

# Rethinking Cultural Competence: Shifting to Cultural Humility

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**ABSTRACT:** Healthcare and social services providers are deemed culturally competent when they offer culturally appropriate care to the populations they serve. While a review of the literature highlights the limited effectiveness of cultural competence training, its value remains largely unchallenged and it is institutionally mandated as a means of decreasing health disparities and improving quality of care. A plethora of trainings are designed to expose providers to different cultures and expand their understanding of the beliefs, values and behavior thus, achieving competence. Although this intention is commendable, training providers in becoming competent in various cultures presents the risk of stereotyping, stigmatizing, and othering patients and can foster implicit racist attitudes and behaviors. Further, by disregarding intersectionality, cultural competence trainings tend to undermine provider recognition that patients inhabit multiple social statuses that potentially shape their beliefs, values and behavior. To address these risks, we propose training providers in cultural humility, that is, an orientation to care that is based on self-reflexivity, appreciation of patients' lay expertise, openness to sharing power with patients, and to continue learning from one's patients. We also briefly discuss our own cultural humility training. Training providers in cultural humility and abandoning the term cultural competence is a long-awaited paradigm shift that must be advanced.

**KEYWORDS:** Cultural competence, cultural humility, intersectionality, racism, stereotype

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*Cultural competence* is well established in the medical and public health lexicon as a means of attending to the culturally diverse backgrounds of patients, providing person-centered care, and reducing health disparities. The term cultural competence and trainings designed to ensure healthcare and social services providers acquire such competence have existed for decades.<sup>1,2</sup> However, it might be time to re-examine both the meaning and connotations of the term and the utility of these trainings, given our advances in understanding the root causes of health disparities. Based on our experience in cultural and structural competence training for the New York statewide workforce caring for youth with serious emotional disturbances, we propose training in cultural *humility* and abandoning the term *competence*.

In the US, medical schools, health-related professional associations, and government entities currently mandate staff trainings in cultural competence. Although the format, content, and quality of such trainings vary widely, they all aim to enhance providers' knowledge about the cultures of different social groups—typically defined as racial/ethnic or sexual “minority” groups.<sup>1,2</sup> The thinking underlying these trainings is that provider familiarity with cultures *other* than their own can improve their communication skills and ability to establish effective relationships with patients.<sup>3</sup> Providers' recognition that they need to improve their understanding of how best to care for diverse patient populations is laudable and presents an opportunity to improve quality of care and reduce disparities.

However, the assumptions behind trainings in cultural competence and the use of the term *competence* are problematic. As discussed below, seeking cultural competence can contribute to the reproduction of social stereotypes and an imbalance of power between patients and providers.<sup>2–4</sup> Therefore, we strongly recommend providers undergo training in developing *cultural humility* and provide a training example we are currently delivering to care managers and peer advocates in New York State.

Our call to deconstruct the meaning of the term cultural competence and rethink the utility of related trainings is based on the semantic and pragmatic social consequences of these trainings, as indicated by both theoretical arguments and assessments of the trainings' limited effectiveness in combating health inequities. Culture is not stagnant, but a changing system of beliefs and values shaped by our interactions with one another, institutions, media and technology, and by the socio-economic determinants of our lives.<sup>5</sup> Yet, the claim that one can become competent in any culture suggests that there is a core set of beliefs and values that remain unchanged and that are shared by all the members of a specific group. This static and totalizing view of culture that connotes a set of immutable ideas embraced by all members of a social group generates a social stereotype.<sup>2,3</sup> This stereotype is negative and stigmatizing because it refers to beliefs that likely *deviate* from the providers' own *normative* belief system. Cultural competence trainings assume that most US providers are White non-Hispanic, male, heteronormative, and English speaking, and



seek to expose them to the cultures of *other* social groups (eg, Black Americans, Spanish-speaking Latinx, or LGBTQ+ persons).<sup>6</sup> Moreover, because of the pervasive health inequities by race and ethnicity, these trainings often focus on familiarizing a prototypical White non-Hispanic provider to communicate with non-White patients who are assumed to embrace common beliefs and experiences solely based on their race and/or ethnicity. This approach contributes to the reproduction of racial and ethnic stereotypes and racism. Providers' application of the stereotypes generated in trainings raises the risk of *othering* patients, a process of amplifying the "us" versus "them" orientation. Significantly, this in-group/out-group perspective can also contribute to *implicitly* discriminating against patients, if adopted by providers.<sup>2,3</sup>

