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BEYOND CULTURAL COMPETENCY:

USING LITERATURE TO FOSTER SOCIALLY CONSCIOUS MEDICINE

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BEYOND CULTURAL COMPETENCY:

USING LITERATURE TO FOSTER

SOCIALLY CONSCIOUS MEDICINE

by

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Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas Medical Branch

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas Medical Branch

August 2008

Dedication

For Andrea, Julia, Mia, C. J., and Gabriella

Preface

Throughout the course of my ministerial training and formation, I was required to meet with a spiritual director on a regular basis. One of the individuals who guided me was a religious sister. Once a week, she took time from her busy schedule of pastoral care, community organizing, and homeless advocacy to sit and listen to me reflect upon my self-discoveries as a dishwasher in a kitchen that served the clients of a medical recovery center for homeless men and women. She was not usually very assertive in her approach. Mostly, she would sit and listen as I tried to sound as eloquent and as spiritual as I possibly could. She would ask questions, and on occasion she would encourage me to consider a different perspective on a situation. She would occasionally suggest that I read an article or an essay or that I attend some event in the community. Towards the end of our time together, during a conversation in which I shared my frustration over some social ill or another, she leaned forward, stopped me by placing her hand on mine, and said,

> Ernie, your *injustice button* works just fine. After all these months, we know that. It's going to be up to you now to learn what do when that button gets pushed. Indignation is a start, but it is never enough. Use your intellect and use your experience and learn how to see your way out of the anger that explodes each time you encounter some new injustice.

I knew enough then, at twenty-three years of age, to take note and to write the words she spoke that day in the unused journal that was the sole occupant of the bottom drawer of my desk. I would not know for some time, however, what to do with her advice. Yet as I drew

near to the end of this dissertation I began to realize that, in many ways, I have been responding to her challenge throughout my time at the Institute for the Medical Humanities. These four and a half years have been a search for intellectual schema from which to argue for a greater call to justice and solidarity with those who suffer.

Sister Marcella encouraged me to begin my work from within my own lived experience. Thus, I began my research for this dissertation by recalling my own experiences of attending training programs for cultural competency. As a health-care chaplain of many years, I spent a great many Saturdays in workshops and training sessions where I listened as presenters described the socially disruptive grieving process of African-Americans, the primitive health practices of Mexicans, and the debilitating need to succeed in Asians. Participants were instructed to tolerate the occasional animal sacrifice, to overlook the excessively large families of cultural minorities, and never to tell an Asian patient that she has a terminal illness.[1] Somehow, despite the animosity that was communicated, participants were expected to understand the importance of showing respect for the cultural differences they would encounter in patients.

I will admit here that (for a very brief time) when I attended my first training session, I was quite taken with the idea. I was persuaded by the presenters as they argued that training in cultural differences would lead to greater justice in health care. Yet my appreciation for the project quickly faded. I grew frustrated with the content of the programming and the attitude of the presenters. Unfortunately, despite Sister Marcella's advice, I spent a great deal of time at the mercy of my *injustice button*. I did not take the

[1] The negative representation of these concepts is intentional. Very often, presenters expressed condescending attitudes towards the "traditional" practices of "primitive" minorities.

time to formulate an intellectual critique of the material that was presented. Instead, I settled for being a thorn in the side of presenters who, seemingly, were accustomed to participants who were less vocal and less antagonistic. As I was unable to formulate a rational objection to the material, my comments were dismissed and my questions were ignored. I soon realized that I needed to find a new path to explore my questions and to articulate my objections to training programs in cultural competency.

The ways in which many training programs in cultural competency reinforce the patterns of dominance that lead to racial disparities would become only a part of the work. In the course of my research and writing, I came to understand the issues at a much deeper level than I had anticipated. Fortuitously, my proposed response (the use of literary works and the development of narrative skills in medical education) proved to be even more applicable at the deeper levels of the issues I explored. I trust that Sister Marcella would be pleased that I have finally taken her advice.

Acknowledgments

I am truly grateful for the expert guidance of my mentor, Dr. Anne Hudson Jones, and the members of my dissertation committee. Their insights and their challenges moved me in unexpected directions where new discoveries were possible. Dr. Sayantani DasGupta's willingness to participate and contribute from such a distance enriched my work in ways that I could not have anticipated.

I would like to thank the faculty at the Institute for the Medical Humanities (IMH). They have taught me well, and I trust that they are pleased with what I have accomplished. I would especially like to thank Dr. Michele Carter, the chairperson of my qualifying examination committee, and Dr. Harold Vanderpool, who served as my first advisor.

My successes at the IMH were built upon the work of the many educators who have challenged and inspired me over the years. I thank my instructors at the Washington Theological Union, the University of Texas at Austin, and the Zaragoza Air Base Schools.

I thank the many individuals who have guided and accompanied me in my search for justice.

I am thankful for those individuals who agreed to be interviewed. Their insights proved invaluable. I would especially like to thank Dr. Alejandro Morales for his generosity. I am grateful for having spoken with my uncle Mr. Guadalupe Salinas regarding events that continued to haunt him. He died on July 15, 2008.

I extend my thanks to Dr. Helena María Viramontes for her permission to reprint her short story "The Cariboo Cafe."

Although I do not have the space to list each of them by name or to describe all that they have done to keep me grounded, I am grateful for my many friends who have loved me through this challenging experience.

I thank my parents, Juan and Margie Aguilar, my brother Christopher Aguilar, and my sister-in-law Corazón Aguilar for their unwavering belief that I could do this—a confidence that served to replenish my own. They may not have always known what I was doing, but they never doubted that I could do it.

Finally, I know that this dissertation would not have been possible without David Aguilar, my loving husband. He enthusiastically uprooted his life to join me on this journey. Even when overwhelmed with his own studies, his support and encouragement never faltered. I thank him for knowing when to make me work, when to get me to play, and when to let me sleep.

Beyond Cultural Competency:

Using Literature to Foster Socially Conscious Medicine

Publication No._____

John Ernest Aguilar, Ph.D.

The University of Texas Medical Branch, 2008

Supervisor: Anne Hudson Jones

Abstract: For at least the past three decades, training programs in cultural competency have enjoyed increasing popularity in medical schools and in continuing medical education. Proponents of cultural competency generally hold that when physicians and other health-care professionals are trained in cultural issues, there will be a reduction in race-based disparities in both the access to and the quality of health care. Yet there has been little evidence to support this claim. Further, a conceptual analysis of cultural competency suggests that this type of training may serve only to maintain or further aggravate the current state of affairs faced by cultural and racial minorities. New pedagogical models are needed. These models will need to include an opportunity (and the support) for the unlearning of old patterns of viewing society. Participants will need to reflect on the social factors and structures that are more likely to lead to race-based

disparities. These factors include but are not limited to a legacy of interracial hostility and mistrust, the unjust distribution of social power, and a defective understanding of the proper posture to be taken towards the one that is *other*. Educational theories that promote participatory, transformative, and reflective learning experience must be used to shape new educational efforts. Reforms in medical education can draw more heavily from the theories developed by scholars in literature and medicine. These theorists argue that the development of narrative skills contributes to improved communication across interpersonal differences. Further, many scholars agree that reading well-written works of literature contributes to the skill required for recognizing injustice and engaging in the moral and ethical reflection needed to address it.

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Introduction

Those who have participated in clinical discussions regarding patients (from hospital rounds to admission reports) are familiar with the standard litany of information that is communicated in order to identify the patient being discussed:

> Ms. Xiao is a fifty-seven-year-old Chinese female who was transferred to the unit from the Emergency Department at 2:30 a.m. Ms. Xiao has a three-week history of fatigue and reported to the Emergency Department with a complaint of increasing shortness of breath. The patient's temperature is ...[2]

The symptoms, as reported, are essential to the diagnosis, the implementation of appropriate tests and diagnostics, and the prognosis. In this scenario, however, many terms are used to identify and to socially situate Ms. Xiao. Such terms are intended, presumably, to serve as a type of shorthand that allows clinicians to further focus their diagnostic efforts. Yet these terms, while often used as if concrete, are far from being so. For example, what clinically specific information is provided by indicating that Ms. Xiao is Chinese?[3] Has she lived her entire life in rural China and only recently immigrated to the United States? Or was she born here? Does she speak only Mandarin? Does she speak only English? Does she speak other languages? Is she an illiterate laborer or a renowned professor of Italian Renaissance literature? Does she devoutly espouse the practices of Traditional Chinese Medicine—to the total exclusion of Western medical interventions? Or does she prefer a

[2] The case of Ms. Xiao is a fictional account constructed exclusively for the purposes of this illustration.

[3] Age and gender, as social constructions, are equally nebulous in what they represent. One's understanding of culture, race, gender, and age are socially defined and understandings vary across the social map. Social understandings of age and gender, while very important, will not receive the same degree of analysis that is provided for culture and race in this dissertation.

more integrated approach to health and healing? If she requests a visit from a spiritual counselor, will it be a Buddhist monk, a Roman Catholic priest, a Pagan priestess, or a Orthodox Jewish rabbi?

Reporting that Ms. Xiao is Chinese, in effect, provides very little information. Yet it has become somewhat standard to identify patients by race, culture, or national origin.[4] Why? Is it to show respect for a patient's heritage? If so, is this accomplished by stating that a patient is Chinese? Is it to alert health-care providers that certain patients will necessarily have particular concerns and needs—unique to racial identity? Are there diseases that are contracted only by people of certain racial groups? Is there no particular reason, and this practice is simply the manner in which practitioners learned to make a patient report? What are the clinical implications, if any, of including Ms. Xiao's racial or cultural identity in the case report?

In one sense, the inclusion of *Chinese* may be an ironic extension of the reductionistic model that permeates so much of medicine—despite the many calls by noted scholars to embrace a holistic understanding of the patient as person. Ironically, in an attempt to identify the patient in broader terms, cultural identities are flattened and reduced to meaningless labels. If cultural and social contexts are to be important in clinical care, patients' identities and histories must be understood at a deeper level than is possible with a superficial label. The physician George L. Engel, in his call for a new medical model, emphasizes the importance of understanding the patient and her illness in the fullest context possible:

[4] In certain medical institutions, there has been a trend to exclude racial or cultural identity from the case report. However, including this information remains the standard in many other institutions.

