forces and military groups.

U.S. involvement in the country was singled out by the commission as a key factor contributing to human rights violations, including training in counterinsurgency techniques and assisting the national intelligence apparatus.

Modern day Guatemala still carries the wounds inflicted by this internal conflict as well as past colonial scars. Despite these substantial generational traumas, Guatemala is culturally rich and is home to 24 principle ethnic groups. Spanish is the official language, although there also exists twenty-two unique Mayan languages, one Garifuna, one Xinca, and one of the African descendant peoples. Today, there continues to be a strong cultural divide between the unique cultures that manifests as persistent racism and discrimination against the Indigenous Peoples. There exist strong disparities between the Indigenous and the non-indigenous population in employment, income, health, and education (Elías, 2022, p. 403). Unfortunately, “Guatemala is well known not just for its extreme wealth inequalities but for having a ruling class or oligarchy comprising around fifty families of European descent who have maintained economic and political dominance since colonial times” (Green, 2022).

One stark example of this inequity is seen in nutrition. Guatemala has the fourth highest rate of chronic malnutrition in the world. According to the World Food Program, 46.5% of Guatemalan children under the age of five are chronically malnourished. This devastating problem is even more severe among indigenous children, which is represented by stunting/short stature affecting the poorest, less educated and indigenous two times more than the richest, more educated and non-indigenous (Mazariegos 2020).

CULTURAL HUMILITY IN PRACTICE

DEFINITION

In their 1998 discussion on *Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education*, Dr. Tervalon and Dr. Murray-Garcia propose a definition for the term cultural humility as “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.” This is in contrast to the idea of cultural competency, which implies that there is a possible endpoint or mastery of learning about another culture. Part of the beauty of cultural humility is being able to acknowledge that we will never be able to learn everything about a person’s culture and that each person has a unique relationship with their culture. Cultural humility means that we are never done learning and growing, or finding new ways to embrace and lift up those we encounter.

BIASES

We also must start by acknowledging that we all make assumptions (consciously or unconsciously) about others based on their appearance, culture, and background. I highly recommend reading a book about unconscious biases; two of my favorites are *Blindspot: Hidden Biases of Good People* by Mahzarin R. R. Banaji and *Blink* by Malcom

Gladwell. I think it is also very valuable to use the Harvard [Implicit Association Test](#) to help build conscious awareness of exactly what our unconscious biases are.

It is also important to develop cultural self-awareness by considering our own cultural norms, attitudes, beliefs, and behaviors. From there, we can work to identify and examine our own personal biases, stereotypes, and prejudices (UNC, 2016).

Seek out self-education with resources such as: [Project READY: Reimagining Equity & Access for Diverse Youth](#) and the Kirwan Institute for the Study of Race and Ethnicity (Ohio State University) [Implicit Bias Module Series](#)

Consider the impact cultural differences might be having on our interactions. By reflecting on the stories we tell ourselves about another person, we can pause before our assumptions influence our interaction or the care we are providing to a patient.

Step one: what are some possible biases I may be bringing to the situation?

Step two: what information do I have and do I not have?

Step three: what story am I telling?

We can also utilize resources to examine and reflect on areas for growth in our implementation of cultural humility. One such example was developed by the National Center for Cultural Competency and can be found [here](#).



Photo depicts two children being seen by a Guatemalan physician. Photo taken while shadowing in a Centro de Salud (government healthcare facility) in Antigua Guatemala. Consent obtained from those photographed and guardians.

PERSON CENTERED CARE

Make sure to address patient concerns by making an agenda at the beginning of a visit and try to elicit patient ideas, concerns, and expectations about the problems you are discussing.

As described further by Dr. Tervalon and Dr. Murray-Garcia in *Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education*:

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.

WHAT QUESTIONS CAN I ASK

Fraser Health Diversity Services has compiled a list of possible questions to ask patients in order to provide more informed and considerate care. This document is based on *Cultural Assessment and Care Planning* (Narayan 2003). Please see this [resource](#) for a more complete list of questions to consider asking during patient care. Below are some examples from this document.

Many people draw on their religious/spiritual beliefs to help them...

- "Is there anything we can do to help you find the spiritual strength you need at this time?"
- "Is there a religious leader/healer who you might find helpful to include in our conversation?"

The healthcare team that will be caring for you want to be polite and respectful to you and your family...