The notion of cultural competence is also challenged by intersectionality which suggests that the beliefs and values a patient brings to the clinical encounter are shaped by the intersection of their different characteristics, such as race, class, gender, and sexual orientation.<sup>7-9</sup> Trainings that familiarize providers with, for instance, the culture of the patient's racial group will be of limited use, since they cannot elucidate the patient characteristics that are at play in a specific clinical encounter. If providers assume that race or sexual orientation is the master status that overshadows other statuses, they risk *essentializing* the patient and discrediting their perspective.<sup>2,3</sup> Such interactions raise the risk of reproducing the power discrepancy between providers that embody medical expertise and authority and patients that embody lay expertise based on their actual lived experiences.<sup>10</sup>

The risks and limitations of the cultural competence approach to providing services are also supported by the peer-reviewed literature on the effectiveness of cultural competence trainings and programs. We examined published reports within the past 2 decades, since government entities began mandating trainings in cultural competence in the early 2000s.<sup>11</sup> Across studies and time, three overarching findings emerged. First, there is extensive variability in all features of trainings and programs in cultural competence, including in their scope, length, content and mode of delivery.<sup>3,12,13</sup> This variability has been associated with the ongoing lack of clarity of what constitutes cultural competence and how it develops and hence, a lack of guidelines on designing and delivering related trainings and programs.

Second, trainings in cultural competence primarily increase provider knowledge, attitudes and skills, but have had little or no effect on patient satisfaction and/or patient health outcomes to decrease disparities.<sup>3,12-14</sup> Furthermore, there is extensive heterogeneity in the type of knowledge, attitudes and skills that have been found to improve as a result of cultural competence endeavors. For instance, some trainings improve providers' general understanding of the role of culture in patient-provider relationships, while others improve factual knowledge on disease incidence or traditional cultural practices among specific populations.<sup>14</sup> The provider skills that improve through cultural

competence range from cross-cultural communication skills (e.g., when serving diverse or non-English speaking patients), to assessing cultural factors in patient provider interactions, to skills to follow treatment plans.<sup>12-14</sup> With reference to attitudes, many trainings focus on enhancing provider self-confidence or self-efficacy in serving diverse patient populations.<sup>3,12,14</sup> This improvement, however, has limited significance, given the lack of data on whether greater provider confidence or efficacy enhances patient satisfaction or outcomes.<sup>12,13</sup> On the contrary, we suggest that provider self assessment of their own efficacy and competence as higher post training can detract from their humility, increase their authority, and thus, intensify the power imbalance between providers and patients.

Finally, the extensive heterogeneity of the knowledge and behavioral domains that the cultural competence trainings aim to improve accounts for their equivocal effectiveness identified by reviews spanning the past 20 years.<sup>3,12-14</sup> Despite this lack of evidence, the mandatory nature of these trainings applied by funding by government entities, institutions along the private-public spectrum, and provider professional groups suggests a taken-for-granted significance of these trainings that has continued unchallenged for decades.<sup>3</sup>

Given the shortcomings of cultural competence trainings, like others, we recommend trainings that foster providers' cultural humility.<sup>2,4,10</sup> Cultural humility refers to *an orientation towards caring* for one's patients that is based on: self-reflexivity and assessment, appreciation of patients' expertise on the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning.<sup>2-4,10,15</sup> Cultural humility means admitting that *one does not know* and is willing to *learn from patients* about their experiences, while being aware of one's own embeddedness in culture(s). While competence suggests mastery, humility refers to an intrapersonal and interpersonal approach that cultivates person-centered care. Cultural humility training encourages providers to reflect on their own beliefs, values and biases—explicit and implicit—through introspection thus, revealing their own culture's impact on patients.<sup>16,17</sup> On an interpersonal level, guiding providers to adopt a person-centered stance, open to and respectful of patients' views, promotes real patient-provider partnerships. Providers' humble disposition counterbalances their authority and by equalizing the patient-provider relationship, it can improve communication and quality of care.<sup>15-17</sup>

Therefore, cultural humility trainings are *process-oriented* and aim to enhance providers' capabilities to deliver patient-centered care, while cultural competence trainings are *content-oriented* and aim to increase providers' knowledge, confidence and self-efficacy in communicating with and treating diverse patients.<sup>10</sup> The suggestion to focus on fostering provider awareness, openness and humility through the recognition of their own bias, privilege and the limits of their knowledge and expertise was suggested in a seminal article by Tervalon and