> In all societies, ancient and modern, preliterate and literate, the major criteria for identification of disease have always been behavioral, psychological, and social in nature.[5]

Edmund D. Pellegrino and David C. Thomasma, both medical ethicists, sought to reorient the practice of medicine as an activity of human life—an activity that must be more fully integrated into the broader scope of the whole person. This broader scope must allow for reflection on economics, politics, and culture as they influence the lives of patients. According to Pellegrino and Thomasma, it is only when medicine is engaged from this perspective that healing may take place.[6] The physician Eric J. Cassell has, on several occasions, appealed to fellow physicians to recognize that patients are more than a collection of biological processes. Cassell joins in the work of others who have sought to mend the rupture between the patient as person and the patient as locus of disease. Cassell's topology of the person invites physicians to take a broader view of their patients.[7] Understanding the patient's social context, past, and perceived future are, according to Cassel, essential to successfully treating the patient. Arthur Kleinman, a psychiatrist and medical anthropologist states, "Illness becomes embodied in a particular life trajectory, environed in a concrete life world."[8]

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[5] George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, no. 4286 (April 8, 1977): 130. Engel is best known for his conception of the biopsychosocial model. His work influenced generations of physicians.

[6] Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice* (Oxford, UK: Oxford University Press, 1981).

[7] Eric J. Cassel, "The Nature of Suffering and the Goals of Medicine," *New England Journal of Medicine* 306, no. 11 (March 18, 1982): 641.

[8] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York, NY: Basic Books, 1988), 31.

These scholars and many others are addressing what are reportedly the essential components of cultural competency in medicine. *Cultural competency* has come to be understood loosely as a style of clinical practice that is attentive to the many ways in which various cultural practices influence the behavior, perspective, and needs of patients. The expectation is that culturally competent medicine will serve to correct the long-standing trend of racially based disparities in access to health-care services (this expectation is evident in a number of documents, reports, and journal articles; relevant excerpts from a selection of these sources are available in Appendix A).[9] Ironically (and unfortunately), by focusing exclusively on the cultural practices of minority groups, training programs in cultural competency often mask the complex of social factors that lead to these disparities and simultaneously contribute to the further disintegration of the patient by reducing culture to its most observable elements. [10]

Many questions should be raised regarding the inclusion of cultural competency in medical education and clinical care. Advocates for cultural competency in health care report that culture directly influences patient care. But what is culture and what are those influences? Further, poor communication is frequently cited as the cause of racial disparities in access to health care.[11] In response, cultural competency is presented as being

[9] Different agencies and individuals understand *health disparities* to mean different things. Ordinarily, the term is used to refer to the differences in health and health care across racial and socioeconomic groups. When speaking of health disparities, one may be referring to one of several different (but related) issues: 1) disparity in access to medical services, 2) disparity in quality of medical services received, or 3) disparity in health outcomes.

[10] The term *minority* is relative. Currently, persons of Mexican descent may represent a minority of the population in Honesdale, Pennsylvania, yet they represent a majority of the population in Palenque, Mexico. For the purposes of this dissertation, *minority*, as a term, will be used in relation to the current population in the United States of America where the majority of the population is still identified by federal agencies as *white*.

[11] See, e.g., Gregory B. Diette and Cynthia Rand, "The Contributing Role of Health-Care Communication to Health Disparities for Minority Patients with Asthma," *Chest* 132, no. 5 Suppl. (November 2007): 803S.

essential to effective communication with patients who are racial minorities and is accepted as the ideal means by which those disparities will be eliminated.[12] There has been little documentation, however, that communication has improved as a result of training in cultural competency. Further, there is no consensus among medical educators as to what constitutes clinical care that is culturally competent. Very often, when attempts are made to define cultural competency, the definitions reflect false assumptions and misinformation. But there are more important questions that must be considered.

In *Unequal Treatment*, a publication of the Institute of Medicine, the editors analyze data from a number of studies.[13] The editors argue that this data is evidence of consistent racial disparities in both access to and quality of health-care services. The editors acknowledge that some researchers hold that disparities diminish as socioeconomic factors are controlled. However, the editors assert that the majority of the evidence indicates that "disparities remain even after adjustment for socioeconomic differences and other healthcare access-related factors."[14] In light of this evidence, is it reasonable to conclude that cultural differences and intercultural miscommunication are what lead to these racial disparities in health care? Does focusing on cultural differences take attention away from more egregious social factors that may more directly contribute to health disparities? What are these social factors? How should they be addressed? And how does one foster in medical students and practitioners the insight and the willingness needed to attend to these

[12] Stephanie T. Taylor and Nicole Lurie, "The Role of Culturally Competent Communication in Reducing Ethnic and Racial Health Disparities," *American Journal of Managed Care* 10, no. 1 Suppl. (September 2004): SP1; Cindy Brach and Irene Fraser, "Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model," *Medical Care Research and Review* 57, no. S1 (November 1, 2000): 184.

[13] Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: National Academies Press, 2002), 5-6.

[14] Ibid., 5.

deeper issues? Returning to the case of Ms. Xiao, if she receives substandard care, is treated disrespectfully, or is denied access to specialty services, will it be because her physicians did not understand some aspect of her *culture*? Or will it be because her physicians have certain (possibly subconscious) attitudes towards her because she is not "one of them"?

In Part I of this dissertation, I offer a critique of cultural competency as a concept and as a practice. In Part II, I explore the social factors that are more likely what contribute to racial disparities in health care. It is my position that racism, abuses of social power, and malformed attitudes towards otherness contribute directly to health disparities and that cultural competency, as it is popularly conceived, is an inappropriate model for exploring and critiquing these issues. Finally, in Part III, I reflect on the need for critical thinking and the manner in which it can best be fostered in adult learners. Based on that material, I make a proposal for a different model for educating and training students of the health professions and health-care professionals to address race-based disparities in health care. This model draws from the work of literary theorists who have affirmed the efficacious role of literature in medical and sociological education. Although the importance of literary and narrative skills has been argued by many scholars, few have considered the ways in which effective development of this approach to medicine illuminates the deficiencies and dangers of traditional education in cultural competency. A literary approach provides clinicians with the skills necessary for both effective communication with cultural strangers and the capacity to recognize and address social structures that negatively affect the health of cultural and racial minorities by, among other factors, limiting their access to health-care services.

According to these scholars, literature can enhance observational and interpretive skills. Literary texts can challenge long-standing, misguided beliefs and provide opportunities to unlearn old perspectives. Finally, literature can provide insights into the function of social power both as an oppressive force and as a means to effect meaningful change. The insights of literary theorists, narratologists, literature scholars, and writers of fiction will be brought to bear on these questions and issues at nearly every stage of this dissertation.

I conducted several interviews as part of the research for this dissertation. Permission to conduct the interviews was granted by the Institutional Review Board at the University of Texas Medical Branch. Information provided by interview subjects is included here with their permission. Documentation of the permission to conduct the interviews and the consent given by research subjects is available upon request.

All translations from Portuguese, Spanish, and Greek into English are my own.

PART I: A CRITIQUE OF CULTURAL COMPETENCY

Chapter 1: A Review of Cultural Competency

Cultural competency, as an approach to clinical care of cultural minorities, has captured the attention of medical educators, policy makers, and legislators across the country. It is repeatedly heralded as the ideal solution to the problem of racial disparities in access to health care in the United States (see Appendix A). As a concept, however, it is poorly defined. In practice there is little consistency from institution to institution, and there has been little evidence to suggest that training in cultural competency bears any fruit in clinical practice or in eliminating health disparities between racial groups.[15] These shortcomings are significant. What is more alarming, as I will argue in this dissertation, is the degree to which training programs in cultural competency reflect social attitudes that contribute to the marginalization of racial and cultural minorities. Despite these deficiencies, there has been significant investment made in training health-care professionals in cultural competency.

I hold that in order to address racial disparities in health care, significant reform in medical education is necessary. But a reform of this magnitude will require the support of leaders in medical education and in the medical profession who will need to be convinced of both the ineffectiveness and the detrimental nature of training programs in cultural

[15] Daniel L. Howard, "Culturally Competent Treatment for African American Clients among a National Sample of Outpatient Substance Abuse Treatment Units," *Journal of Substance Abuse Treatment* 24, no. 2 (March 2003): 89; and Eduardo Peña Dolhun, Claudia Muñoz, and Kevin Grumbach, "Cross-Cultural Education in U.S. Medical Schools: Development of an Assessment Tool," *Academic Medicine* 78, no. 6 (June 2003): 615.

competency. To that end, in Part I of this dissertation, I review the origins of the concept of *cultural competency* and its multiple mandates. I then provide an extensive and critical exploration of the conceptual flaws that are imbedded in the rhetoric of cultural competency. Based on these conceptual problems, I evaluate various models that have been developed, and assess some of the tools that have been designed to evaluate the development of cultural competency in students and practitioners. After reviewing some of the limited evaluations that have been made of training programs in cultural competency, I provide a more extensive critique of my own. I argue that the many deficiencies are the direct result of the conceptual problems within the rhetoric of cultural competency. As a result, I argue in this dissertation that despite some positive aspects, cultural competence in health care, as popularly conceived, may serve only to perpetuate the social practices that keep certain groups from accessing medical services. These deeper social practices will be explored in greater detail in Part II of this dissertation.

