Is Cultural Humility the missing ingredient in your community-based practice?

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Today's agenda

1. Literature review
2. Reflections on personal experiences
3. Suggestions to improve practices

Brief Summary of Literature on "Cultural Humility" in Healthcare

- Tervalon & Murray-Garcia generally credited with coining the term in 1998 article on physician education which appeared in the Journal of Health Care for the Poor and Underserved
- Most literature which specifically describes the term “cultural humility” found in other disciplines; especially nursing, medicine & psychology; just emerging in OT literature now
- Emphasizes the distinction between “cultural humility” approach & the more widely known “cultural competency” approach
What sets Cultural Humility apart from Cultural Competency?

“Competency: an ability or skill”
(Merriam-Webster)

Humility: the quality or state of not thinking you are better than other people”
(Merriam-Webster)

Cultural Competency in Healthcare:
• Can generate a false sense of security/expertise in provider
• Can uphold a sense of cultural superiority/“colonial imperialism”
• Can support power imbalance in patient-provider relationship

Cultural Humility in Healthcare:
• Generates hunger for lifelong learning & reflection
• Promotes relinquishing “expert role”
• Patient & provider become partners in therapeutic alliance

Cultural Humility vs. Cultural Competence continued

“Cultural Humility”,
John Tervalon & Jann Murray-Garcia
• “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.” –Journal of Health Care for the Poor and Underserved, vol. 9 (2) 1998

“Cultural Competency”
• “the attitudes, knowledge, and skills necessary for providing quality care to diverse populations”. - The American Association of Colleges of Nursing (2008)
• “The ideal of cultural competence was originally conceived as knowledge of the values, customs, and traditions of a specific group” - Handel, R.I.R.W., CJOT, vol. 60, 2013, 352-354.

Which of these approaches sounds like your training experience to work with clients of diverse cultures?
Why is cultural humility proposed as a better approach to training practitioners & improving service delivery?

• It promotes continuous learning & reflection, avoiding a false sense of security or “expertise”

• Example: Tervalon & Murray-Garcia described the following case: “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 over-express “the pain they are feeling…”

• ...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.”

I can tell you about the dangers of feeling “culturally competent” from personal experience...
Suggestions for cultivating cultural humility in healthcare found in current literature...

For students:

- Tervalon & Murray-Garcia: “have trainees think consciously about their own, often ill-defined and multidimensional cultural identities and backgrounds... 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.”

More suggestions for students:

- Isaacson, M. (2014) promotes reflective exercises & immersion experiences for nursing students:
  - “Nurse educators must help students see and understand their preconceived notions about cultures other than their own by first reflecting on their worldview.”
  - In her study she had nursing students reflect on their attitudes & experiences before & after immersion on an Indian reservation.

  - Excerpt from a student's journal post-immersion: “it was interesting walking into a room full of people and trying to feel like I belonged there. I felt like it was better to stay on the fringe and out of the people's way. It must be what minorities feel sometimes in my society. It was easy to cope thought-bubbles after a few minutes they were no longer on my mind and I was able to feel more comfortable. It was hard to put myself in the minds of these people and truly experience what they may be feeling as a minority. Feeling vulnerable opened my eyes to minority feelings. I believe that this will influence my future practice... It makes me realize that they deserve and not whatever others see out there their way.”
For practitioners:

- **Tervalon & Murray-Garcia** have suggestions for physician trainees & community-based practice:
  - 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...physicians potentially create an atmosphere that enables and does not obstruct the patient's telling of his or her own wellness story. This eliminates the need for 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...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."

More suggestions for practitioners:

- Community-based care: “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...[this] requires that the physician trainee recognize that the foci of expertise with regard to health care indeed reside outside of the academic medical center and even outside of the practice of Western medicine...physicians and physician trainees are both effective students of and partners with the community.”

For Medical Schools:

- **Tervalon & Murray-Garcia** re: physician training institutions:
  - “Self-reflection and self-critique at the institutional level is required...What is the demographic profile of the faculty?...Are faculty members required to undergo multicultural training as are the youngest students of the profession?...What is the history of the health care institution with the surrounding community?”
Academia in Occupational Therapy:

- Hammel, K. (2014) observes that theories of occupation lack cultural humility:
  - “Dominant theories of occupation reflect the culturally specific perspectives of a minority of the global population, being derived predominantly from middle-class, White, heterosexual, able-bodied experiences, and further, that there has been little effort to enable the perspective of a diversity of people to infuse theories of occupation.”
  - “For example, when publications produced by the Canadian Assoc. of Occupational Therapists are exported, without amendment, to other regions of the world, this constitutes a subtle form of intellectual colonization, or ‘theoretical imperialism’... an assumption that these theories and models developed in a Western context are applicable and relevant in other, different contexts, that specific, Western perspectives are somehow universally applicable and that the rest of the world has much to learn from our wisdom.”

Hammel's suggestions:

- Conclusion: “Engaging in research from a stance of cultural humility—respecting the specific life experiences and perspectives of those who differ from ourselves—may assist the development of culturally safe theories that reflect the multiple realities of our diverse client groups... Cultural humility requires occupational therapists to think critically, not solely about their theories and practices but about themselves... to examine critically the cultural values and assumptions that underpin their theories and models and to understand “that the way we think is a product of our history and of the values promoted in our society.”

Please form small groups for discussion
My suggestions for Occupational Therapy Practitioners to practice Cultural Humility:

- During therapy with someone of a culture you consider different than your own:
  1. When getting to know them and their health beliefs/practices, keep an open mind
  2. Ask if you can demonstrate new techniques as an experiment
  3. Give them the option of not taking your recommendations and let them know that you will support their right to decide what’s best for them
  4. When difficulties/concerns arise consult with community leaders

Questions / Comments?

• “My recipe for you is number one, don’t go in with prejudiced attitudes about what I am, who I am, what you think I should be and where you think I should be at. Now, if you can work on yourself, then you can work with me. If you can work on yourself, then you can work with me. That’s the recipe.” –Jacqui Smith
References