- "How would you like to be addressed?"
- "Are there certain cultural courtesies we should practice when we meet?"
- "Are there things we might do that you would find offensive?"
- **"Could you please let us know if anything we do seems rude or offensive so we can fix it?"**

Everyone has cultural beliefs and customs that they find help them to heal...

- "Are there special beliefs or customs you would like to keep related to this health problem?"
- "Are there special herbs/ foods/treatments you have found helpful?"
- "Are there healers from your community who might also be able to help you?"
- "How does your family think this illness should be treated?"
- "What do you think about this treatment?"

Language and Communication

- “What language are you most comfortable speaking?”
- “There are trained medical interpreters available and we recommend our patients use them instead of family members or friends. Would you like an interpreter?”

Life Span Rituals/Practices

- What beliefs, values, and practices surround life events? (E.g. birth, childcare, aging, death).
- If the patient has a terminal disease, should one “tell the truth” or “maintain hope”? Is it okay to talk about death/dying or is that considered bad luck?

Patient’s Explanation of Health Problem

- “What do you call the problem you are having?” (Use the patient’s term instead of “the problem” when asking the rest of the questions.)
- “When and how did your problem begin?” “Why do you think the problem started when it did?”
- “What do you think caused this problem?”
- “Do you know someone who has had this problem?” “What happened to that person?” “Do you think this will happen to you?”
- “What are the chief problems this condition has caused you?”
- “What do you fear most about the problem?” “How serious is this problem?” “Do you think it is curable?”
- “How have you treated the problem so far?” “What have you done to feel better?” “Have you tried remedies like herbs or remedies?”

Family Structure and Importance

- “Who are the people in your life who serve as key sources of primary support.” “How would you like them to be involved in your care?”
- “Who in your family/ community/religious group can help you?” “Are you consulting with other healers?”

WHAT HAPPENS IF I MAKE A MISTAKE

Key tenets of cultural humility are curiosity and self-critique. In situations where we are being vulnerable by admitting what we don't know, it is so important to be able to respond when we make a mistake (Broughton, 2023). Making mistakes is part of any learning process, but learning how to apologize is an important part of viewing mistakes as learning opportunities too. The University of Michigan has created a wonderful method to remember how to apologize if you are made aware that you've made a mistake.

Re

Reflect.

Reflect on the situation and listen to people if they indicate you have hurt someone or a group of people.

A

Acknowledge.

Acknowledge and accept responsibility for your actions.

A

Apologize.

Say you are sorry. It doesn't really matter what you intended. If you have made a mistake or violated someone else's dignity, you simply need to address the impact of your actions on the other person.

C

Change your behavior.

Share exactly what you will do in the future to avoid such a mistake. Recognize that your apology is just the beginning.

T

Thank...

the person for sharing the new information.

CONCLUSION AND KEY TAKEAWAYS

Cultural Humility is a lifelong commitment to curiosity, self-evaluation, addressing power imbalances, and developing nonpaternalistic partnerships with communities and individuals (Tervalon, 1998). It is vitally important to do the work of self-education about others and their cultures; however, when entering a patient encounter it is also important to remember the patient is an expert on themselves and are the only ones that fully understand how the intersection of their identities impact their present illness or wellness experience. Physician strategies in disease prevention, wellness promotion, and therapeutic treatments should be developed with the patient's input and take into account the patient's life priorities, health beliefs, and life stressors (Tervalon, 1998). Patient care is individualized as we take time to consider a

1. **Cultural Humility is a lifelong commitment to curiosity, self-evaluation, addressing power imbalances.**
2. **Seek out education resources to learn more about implicit bias and racial equity. Engage with primary source content to learn from diverse perspectives and experiences.**
3. **We are required to respect the thoughts, beliefs, and decisions of our patients even if they do not align with our own.**
4. **By acknowledging our own biases, asking open ended questions, practicing reflective listening, and engaging in self-reflection we can foster better relationships with our patients and those we interact with in everyday life.**

patient's personal beliefs rather than attempting to place them under a cultural label (Prasad, 2016).

Being open-minded to new ideas and beliefs is also necessary. We are required to respect the thoughts, beliefs, and decisions of our patients even if they do not align with our own. Our curiosity can help us ask ourselves why others might have these thoughts or beliefs as part of their culture and how history has influenced them.

By acknowledging our own biases, asking open ended questions, practicing reflective listening, and engaging in self-reflection we can foster better relationships with our patients and those we interact with in everyday life.

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