Standard Arguments for Cultural Competency

The standard arguments for training health-care professionals in cultural issues follow a general pattern: 1) cultural minorities interpret illness and express themselves in ways that are unfamiliar to physicians trained in the United States; 2) these differences result in miscommunication and misunderstanding between patient and physician; 3) because of poor communication and a lack of understanding, patients from cultural minorities have limited access to health-care services; 4) that same miscommunication leaves physicians unable to treat effectively those patients from cultural minorities who do enter the clinic; 5) patients from cultural minorities subsequently receive medical care that

is inferior to the care that is received by their non-minority counterparts; and 6) when physicians are trained in the cultural practices of others, these disparities can be reduced. Critical of this pattern, Maggie Pearson, a social scientist, states:

> The relationship between culturally 'distinct' minorities and majority white society is seen exclusively in terms of culture, apparently autonomous although interacting with other social processes. It is diversity and difference in languages, religions and cultural 'norms' or expectations which prevent effective communication and create misunderstanding between the majority and the 'distinct' minorities. 'Problems' are therefore the result of mismatches between minority and majority cultures, which according to the pluralistic view, meet on equal terms.[16]

Although written more than two decades ago, the attitude that Pearson is criticizing is emblematic of current thinking. Further, it represents an attitude that continues to influence efforts in cultural competency today. From the perspective represented in this passage, one rooted in a utopian belief that all groups and persons meet on "equal terms," one is expected to believe that all of the problems that are encountered in providing services to cultural minorities are simply the result of benign misunderstanding. In order to remedy such problematic situations, many believe that "the only necessary ingredient is good sound information on culture."[17] Yet, as Pearson states later in the text, when attention is focused exclusively on minority cultures, "it is then a small and imperceptible step to locate the cause of the mismatch and problems in the minorities themselves and their culture which is different."[18] Joy Johnson, a nursing educator, is equally critical of those who maintain that "patients' problems with access, communication, and compliance

[16] Maggie Pearson, "The Politics of Ethnic Minority Health Studies," in *Health, Race, and Ethnicity*, ed. Thomas Rathwell and David Phillips (London, UK: Croom Helm, 1986), 103.[17] Ibid., 104.

[17] Ibid., 104.

[18] Ibid.

[exist] ... because customs and traditions conflict with mainstream medical practices. The focus on cultural differences thereby masks issues of power and control in health care contexts."[19]

It is generally accepted that the miscommunication that arises between physicians and patients who are cultural strangers to each other is what leads to the reported disparities in health care for racial minorities.[20] Subsequently, countless clinicians, educators, and other health-care professionals have accepted that clinical practice informed by an understanding of cultural issues "could go a long way to reducing disparities."[21] Others claim that physicians who have been trained in cultural issues "could save more lives than technological advances."[22] According to Pearson's criticism, however, solutions that are rooted in a belief that all social groups are equal in political and economic power raise but the first of many problems with training and education in cultural competency. In general, there is a lack of any reflection on how power varies from group to group—

[19] Joy L. Johnson et al., "Othering and Being Othered in the Context of Health Care Services," *Health Communication* 16, no. 2 (April 2004): 255.

[20] Risa Lavizzo-Mourey and Elizabeth R. Mackenzie, "Cultural Competence: Essential Measurements of Quality for Managed Care Organizations," *Annals of Internal Medicine* 124, no. 10 (May 15, 1996): 919; Ana I. Balsa and Thomas G. McGuire, "Prejudice, Clinical Uncertainty and Stereotyping as Sources of Health Disparities," *Journal of Health Economics* 22, no. 1 (January 2003): 97-99; and Marjorie Kagawa-Singer and Shaheen Kassim-Lakha, "A Strategy to Reduce Cross-Cultural Miscommunication and Increase the Likelihood of Improving Health Outcomes," *Academic Medicine* 78, no. 6 (June 2003): 580.

[21] Brach and Fraser, "Can Cultural Competency Reduce Racial and Ethnic Health Disparities?" 203; Inginia Genao et al., "Building the Case for Cultural Competency," *American Journal of the Medical Sciences* 326, no. 3 (September 2003): 138; Taylor and Lurie, "The Role of Culturally Competent Communication in Reducing Ethnic and Racial Health Disparities," SP1-SP4; and India J. Ornelas, "Cultural Competency at the Community Level: A Strategy for Reducing Racial and Ethnic Disparities," *Cambridge Quarterly of Healthcare Ethics* 17, no. 2 (April 2008): 191.

[22] Michele M. Carter et al., "Cultural Competency Training for Third-Year Clerkship Students: Effects of an Interactive Workshop on Student Attitudes," *Journal of the National Medical Association* 98, no. 11 (November 2006): 1772.

specifically the power of one group over another. However, this is not to say that culture is not a factor.

Culture and Health Care

Cultural perceptions of authority, suffering, worthiness, and shame all are believed to influence directly how patients attempt to resolve problems with their health. Glenn Flores, a physician and medical educator, and his colleagues state that culture has been shown to influence how a patient chooses to adhere to treatment plans, the manner in which she communicates her needs, and may be an indication of *traditional* remedies that could prove harmful.[23] Flores and others contend that in patients from different cultures, varying degrees of comfort with pain will affect their analgesic requirements just as their conception of death will influence decisions made at the end of life.[24] Scholars such as Arthur Kleinman, a psychiatrist and medical anthropologist, and Laurence Kirmayer, a physician, have suggested that a patient's culture may shape how she interprets her symptoms.[25] According to these scholars, culture will also shape a patient's conception of the source or cause of an illness and will, therefore, affect whether or not the patient even chooses to seek medical services. Others stress that even when symptoms are recognized as an indicator of the need to seek medical intervention, the degree to which an individual may tolerate discomfort or pain (and the time lapse before which she would seek

[23] Glenn Flores, Denise Gee, and Beth Kastner, "The Teaching of Cultural Issues in U.S. and Canadian Medical Schools," *Academic Medicine* 75, no. 5 (May 2000): 451.

[24] Carmen R. Green et al., "The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain," *Pain Medicine* 4, no. 3 (September 2003): 277-294.

[25] Arthur Kleinman, *Patients and Healers in the Context of Culture* (Berkeley and Los Angeles, CA: University of California Press, 1981); and Laurence J. Kirmayer, Allan Young, and James M. Robbins, "Symptom Attribution in Cultural Perspective," *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie* 39, no. 10 (December 1994): 584-595.

assistance) may be influenced by cultural norms.[26] Further, many scholars are of the mind that when physicians do not understand certain cultural practices or expressions, they miss important cues that would serve to improve the care they are able to provide for their patients.

Such misunderstandings can have significant and negative consequences on the communication between patient and physician. One example that is occasionally cited is the manner in which certain individuals express their relationships with deceased relatives. A culturally inexperienced and linguistically limited physician may misinterpret a patient's report of "hearing the voice of a deceased relative" and refer the patient for a psychiatric evaluation.[27] Learning to communicate effectively with persons who embody cultural traditions and perspectives that differ from one's own is clearly an important step in improving communication. It is arguable that certain approaches to training health-care professionals to communicate with patients from other cultural groups have resulted in improved health-care outcomes for those particular patients. However, despite many decades of work in this area, efforts to prepare physicians for cross-cultural communication have proven largely ineffective at eliminating or reducing racial disparities in health care at a broader, societal level.

[26] Joseph Betancourt, "Cross-Cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation," *Academic Medicine* 78, no. 6 (June 2003): 560.

[27] William A. Vega, "Higher Stakes ahead for Cultural Competence," *General Hospital Psychiatry* 27, no. 6 (November 2005): 447.

A History of Cultural Competency

The incorporation of cultural matters into clinical practice has come to be known by the umbrella term c*ultural competency*, and it was quickly identified as a means of addressing and eliminating racial disparities in health care.[28] Cultural competency, however, is not a new concept. While not specifically in these terms, scholars have been reflecting for decades on the role of culture on health and illness.[29]

Many believe that the civil rights movement of the 1960s was a major catalyst in changing the perspectives of professionals across the country. The belief is that in the wake of the expansion of civil rights, professionals were forced to recognize that the United States was "a pluralistic society rather than a monolithic society."[30] As early as 1970, Chase Patterson Kimball, a physician and educator, published a report on an "intracultural medicine" program at Yale University.[31] In the 1970s and 1980s, researchers in nursing were investigating the ways in which ethnocentrism in practitioners influenced patient care.[32] And, in 1988, Paul B. Pedersen, a psychologist and educator, presented the term *multicultural competence*.[33]

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[28] Ibid., 446.

[29] Byron J. Good, "The Heart of What's the Matter: The Semantics of Illness in Iran," *Culture, Medicine, and Psychiatry* 1, no. 1 (April 1977): 25-58; and Leon Eisenberg and Arthur Kleinman, eds., *The Relevance of Social Science for Medicine: Culture, Illness and Healing* (Dordrecht, Holland: D. Reidel, 1981).

[30] Elaine J. Copeland, "Cross-Cultural Counseling and Psychotherapy: A Historical Perspective, Implications for Research and Training," *Personnel and Guidance Journal* 62, no. 1 (September 1983): 10.

[31] Chase Patterson Kimball, "Yale's Program in Intracultural Medicine," *Journal of Medical Education* 45, no. 12 (December 1970): 1032-1040. Kimball's textbook, *The Biopsychosocial Approach to the Patient*, was a standard in the field of medical ethics for many years. Chase Patterson Kimball, *The Biopsychosocial Approach to the Patient* (Baltimore, MD: Williams and Williams, 1981).

[32] Beverly H. Bonaparte, "Ego Defensiveness, Open-Closed Mindedness, and Nurses' Attitudes toward Culturally Different Patients," *Nursing Research* 28, no. 3 (May/June 1979): 166; Carolyn Mae Fong, "Ethnicity and Clinical Nursing," *Topics in Clinical Nursing* 7, no. 3 (October 1985): 1-10; Kem B. Louie, "Transcending Cultural Bias: The Literature Speaks," *Topics in Clinical Nursing* 7, no. 3 (October 1985): 78-84; Jane P. LaFargue, "Mediating between Two Views of Illness," *Topics in Clinical Nursing* 7, no. 3 (October 1985): 70-77; and Janet

It is generally accepted, however, that *cultural competency*, as a specific term, was introduced by Terry Cross and his associates in 1989 in their *Monograph on Effective Services for Minority Children*.[34] While the concept has been developed by countless scholars since, this original document is frequently cited by those intent upon adding to the dialogue on cultural competency. According to Cross and his colleagues:

> Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations.[35]

Their work was developed to improve social services available to children. Although the language of health disparities would not become popular for a few more years, it could be argued that Cross and his associates were responding to a perceived injustice in the delivery of social services. Their work was in direct response to a disparity in the quality of services between persons of different cultural and racial identities. When a similar pattern was recognized in the delivery of health-care services, the insights of Cross and his associates were quickly adopted by leaders in health care. Since the early 1990s, various medical authorities have released documents endorsing this new direction in medical education and

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Tull Foreman, "*Susto* and the Health Needs of the Cuban Refugee Population," *Topics in Clinical Nursing* 7, no. 3 (October 1985): 40-47.