Murray-García in 1998.<sup>4</sup> Yet, only recently, have researchers and practitioners began to advocate for humility trainings, and most of this work is theoretical.<sup>2,6,16,17</sup> In an attempt not to reproduce the limitations of the cultural competence trainings and evaluations, cultural humility scholars have recognized the need for assessing the trainings' effectiveness from both the provider and, more importantly, the patient point of view.<sup>15,17</sup> We also add the need for a clear conceptualization and measurement of cultural humility, and advise against the proliferation of similar constructs such as cultural safety, cultural sensitivity and cultural respect.<sup>3,16</sup>

### New York State Cultural and Structural Competence (Humility) Training

To move research and practice forward, we have designed a dual-component training for family peer advocates, youth peer advocates and care managers serving families with children or youth with serious emotional disturbances, that integrated several of the Tervalon and Murray-García principles. Our Cultural and Structural Competence (CSC) training is led by expert facilitators with advanced degrees in the social sciences and/or public health. The 6.5-hour training session is conducted in person and is followed by a one-hour webinar "booster" at 4 weeks to enhance trainees' practice.

In brief, the first training component reviews the Cultural and Linguistically Appropriate Services (CLAS) standards with a focus on the domains of culture, structure and health equity. This lecture- and discussion-based component is designed to provide trainees with a shared language for discussing cultural and structural differences and health disparities. We discuss the significance of adopting the term and orientation of cultural humility instead of cultural competence. We also examine the differences between implicit and explicit bias and include Harvard University's Implicit Association Test (IAT) as a self-reflexivity tool trainees can use that can contribute to humility. This lays the foundation for the novel, second component of our training, the Health Habitus Integration (HHI) training.

The Health Habitus Integration component is theoretically driven and aims to provide trainees with the skills and tools to integrate their insights regarding cultural and social determinants of health into their practice as they support families contending with mental health challenges and as they collaborate with colleagues from diverse backgrounds and disciplines.

The Health Lifestyle Model is the theoretical framework of the training. This model emphasizes the concept of *health habitus*, that is, our tendencies to care for our emotional, mental and physical wellbeing in ways that are shaped by culture and social structure.<sup>18</sup> The model indicates that health habitus, informed by (1) our culture, (2) our place in the social structure, and (3) our choices, shapes our health behavior (e.g., whether and how we communicate with providers) and, over time, becomes a health lifestyle.

To familiarize trainees with the application of the model, we engage them in writing about their own health habitus and

participating in a group discussion of how culture, structure and choices shaped trainees' *own* health habitus and actions. This activity is consonant with the Tervalon and Murray-García's<sup>4</sup> principle of "cultivating self awareness and awareness of the perspectives of others" (p. 120) that contributes to trainee and trainer humility.

A didactic phase on conducting in-depth interviews to elicit the family and the youth's health habitus follows. This type of interviewing exemplifies Tervalon and Murray-García's<sup>4</sup> suggestion for providers to communicate their respect for "the patient agenda and perspectives" by adopting a "less controlling, less authoritative (interviewing) style" (p. 120). Conceding the power of guiding the communication to the patient, the authors argue, presupposes humility. Ongoing feedback from trainees suggests HHI is generating humility as the trainees discover that many of their prior assumptions (often racial biases) about the families they serve are not supported by information they collect in the interviews. Common racial stereotypes about health beliefs and behaviors are deconstructed through our training activities (eg, interview practice scenarios and role play by diverse trainers). A process and outcomes evaluation of our dual-component training using a mixed-methods approach is currently underway with results forthcoming in 2021.

In summary, we have provided a strong and overdue argument for eliminating the term competence and embracing humility in its place, based on theoretical and peer-reviewed literature. We have also suggested a theoretically-based strategy for training in cultural and structural humility that is currently being evaluated. Although striving to become humble is challenging, claiming that we can achieve competence in any culture is untrue and dangerous. The recent appreciation of implicit bias and intersectionality signals the need to abolish the notion of cultural competence and prioritize the development of humility to begin dismantling racism to address health disparities.

### Author contributions

H-M L, KP, and CL conceived the idea and co-wrote the article. H-M L and CL also led the training and evaluation of the cultural humility project discussed in the article.

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