[33] Paul B. Pedersen, *A Handbook for Developing Multicultural Awareness* (Alexandria, VA: American Association for Counseling and Development, 1988).

[34] Terry Cross et al., *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed* (Washington, DC: Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center, 1989).

[35] Ibid., 17. In this document, Cross and his associates present *cultural competency* as one stage in a broader scale of professional development where it is found just below *cultural proficiency*, the most advanced stage of development.

clinical practice. In some of these documents, the expectation that cultural competency will remedy race-based disparities in access to health care is explicitly stated (see Appendix A).

In 1990, the American Psychological Association published its *Guidelines for Culturally Diverse Populations*.[36] In 1992, the *Merck Manual of Diagnosis and Therapy* included a section on "Cross-cultural Issues in Medicine."[37] In 1996, the Society of Teachers of Family Medicine endorsed the "Recommended Care Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care."[38] In 1998, the Association of American Medical Colleges published "Teaching and Learning of Cultural Competence in Medical School."[39] In 2000, the Office of Minority Health of the United States Department of Health and Human Services published the National Standards for Culturally and Linguistically Appropriate Services (CLAS).[40] While lacking any substantive authority, the authors of the CLAS standards recommended national benchmarks for culturally appropriate health-care services. The authors were responding to the reality that although virtually every health profession has incorporated cultural competency into its curriculum, there has been no consensus across health-care institutions (or specialties) regarding what defines *cultural competency* or how it should be assessed. According to the authors of the report, national

[36] American Psychological Association, *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*, http://www.apa.org/pi/guide.html (accessed on April 1, 2008).

[37] Robert Berkow, ed. *The Merck Manual of Diagnosis and Therapy* (Whitehouse Station, NJ: Merck, 1992).

[38] Robert C. Like, Prasaad Steiner, and Arthur J. Rubel, "Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care," *Family Medicine* 27, no. 4 (April 1996): 291-297.

[39] Association of American Medical Colleges, "Teaching and Learning of Cultural Competence in Medical School," *Contemporary Issues in Medical Education* 1, no. 5 (October 1998): 1-2.

[40] Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report* (Washington, DC: U.S. Department of Health and Human Services, 2001).

standards in training for cultural competency would "contribute to the elimination of racial and ethnic health disparities."[41]

Various other institutions and agencies have contributed to this national dialogue by articulating their own definitions of cultural competency. In 2002, the Commonwealth Fund, a private, charitable foundation that promotes excellence in health care, defined *cultural competency* in this way:

> The ability of systems to provide care to patients with diverse values, beliefs and behaviors including tailoring delivery of care to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency.[42]

By drawing attention to the *quality* of the care that is to be offered to members of various social categories, the authors of this definition are implicitly acknowledging that persons of certain groups have, historically, received inferior care and have encountered increased barriers when attempting to access health-care services.

In 2004, the American College of Physicians (ACP) issued a position paper on racial disparities in health care.[43] According to this document:

> Cultural competence techniques include the use of interpreter services, racially or linguistically concordant clinicians and staff, culturally competent education and training, and culturally competent health education. These techniques change provider and patient behavior by improving communication, increasing trust, improving racially or ethnically specific

[41] Ibid., 3.

[42] Joseph R. Betancourt, Alexander R. Green, and J. Emilio Carrillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* (New York, NY: Commonwealth Fund, 2002), v.

[43] American College of Physicians, "Racial and Ethnic Disparities in Health Care: A Position Paper of the American College of Physicians," *Annals of Internal Medicine* 141, no. 3 (August 3, 2004): 226-233.

> knowledge of epidemiology and treatment efficacy, and expanding understanding of patients' cultural behaviors and environment.[44]

Here the ACP states that it is responding to evidence that there are clear disparities between the quality and availability of the health-care services received by those patients who represent the social majority and racial minorities. The ACP, recognizing these disparities as a serious problem, issued this position paper in the hopes of eliminating—or at least reducing—those disparities through the use of training in cultural competency.[45] Similarly, in 2005, the American Medical Association (AMA) stated in its *Code of Medical Ethics*:

> Physicians should seek to gain greater understanding of cultural or ethnic characteristics that can influence patients' health care decisions. Physicians should not rely on stereotypes; they should customize care to meet the needs and preferences of individual patients.[46]

In its commentary on cultural competency, the AMA argues that health disparities endured by cultural and racial minorities are "not directly attributable to variances in clinical needs or patient preferences."[47] Also in 2005, the AAMC released a more extensive document on cultural competency in medical education.[48] Here the authors argue:

> With the ever-increasing diversity of the population of the United States and strong evidence of racial and ethnic disparities in health care, it is critically

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[44] Ibid., 227.

[45] Ibid., 228.

[46] American Medical Association, *Code of Medical Ethics of the American Medical Association* (Chicago, IL: AMA Press, 2006), 298.

[47] Ibid.

[48] Association of American Medical Colleges, *Cultural Competence Education* (Washington, DC: Association of American Medical Colleges, 2005).

> important that health care professionals are educated specifically to address issues of culture in an effective manner.[49]

Most recently, in June 2007, the Liaison Committee on Medical Education (LCME), which accredits medical schools in the United States, published its standards for accreditation of medical education programs. What follows is an articulation of the expectations established by the LCME:

> The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on their health. To demonstrate compliance with this standard, schools should be able to document objectives relating to the development of skills in cultural competence, indicate where in the curriculum students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.[50]

The authors of this document connect cultural issues and bias with racial disparities in health care.[51] The Accreditation Council for Graduate Medical Education (ACGME) also identified cultural competency as a necessary component of any training programs for medical residents.[52]

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[49] Ibid., 1.

[50] Liaison Committee on Medical Education, *Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree* (Washington, DC: Liaison Committee on Medical Education, 2007), 15.

[51] Ibid., 16.

[52] Accreditation Council for Graduate Medical Education, *Outcome Project: General Competencies*, http://www.acgme.org/outcome/comp/compMin.asp (accessed on December 5, 2007).

Legislation

In some cases, authorities outside of the medical profession have intervened to address the perceived lack of cultural understanding in the practice of medicine. Several states have enacted laws that mandate training in multicultural issues for health-care professionals. These laws vary widely in the extent to which they prescribe content and in the consequences incurred if training is not completed.

In 2000, the Massachusetts legislature enacted a law that requires that "[e]very acute-care hospital ... shall provide competent interpreter services in connection with all emergency room services provided to every non-English speaker who is a patient or who seeks appropriate emergency care or treatment."[53] The Bryant Law, in New Jersey, was enacted and passed in 2005. This law stipulates that all medical students are required to complete training in cultural competency before being granted a license to practice.[54] In 2005, the California General Assembly approved a bill that mandates the development of standards for continuing medical education (CME). These standards include cultural and linguistic competency.[55] In 2006, the Washington State Legislature passed a bill that requires that *multicultural health* must be integrated into all health professional curricula.[56]

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[53] An Act Requiring Competent Interpreter Services in the Delivery of Acute Health Care Services (April 14, 2000), Senate and House of Representatives in General Court of the Commonwealth of Massachusetts, no. 4917, http://www.mass.gov/legis/laws/seslaw00/sl000066.htm (accessed on April 2, 2008).

[54] Requires Physician Cultural Competency Training as a Condition of Licensure (March 24, 2005), State and General Assembly of the State of New Jersey, Senate Bill S144, http://www.njleg.state.nj.us/2004/Bills/PL05/53_.PDF (accessed on April 2, 2008).

[55] Continuing Education: Cultural and Linguistic Competency (October 4, 2005), General Assembly of the State of California, Assembly Bill 1195, chap. 514, http://www.leginfo.ca.gov/pub/05-06/bill/asm/ab_1151-1200/ab_1195_bill_20051004_chaptered.pdf (accessed on April 2, 2008).

[56] Requiring Multicultural Education for Health Professionals (June 7, 2006), Washington State Legislature, Senate Bill 6194, http://apps.leg.wa.gov/documents/billdocs/2005-06/Pdf/Bills/Session%20Law%202006/6194.SL.pdf (accessed on April 2, 2008).

The Ohio General Assembly is considering a bill that would make training in cultural competency a component of CME. This bill would make ongoing training in cultural competency mandatory for both obtaining and renewing one's license to practice.[57] A bill that is pending in New York would require training in cultural competency for all medical students and physicians.[58]

Lack of Clarity

Despite these many statements and mandates, there has been no single approach to or understanding of cultural competency. The physician Eduardo Peña Dolhun and his colleagues state that in the absence of a standard, there can be no consensus regarding the content, methods, or assessment of such training programs.[59] The lack of agreement is significant. In the absence of any authoritative oversight, practical and conceptual problems are easily overlooked.

[57] To Amend Sections 4731.091, 4731.14, and 4731.281 and to Enact Sections 4731.093 and 4731.284 of the Revised Code to Require Instruction in Cultural Competency to Qualify to Obtain or Renew a Certificate of Registration to Practice Medicine (July 7, 2005), Ohio General Assembly, State Bill 160, http://www.legislature .state.oh.us/BillText126/126_SB_160_I_Y.pdf (accessed on April 2, 2008).

[58] An Act to Amend the Education Law, in Relation to Authorizing the State Board for Medicine and the Commissioner of Education to Promulgate Rules and Regulations for Physician Training (April 25, 2008), New York State Assembly, State Bill S07711, http://assembly.state.ny.us/leg/?bn=S07711&sh=t (accessed on April 2, 2008).

[59] Dolhun, Muñoz, and Grumbach, "Cross-Cultural Education in U.S. Medical Schools," 615.

Chapter 2: Lack of Conceptual Clarity

As I have shown in the previous chapter, in the last several decades there has been consistent attention given to the belief that cultural differences lead to racial disparities in access to health care and in health outcomes, but in the absence of any substantively authoritative voice, various institutions, associations, departments, and committees have developed their own approaches to the issues broadly and nebulously encompassed by the term *cultural competency*. These efforts have suffered from flaws in both method and design. First and foremost, there is a lack of agreement on what exactly constitutes cultural competency.[60] There is no consensus on the scope of, the need for, or the goals of cultural competency. Repeatedly, scholars report that efforts to measure cultural competency have proven difficult or impossible and much has been written about the ineffectiveness of the training that is provided. This difficulty is very likely due to the lack of conceptual clarity, at so many levels, when discussing this issue. Voices from anthropology and comparative literature, amongst others, provide sharp criticism regarding the many misconceptions that undergird the rhetoric of cultural competency.

Defining Culture

Nationalities, Inc. has found a market for novelty clothing that displays descriptions of various cultural identities. Their products describe Mexicans as “loyal to family and a

[60] Mary Catherine Beach et al., "Cultural Competence: A Systematic Review of Health Care Provider Educational Interventions," *Medical Care* 43, no. 4 (April 2005): 356-373; Victoria Stanhope et al., "Evaluating Cultural Competence among Behavioral Health Professionals," *Psychiatric Rehabilitation Journal* 28, no. 3 (Winter 2005): 225-232; and Scott Miyake Geron, "Cultural Competence: How Is It Measured? Does It Make a Difference?" *Generations* 26, no. 3 (Fall 2002): 39-45.

strong belief in [drawing of a church]," Greeks as "generous, affectionate, and family oriented," and Germans as the "the world's finest craftsmen and engineers."[61] The expectation is that customers will find these descriptions humorous and recognize them for the gross overgeneralizations that they are. What is troubling, however, is the degree to which these descriptions resemble the descriptions found in training materials for cultural competency. When describing Hispanic Americans, Sue Wintz and Earl Cooper state that they will have a "strong sense of loyalty, reciprocity, and solidarity among [family] members" and that the "Virgin of Guadalupe may be a powerful and popular cultural religious image."[62] Larry D. Purnell and Irena Papdopoulos state, "Greek and Greek Cypriot families tend to be very close."[63] In this same volume, Jessica A. Steckler notes, "Germans take pride in their school system, particularly in their craftsmanship and technology."[64] In many instructional materials cultures are reduced to caricaturized compendia of the commonly shared traditions and practices of particular groups. But can a collection of stylized traits and behaviors (on a t-shirt or in a training manual) define a culture? In much of the material provided for training in cultural competency, *culture*, as a concept, is not defined. In the absence of adequate reflection on this concept, individual cultures are easily

[61] Nationalities Inc. official Web site, *Identities Online*, http://www.identitiesonline.com/browse.asp ?code=NAT-DEF (accessed on January 15, 2008).

[62] Sue Wintz and Earl Cooper, *A Quick Guide to Cultures and Spiritual Traditions* (Yuma, AZ: Catholic Healthcare West Arizona and Yuma Regional Medical Center, 2001), 19-20. Wintz and Cooper state that the Virgin of Guadalupe may be a powerful and popular image for Hispanic Americans. This is a particularly gross overgeneralization. The Virgin of Guadalupe is the Roman Catholic patron saint of Mexico. She may have limited or no significance for persons from other Latin American countries or other religious traditions.

[63] Irena Papadopoulos and Larry D. Purnell, "People of Greek Heritage," in *Transcultural Health Care: A Culturally Competent Approach*, ed. Larry D. Purnell and Betty J. Paulanka (Philadelphia, PA: F. A. Davis, 2003), CD-ROM, 60.

[64] Jessica A. Steckler, "People of German Heritage," in *Transcultural Health Care: A Culturally Competent Approach*, ed. Larry D. Purnell and Betty J. Paulanka (Philadelphia, PA: F. A. Davis, 2003), CD-ROM, 39.

transformed into caricatures and stereotypes. Individuals and the groups with which they may identify are reduced to short lists of traits and characteristics.

A review of the literature provides yet another operative definition of culture, even if it is rarely articulated. Very often, a close reading of the material allows one to recognize that many of these authors are working under the assumption that culture is equivalent to race. This conflation is also evident in many of the self-assessments provided to participants of training programs for cultural competency. However, it is problematic to conflate race and culture. Such an understanding inevitably leads to erroneous assumptions about specific persons. Physicians may make a visual assessment of a patient's race and, perhaps in good conscience, proceed to project certain cultural practices and needs onto the patient. However, according to Linda M. Hunt, a medical anthropologist, "It is not possible to predict the beliefs and behaviors of individuals based on their race, ethnicity, or national origin. Individuals' group memberships cannot be assumed to indicate their culture."[65]

A better understanding of culture is possible when one considers the scholarship within the discipline of anthropology. According to the American Association of Physical Anthropology (AAPA):

> There is no necessary concordance between biological characteristics and culturally defined groups. On every continent, there are diverse populations that differ in language, economy, and culture. There is no national, religious, linguistic or cultural group or economic class that constitutes a race.[66]

A better understanding of culture will make this clear.

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[65] Linda Hunt, "Beyond Cultural Competence: Applying Humility to Clinical Settings," *Park Ridge Center Bulletin* 24, no. 6 (November/December 2001): 4.

[66] American Association of Physical Anthropology, "AAPA Statement on Biological Aspects of Race," *American Journal of Physical Anthropology* 101, no. 4 (December 1996): 570.

This lack of a definition for *culture* in much of the literature may be an oversight, but it may also be the result of the ambiguity that exists in the domain of cultural studies. In 1963, the anthropologists Alfred L. Kroeber and Clyde Kluckhohn published an important text, *Culture: A Critical Review of Concepts and Definitions*.[67] Intent upon providing a theoretical conception of culture, the authors collected and presented nearly three hundred definitions of culture. Their research focused on the work of anthropologists, sociologists, and other social scientists. And, even there, they discovered that many of those scholars produced materials in which "the word culture was being used without definition."[68] This information is provided here to emphasize that *culture* is an elusive term and that defining it has challenged many of the great thinkers in the social sciences.

However, the difficulty of a task ought not to be a reason to avoid it. With regard to cultural competency, the absence of even a working definition for what is a foundational concept has resulted in weakened scholarship, unsophisticated solutions, and superficial reflection on the issues. In the absence of an adequate understanding of culture, proponents of cultural competency have misidentified the root causes of health disparities. Subsequently, efforts to resolve health disparities will be impeded.

Among the many definitions that Kroeber and Kluckhohn collected, they identified noted anthropologist Edward B. Tylor as the first to document a definition for culture. Tylor's definition, while the oldest of the known definitions, is still frequently quoted. Tylor states that culture "is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of

[67] Alfred L. Kroeber and Clyde Kluckhohn, *Culture: A Critical Review of Concepts and Definitions* (New York, NY: Vintage Books, 1963).

[68] Ibid., 292.

society."[69] Kroeber and Kluckhohn conclude their analysis of the many definitions they collected by offering their own definition. Theirs is very similar to Tylor's, yet slightly more extensive:

> Culture consists of patterns, explicitly and implicitly, of and for behavior acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional (i.e., historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as patterns of action, on the other as conditioning elements of further action.[70]

The substantive difference between these two definitions is their description of the manner in which culture affects human action. While Tylor's definition does not address this, Kroeber and Kluckhohn's definition offers insight into how a culture can provide patterns for how people of a particular group may have acted in the past and how aspects of a culture may provide a framework, or "conditioning elements," through which individuals may understand themselves, their environment, and their future choices. Culture, however, "does not determine behavior."[71] Such thinking only "reinforces prejudicial and stereotypical attitudes that inevitably culminate in more or less overt forms of discrimination."[72]

The pedagogical methods in training programs for cultural competency can reflect this misunderstanding of the nature of culture. Many programs are modeled on what might best be understood as an *encyclopedic* approach to cultural education. Texts like Purnell

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[69] Edward B. Tylor, *Primitive Culture V1: Researches into the Development of Mythology, Philosophy, Religion, Language, Art and Custom*, 2 vols., vol. 1 (London, UK: Kessinger Publishing, 2006), 1.

[70] Kroeber and Kluckhohn, *Culture: A Critical Review of Concepts and Definitions*, 357.

[71] Hunt, "Beyond Cultural Competence," 3.

[72] Antonella Surbone, "Cultural Competence: Why?" *Annals of Oncology* 15, no. 5 (May 2004): 698.

and Paulanka's *Transcultural Health Care* or Wintz and Cooper's *A Quick Guide to Cultures and Spiritual Traditions* give the impression that to understand the cultural practices and needs of a Chinese patient, one only need know that Chinese women do not appreciate being touched by male health-care providers and that all Chinese people prefer health-care interventions that do not cause physical pain or discomfort.[73] The Health Resources and Services Administration (HRSA) Web site provides a portal to a number of cultural resources including descriptions of the practices and preferences of various cultural groups.[74] In reviewing the materials recommended by HRSA, one is presented with the following information.

- Some African Americans tend to speak loudly.[75]
- Hispanic culture tends to view health from a more synergistic point of view. This view is expressed as the continuum of body, mind, and espiritu (spirit).[76]
- Many Native Americans are more oriented to living in the present than the future which is often emphasized in Western culture. Since the future is vague and ambiguous, it is not unusual for the focus to be on immediate gratification.[77]

[73] Wintz and Cooper, *Quick Guide to Cultures and Spiritual Traditions*, 44; and Larry D. Purnell and Betty J. Paulanka, *Transcultural Health Care: A Culturally Competent Approach* (Philadelphia, PA: F. A. Davis, 2003).

[74] Health Resources and Services Administration, *Cultural Competence Resources for Health Care Providers*, U.S. Department of Health and Human Services, http://www.hrsa.gov/culturalcompetence/ (accessed on May 12, 2008).

[75] Josepha Campinha-Bacote, Eleanor Tapscott, and Gwen Vample, *Be Safe: A Cultural Competency Model for African Americans*, ed. John McNeil (Washington, DC: Howard University Medical School, 2002), 59.

[76] Health Resources and Services Administration, *Quality Health Services for Hispanics: The Culturally Competency Component*, U.S. Department of Health and Human Services, http://www.hrsa.gov /culturalcompetence/qualityhealthservices/knowtheculture.htm (accessed on April 5, 2008).

[77] Laura Oropeza, *Clinician's Guide: Working with Native Americans Living with HIV* (Oakland, CA: National Native American AIDS Preventions Center, 2002).

- Some Pacific Islanders believe that illness and other misfortune can be attributed to the loss of mana, defined as special power or life force.[78]

Granted, Wintz and Cooper include "Directions for Use" in which they state: "This material is designed to give a general overview of cultures and spiritual traditions. Remember that within all traditions are individual differences, and that all people will not necessarily fall into each category."[79] Regrettably, the format of their text (and the materials published by the various other agencies cited here), full of charts and bullet points, overpowers this discrete admonition and communicates to the reader that a patient's cultural issues can be known even before stepping to her bedside.

Patterns and Conditioning Elements. In society, solutions are developed in response to challenges in daily life. In time, responses to certain repeated situations are adopted across that society and passed from one generation to the next. This shared set of solutions provides the members of a particular society with an established set of responses to certain situations and a battery of conceptual models for interpreting the world around them. Each person does not have to discover for herself how to shelter and clothe herself. Individuals, families, and communities have models for how to grieve the loss of a loved one. Parents do not need to discover the utility of naming their children. These are the patterns that *condition* (but do not restrict or determine) how one acts and reacts in one's environment. Often, these patterns go unrecognized. Persons may believe that they are acting on human instinct and fail to recognize that they have been conditioned to act in

[78] Management Sciences for Health, *Reducing Health Disparities in Asian American & Pacific Islander Populations: AAPI Medical Traditions*, http://erc.msh.org/aapi/mt5.html (accessed on May 4, 2008).

[79] Wintz and Cooper, *Quick Guide to Cultures and Spiritual Traditions*, 2.

certain way by the society in which they live—by *their* culture. As these are learned behaviors—and not genetic traits—individuals are free to act against such patterns. Further, there will be an infinite number of variations in these patterns—even among persons who identify with the same general cultural group.

Culture as Static and Immutable

Culture is often treated as though it were a static and fixed entity that one can apprehend, define, and control. Subsequently, it is assumed that one can know all of the relevant data regarding individuals who identify with particular groups. Refuting such a position, Arthur Kleinman states, "Culture is not a thing; it is a process by which ordinary activities acquire emotional and moral meaning for participants.... Culture is inextricably caught up with economic, political, psychological, and biologic conditions.[80]

In 1992, the editors of the *Western Journal of Medicine* invited scholars to contribute to a special issue dedicated to a review of efforts made to promote cultural competency in the previous decade. One article exemplifies the belief that cultures are concrete and definable—despite a passing admission to the contrary. The authors' actual beliefs cannot be known, but their article places a strong emphasis on the idea of cultures as static entities. After exploring the ethical issues in dealing with a Chinese family, the authors conclude:

> It is difficult to generalize about cultural representativeness from one Chinese family. In many ways—the family's demand for heroic interventions, the excessive protectiveness of the son, the furious family response—this case is unusual. Nevertheless, it dramatically illustrates some of the issues

[80] Arthur Kleinman, "Culture and Depression," *New England Journal of Medicine* 351, no. 10 (September 2, 2004): 952.

> physicians face in working with Chinese patients and families, such as extensive family involvement in health care decisions and the importance placed on the nondisclosure of a terminal diagnosis.[81]

By acknowledging the difficulty in generalizing from one cross-cultural contact experience, the authors appear to accept that cultural expression varies widely even within one cultural group (e.g., Chinese persons). However, they negate this admission by their assessment that this particular case is "unusual." This implies that there is a usual manner in which Chinese patients are supposed to act. Further, they counter the unusual features of the case by identifying other features they believe are universal across Chinese culture (e.g., the preference for nondisclosure of a terminal diagnosis). Although this article was written more than a decade ago, many contemporary arguments reflect this author's attitude towards how culture operates in the lives of individuals. Should culture continue to be addressed in medical education and clinical practice, a better understanding is necessary.

Social scientists and cultural anthropologists insist that culture is not genetically transmitted from one generation to the next.[82] Rather, as Kroeber and Kluckhohn state in their definition, culture is "historically derived." Culture is not a fixed social artifact, but a process that is always in flux. According to Kleinman, "treating culture as a fixed variable seriously impedes our ability to understand and respond to disease states."[83] Believing that culture is equivalent to race is the first step in committing this error. Culture is learned. As a learned trait, therefore, it is generally the case that persons raised in the same

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[81] Jessica H. Muller and Brian Desmond, "Ethical Dilemmas in a Cross-Cultural Context: A Chinese Example," *Western Journal of Medicine* 157, no. 3 (September 1992): 327.

[82] American Association of Physical Anthropology, "AAPA Statement on Biological Aspects of Race," 570.

[83] Kleinman, "Culture and Depression," 952.

environment will share many cultural features. But it is important to remember that any similarity is a result of shared experience and geography. This is why culture and race sometimes may *coincide*—but only sometimes.

There can be no definitive statement regarding the content, shape, and practices of a particular culture. Norma Alarcón, a professor of ethnic studies, addresses the attempts to define particular cultures by reflecting on efforts to identify and define "'the' native woman."[84] Alarcón recalls when persons of Mexican-American descent were calling for an articulation of their own *Chicano* history. What resulted, however, was a deeper understanding of the nature of cultural and personal identity. According to Alarcón, "The call for the story of Chicanas/os has not turned out to be a 'definitive' culture as some dreamed."[85] Instead, they were brought to an awareness of the "political, ideological and discursive struggle through which the notion of 'definitiveness' and hegemonic tendencies are placed in question."[86]

What often goes unaddressed is the manner in which these cultural descriptions serve the dominant group by further subjugating the dominated groups. Gerrie F. Snyman, a scholar of sacred scripture, is critical of the manner in which marginalized groups are defined and controlled by the inheritors of power in postcolonial societies. He argues:

> By characterising perceived fundamental aspects of a group of people, they are rendered susceptible to *manipulation*. When a certain value or thought pattern is portrayed as typical of a community as a whole, that value or

[84] Norma Alarcón, "Chicana Feminism: In the Tracks of 'the' Native Woman," *Cultural Studies* 4, no. 3 (October 1990): 248-256.

[85] Ibid., 248.

[86] Ibid., 248-249.

> thought pattern receives a totalising effect. On the basis of what one person said, an entire community is characterised.[87]

When cultural groups are characterized and totalized by medical professionals intent upon *improving* the quality of services provided to those groups, they are reduced to caricatures, silenced, and more easily controlled.

Very often, when training in cultural competency is determined to have been successful, it is because participants can demonstrate increased knowledge of the cultural practices of particular groups.[88] Further, Anderson and her colleagues emphasize that a culturally competent health-care system is possible only when health-care practitioners have "training provided about the culture and language of the people they serve."[89] However, there is an increasing concern that is inappropriate to expect that the simple exposure to the practices and traditions of another group would lead to respectful and fruitful attitudes towards cultural strangers. Further, there is a strong belief that such methods could be counterproductive: "... a dangerous by-product of an increased exposure to cultural descriptions could be the increased ability to stereotype."[90] One study indicates that after Australian medical students were introduced to the cultural practices of aboriginal

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[87] Gerrie F. Snyman, "The Body, Rhetoric, and Postcolonial Criticism," *Religion and Theology* 9, no. 1/2 (2002): 66.

[88] Carter et al., "Cultural Competency Training for Third-Year Clerkship Students," 1773; Charlotte Flavin, "Cross-Cultural Training for Nurses: A Research-Based Education Project," *American Journal of Hospice and Palliative Medicine* 14, no. 3 (May/June 1997): 121-126; and Michael A. Godkin and Judith A. Savageau, "The Effect of Medical Students' International Experiences on Attitudes toward Serving Underserved Multicultural Populations," *Family Medicine* 35, no. 4 (April 2003): 273-278.

[89] Laurie M. Anderson et al., "Culturally Competent Healthcare Systems: A Systematic Review," *American Journal of Preventive Medicine* 24, no. 3 Suppl. (April 2003): 69.

[90] Mary Ellen Macdonald, Franco A. Carnevale, and Saleem Razack, "Understanding What Residents Want and What Residents Need: The Challenge of Cultural Training in Pediatrics," *Medical Teacher* 29, no. 5 (June 2007): 447.

people, the students were more inclined to believe that all people from that cultural group would act in similar and predictable ways.[91]

Proponents of providing cultural data about specific groups fail to acknowledge a critical aspect of this practice: who is responsible for developing these cultural profiles? There is no reflection on the dangers of using descriptions that reflect the dominant group's perceptions—or interests. Moon H. Jo, a sociologist, states:

> [P]assive, conforming and acquiescent behavior was not at all characteristic of the early Chinese immigrants ... [T]he 19th-century Cantonese peasants were a worldly, rebellious, and emotional lot ... [T]he passive personality traits exhibited by the progeny of these "bold and vigorous" Chinese pioneers resulted from the long history of racial oppression against the Chinese in the United States beginning with the rabid anti-Chinese movement in the latter half of the 19th century. We need to remind ourselves that the culture of an ethnic group or of a society can be selectively presented and variously interpreted according to the predilections and objectives of the superordinate group.[92]

Without understanding this dynamic, Anderson and her colleagues want to press the importance of cultural distinctiveness to the extreme. In their report, they suggest that cultural minorities might best be served in "culturally specific healthcare settings."[93] Although very little reflection is provided for this concept, the authors suggest that separate clinical sites, each designated for a specific cultural group, would enhance cross-cultural health care. Such a strategy recalls the separate-but-equal era of education in the in twentieth Century. Regardless of the ethical questions that might be raised, the authors of

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[91] Richard C. Copeman, "Medical Students, Aborigines and Migrants," *Medical Journal of Australia* 150, no. 2 (January 16, 1989): 84-87.

[92] Moon H. Jo, "The Putative Political Correctness of Asian Americans," *Political Psychology* 5, no. 4 (December 1984): 587.

[93] Anderson et al., "Culturally Competent Healthcare Systems: A Systematic Review," 69.

this study place a great emphasis on the importance of acquiring culture-specific data. Anderson and her peers are not the only ones to have advocated for such an approach. Vilma Santiago-Irizarry, an anthropologist, describes (and is ultimately critical of) a similar trend in mental health services. Proponents held that mental health services would be more effective if the ambiance reflected *latino* culture: "[T]he components of ambiance ... included décor, artwork, plants, displays, food, signs in Spanish, Spanish media, outings to Latino-related events, and visits by Latino 'cultural groups.'"[94]

Locating Culture

Another misconception that regularly can be found embedded in the literature on cultural competency is the idea that it is only the *other* (i.e., the cultural minority) who has a culture. As I have shown above, anthropologists insist that everyone is influenced by culture—if not several cultures at once. Yet Terry Cross's *Monograph* defines "minority populations" as the intended recipients of "culturally competent" services. The Office for Minority Health, in its CLAS standards, states that cultural competency is important to health care in the United States because of "significant increases in minority and foreign-born populations."[95] In the AMA's *Code of Medical Ethics*, recommendations for attending to cultural issues in the clinical setting are made for the benefit of "racial and ethnic

[94] Vilma Santiago-Irizarry, *Medicalizing Ethnicity: The Construction of Latino Identity in a Psychiatric Setting* (New York, NY: Cornell University, 2001), 60. Santiago-Irizarry is ultimately critical of this practice. However, she does not pursue what might be considered a rather obvious avenue of criticism. Proponents of this model believed that plants indigenous to various Latin American countries, art work, and food would enhance the work done by mental health professionals in *ethnicized* clinics. However, there is no indication (at least in the work of Santiago-Irizarry) that the proponents of such clinics have ever considered what mental health clinics look like in Latin American countries.

[95] Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, vi.

minority populations."[96] The ACP position paper was developed as a commentary on the disparities in the health care of "racial and ethnic minorities."[97] The *Cultural Competence Self-Assessment Questionnaire* addresses cultural competency exclusively in terms of providing services for persons of color. Delia Saldaña, a psychologist, states, "The cultural appropriateness of mental health services may be the most important factor in the accessibility of services by people of color."[98] While these represent only a small selection, they are influential texts (whether nationally or locally) and reflective of the majority of the work in this area.

This trend is regularly repeated in many journal articles that discuss cultural competency. A significant number of these articles cite United States Census Bureau statistics and predictions. Readers are invited to consider the possibility that, as predicted by census data, by 2050 persons who identify as racial minorities could represent more than half of the population of the United States. That is to say, the group of persons who identify as "White-only, non-Hispanic" will no longer be in the majority.[99] The repeated citing of the Census Bureau data and predictions as a way to justify training programs for cultural competency makes it clear that there is a shared sense among these authors that there are many problems that arise in clinical practice when physicians are called upon to treat patients from unfamiliar populations—patients who have a culture. However, here the

[96] American Medical Association, *Code of Medical Ethics*, 298.

[97] American College of Physicians, "Racial and Ethnic Disparities in Health Care," 226.

[98] Delia Saldaña, *Cultural Competency: A Practical Guide for Mental Health Service Providers* (Austin, TX: Hogg Foundation for Mental Health, 2001), 3.

[99] This is a category defined by the United States Census Bureau.

problem is located in the differences the other represents and not in the attitude of the physician.

Racial Minorities as Traditional

Ubiquitous in literature on cultural competency is the term *traditional*. The term is readily used as a descriptor of various other cultures, but, as a term, it is rarely defined. Clues from the context of the literature can be helpful in determining what the author(s) may have implied. Often authors have used the term *traditional* to describe a practice that they deem unsophisticated, primitive, rooted in irrational superstition, or lacking in scientific merit. [100] Further, *traditional* often carries with it an understanding that the subject (whether an individual or a group) is incapable of overcoming the constraints of the tradition.

In essence, by analyzing the use of the term, one gains a sense that to have a culture is to be steeped in a primitive *Weltanschauung*. To be modern or socially evolved, one is then to presume, is to have risen above the constraints of tradition and to have shed any cultural remnants. Of course, given the definition of culture provided by Tylor or Kroeber and Kluckhohn, it is unreasonable to accept that any human being is free of any and all cultural influences. Physicians and patients alike are influenced and conditioned by the cultural standards to which they have been exposed. Physicians and patients alike are free to act according to or against cultural patterns and traditions, but only when first they recognize those conditioning elements and the effects they have on clinical practice.

[100] Hunt, "Beyond Cultural Competence," 4.

Elaine J. Copeland, a counselor and educator, states that those individuals whose cultural practice does not reflect that of the dominant majority have often been identified as inferior.[101] From this perspective, the task of the cultural stranger is to assimilate herself into the cultural practices of the dominant group. Ironically, the dominant majority may often act in ways that suggest a belief that they do not have a culture and somehow represent the normative state of human existence. From this perspective, cultural differentiation results when *others* have strayed from that norm. Very often, medical school curricula, in hidden ways, reinforce the normativity of a particular group.

Normativity and Difference

The conception of what is normal is a very powerful tool. Very often, there is little or no reflection given on the source of the definition of the *norm*. Just as often, a sense of what is familiar is transformed into an understanding of what should be. Dominant persons and groups determine what is *normal* and, in varying ways, attempt to impose that standard on everyone. In the mythology of ancient Greece, Procrustes was a known criminal who deceived weary travelers by offering them lodging in his inn. Once the travelers were inside, they were forced onto an iron bed to be measured. If the travelers were too long for the bed, Procrustes would amputate the appropriate length from the feet and legs until they fit *properly*. If the travelers were too short, Procrustes would stretch them until they were the *proper* length. Different iterations of this myth include either an adjustable bed that Procruestes would shorten for taller travelers and lengthen for short ones or two separate

[101] Copeland, "Cross-Cultural Counseling and Psychotherapy," 10.

beds (one long and one short).[102] Whatever the method of measurement, the myth is representative of the practice of enforcing an arbitrary standard onto others. Procrustes's inconstant rule is an ideal metaphor for the arbitrary (and ever changing) standards of *normalcy* that are used to punish those *others* who do not (and may never) meet the conditions of admission.

In clinical practice, patients who are racial and cultural minorities are regularly held to an unspoken norm. Delese Wear, an educational theorist, captures it well when she writes:

> This approach (like many others) assumes that the locus of normalcy is white, Western culture—that ''difference'' means nonwhite, non-Western, non-heterosexual, non-English-speaking, and most recently, non-Christian—how they are different from us.[103]

When it is only the *other* who has culture, the practices, perspectives, and values of the dominant group or person come to be understood as normative, universal, and free of cultural influence. This is an unrealistic and dangerous attitude to hold. María Lugones, a philosopher, is critical of this practice and argues (to an implied member of the dominant group), "[Y]ou do not see me because you do not see yourself and you do not see yourself because you declare yourself outside of culture. But declaring yourself outside of culture is self-deceiving. The deception hides your seeing only through the eyes of your culture."[104]

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[102] Michael Grant and John Hazel, *Who's Who in Classical Mythology* (London, UK: Routledge, 2002), 447, 551.

[103] Delese Wear, "Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education," *Academic Medicine* 78, no. 6 (June 2003): 550.

[104] María Lugones, "Hablando Cara a Cara/Speaking Face to Face: An Exploration of Ethnocentric Racism," in *Making Face, Making Soul = Haciendo Caras: Creative and Critical Perspectives by Feminists of Color*, ed. Gloria E. Anzaldúa (San Francisco, CA: Aunt Lute Books, 1990), 51.

Physicians Sandra Turbes, Erin Krebs, and Sara Axtell conducted research on the demographic characteristics that appear in medical case studies.[105] According to their study, the majority of the cases reflect an understanding that the *normal* patient is white, male, and heterosexual. The researchers "found that most cases did not indicate the race or ethnicity of the individual featured."[106] Where the subject of the case is identified by race, he or she is of a non-white race. Some argue that such a practice is representative of blindness towards the issues of racism in society. Gloria Anzaldúa argues, "[A]n unmarked race is a sign of Racism unaware of itself, a 'blanked-out' Racism."[107] Turbes, Krebs, and Axtell emphasize that when race is not defined, white is to be assumed. This pattern, they warn, serves to position white as the normative racial category (they also explore similar treatment of sexual orientation and gender). One of their recommendations is to always include racial designations in case studies in order to "remove [certain] characteristic[s] from [their] central, normative position."[108]

A similar study of the content of training cases found that negative racial stereotypes were regularly depicted in the cases themselves.[109] A Dalhousie University medical student, Gaynor Watson, evaluated the cases that were used in the curriculum and found that on the few occasions in which racial minorities were represented, they were shown in a negative light. Watson refers to "a case that examined sickle-cell anemia in a

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[105] Sandra Turbes, Erin Krebs, and Sara Axtell, "The Hidden Curriculum in Multicultural Medical Education: The Role of Case Examples," *Academic Medicine* 77, no. 3 (March 2002): 209-216.

[106] Ibid., 213.

[107] Gloria Anzaldúa, *Making Face, Making Soul = Haciendo Caras: Creative and Critical Perspectives by Feminists of Color* (San Francisco, CA: Aunt Lute Books, 1990), xxi.

[108] Turbes, Krebs, and Axtell, "The Hidden Curriculum in Multicultural Medical Education," 215.

[109] Nancy Robb, "Racism Can Rear Its Ugly Head at Medical School, Study Finds," *Canadian Medical Association Journal* 159, no. 1 (July 1998): 66-67.

black toddler whose mother is 17 and unmarried, and whose father is a 37-year-old alcoholic."[110] Watson's primary concern is that the medical school curriculum provides a very unbalanced social portrayal of racial minorities.

A common misconception in the rhetoric of cultural competency rests in the very understanding of difference. Difference is often treated as though it were a trait that could be possessed by an individual. Martha Minow, a law scholar, directly addresses this confusion when she states:

> Difference, after all, is a comparative term. It implies a reference: different from whom? ... But the point of comparison is often unstated. Women are compared to the unstated norm of men, "minority" races with whites, handicapped persons with the able-bodied, and "minority" religions and ethnicities with majorities.[111]

Patients, despite their racial or cultural identity, are not different without being different from another—in this case, the physician. The physician, in turn, is different from the patient. This may seem an obvious point to make, yet training programs in cultural competency regularly reflect an unstated norm. Donaldo Macedo and Lilia Bartolomé, both linguists, reiterate this important point:

> These methods ... blindly embrace the hidden (and sometimes not so opaque) assumption that the intolerable features of the "other" will be altered, reformed and, ultimately assimilated into an invisible culture of whiteness that serves as the yardstick against which cultural differences are measured.[112]

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[110] Ibid., 67.

[111] Martha Minow, *Making All the Difference: Inclusion, Exclusion, and American Law* (Ithaca, NY: Cornell University Press, 1990), 22.

[112] Donaldo Macedo and Lilia I. Bartolomé, *Dancing with Bigotry: Beyond the Politics of Tolerance* (New York, NY: St. Martin's Press, 1999), 118.

Assumptions of normativity can have a negative impact on clinical care. Without reflection, one's activities of daily life (the style in which one dresses, the configuration of one's work and living spaces, and even the familial structures to which one has grown accustomed) are understood as being natural or normal features of human life. While many aspects of life (e.g., eating, reproduction, sleeping, etc.) are natural, the manner in which these tasks are fulfilled has developed over time and varies from region to region. To illustrate this point, Judith Lee Kissell, a medical ethicist, describes the kinship patterns of a certain group of Sudanese people:

> The Nuer tribe comes from the south Sudan and constitutes a large part of the immigrant population to this country. Traditionally, the Nuer have practiced various forms of marriage for obtaining progeny. One is the "woman-to-woman marriage" that occurs when the first wife cannot have children. The second woman may then have intercourse with another male and become pregnant. The barren woman becomes the child's "father" and the child becomes a member of her father's patrilineal group.[113]

Kissel goes on to describe several other kinship and marriage conventions that have developed within this particular group. For the Nuer who engage in such practices, these arrangements would seem to be quite *natural*. Yet evaluating the practice of the Nuer from an American perspective may lead one to determine that this practice is both an aberration and unacceptable. However, assuming that all persons who can claim a connection to the Nuer people (in the Sudan or in the United States) will engage in these practices is equally dangerous.

[113] Judith Lee Kissell, "'Suspended Animation,' My Mother's Wife and Cultural Discernment: Considerations for Genetic Research among Immigrants," *Theoretical Medicine and Bioethics* 26, no. 6 (December 2005): 525.

It is not unusual for someone to believe that her particular manner (custom, style, architecture, religion, etc.) is standard or universal.[114] What is familiar is confused for what ought to be. Clifford Geertz, an anthropologist, claims that "the sovereignty of the familiar impoverishe[s] everyone."[115] When familiarity or local custom is mistaken for universal truth, cultural variations are interpreted as deviations from the proper practice. When such variations are encountered, they may be a source of fascination or entertainment. Yet, when conflict arises, the expectation is that any resolution will result only when all parties have adopted what is mistakenly believed to be the standard perspective and practice. This mistaken belief in a universal standard, of course, is at the heart of this problem. Linguists and anthropologists repeatedly deny any such claims: "[H]uman beings everywhere rotate their heads upon their necks, blink and open wide their eyes, move their arms and hands—but the significance of these signals varies from society to society."[116] Yet, very often, these assumed deviations are defined in negative terms. And, it is always the other, the cultural stranger, who is different from the unstated (but ever present) sense of a norm.

Social scientists have identified several models by which difference is interpreted. Very often, and often subconsciously, the models that are used are models that do not allow for a positive assessment of diversity and difference. The psychologist Roderick Watts, citing the work of others in his field, identified three such models:

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[114] This belief is not unlike what occurs when speakers from various regions of a particular country meet. Although speaking the same language, variations in pronunciation, grammar, and vocabulary are common. Yet, to each speaker, it is the *other* who has the *accent*, while she herself speaks the *standard* form of the given language.

[115] Clifford Geertz, *Available Light: Anthropological Reflections on Philosophical Topics* (Princeton, NJ: Princeton University Press, 2000), 84.

[116] Peter Farb, *Word Play: What Happens When People Talk* (New York, NY: Vintage Books, 1993), 204.

> (a) models that understand distinctive attributes of populations as psychopathology, (b) genetic or constitutional-constitutional deficiency models for explaining population differences, and (c) cultural deficit models for explaining differences.[117]

Any treatment of health disparities will require a reflection on the ways in which an appeal to normativity and negative attitudes towards difference lead to exclusion and marginalization. Further, physicians must be challenged to understand that both the tendency to appeal to a norm and the definition of the norm itself are culturally constructed. Expecting all persons to conform to a norm and punishing those who fail to do so have a negative impact on both the dominant and subordinate groups.

Cultural Competency only for White Americans

An extension of this appeal to normativity leads to another conceptual problem in cultural competency: the belief that all racial minorities will understand each other. Quite to the contrary, intercultural communication in clinical practice is an issue that has been taken up in non-white societies where physicians encounter patients who may appear to be from the same racial group but have cultural practices that are quite different from their own. A report from Chile indicates that there is often a great deal of conflict between patients from the Mapuche people living in the mountainous regions of Chile and physicians who identify with the segment of the Chilean population that developed when, centuries ago, the Spanish colonialists began to intermarry with the native population of that region of South America. In addition to language barriers, Alarcón-Muñoz and Vidal-Herrera state:

[117] Roderick J. Watts, "Elements of a Psychology of Human Diversity," *Journal of Community Psychology* 20, no. 2 (April 1992): 118.

> Para las madres el conjugar las explicaciones médicas con sus propios modelos de enfermedad resulta un proceso muy controversial. Muchas de ellas plantaron que ocultan al personal de salud sus ideas sobre la enfermedad de sus hijos, y a veces no siguen el tratamiento medico porque consideran que algunos medicamentos son inapropiados para la enfermedad. Estas actitudes se basan en la percepción de que el personal de salud no respeta sus creencias y valores culturales.[118]

Cultural Competency as Mastery

Much of the programming for cultural competency focuses on providing practitioners with cultural data specific to various groups. For example, "Iranians may express their grief over the death of a loved one by crying, wailing loudly, or even striking themselves or an object."[119] Or Japanese patients "may believe chronic illnesses are due to karma/bad behavior in this life or past life, or from actions of another family member."[120] Presumably, one can become competent in another's culture when one has learned the essential details of that culture. Yet, Kluckhohn has this to say: "No participant in any culture knows all the details of the cultural map."[121] If one cannot claim to know all the details of one's own culture, how can one claim mastery (or competency) over the culture of another?

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[118] Ana María Alarcón-Muñoz and Aldo Conrado Vidal-Herrera, "Dimensiones Culturales en el Proceso de Atención Primaria Infantil: Perspectivas de las Madres," *Salud Pública de México* 47, no. 6 (Noviembre/Diciembre 2005). Translation: For the mothers, blending the biomedical explanations with their own models of illness proved to be very controversial. Many of them stated that they hide their ideas regarding the health of their children from the health workers. Sometimes they do not follow the treatment plan because they believe that certain medications are inappropriate remedies for disease. These attitudes are based in the perception that the health workers do not respect their beliefs or cultural values.

[119] Homeyra Hafizi and Juliene G. Lipson, "People of Iranian Heritage," in *Transcultural Health Care: A Culturally Competent Approach*, ed. Larry D. Purnell and Betty J. Paulanka (Philadelphia, PA: F. A. Davis, 2003), 187.

[120] Wintz and Cooper, *Quick Guide to Cultures and Spiritual Traditions*, 23.

[121] Clyde Kluckhohn, "Queer Customs," in *The Practical Skeptic: Readings in Sociology*, ed. Lisa J. McIntyre (Boston, MA: McGraw-Hill, 2009), 67.

There are several problems intertwined when competency is the stated goal. First, there is a mistaken belief that cultures are monolithic and that all members of a cultural group will act, think, and express themselves in the same way. Second, there is the belief that facts and data about specific cultures and cultural practices bestow one with a certain authority over another group and its practices. This attitude is not new.

Academics have long believed that, with proper (and minimal) training, one can develop a degree of mastery over another culture. In the 1950s, scholars of Spanish language and literature stated, "The [undergraduate] student who has chosen to specialize in Spanish can become an interpreter of Hispanic thought and culture to those of his fellow citizens who know no Spanish."[122] From this perspective, proficiency in the Spanish language is determined as sufficient for interpreting cultural practices and resolving any conflicts between a practitioner and a patient from different cultural backgrounds. Despite the fact that this quotation is fifty years old, it reflects an attitude that continues to shape training programs and assessments for cultural competency today.

Yet another problem can be found in this model. When a practitioner encounters unfamiliar behaviors and beliefs, they may be attributed to the patient's culture. But what occurs when that particular patient's cultural practices do not reflect the broader culture to which she has been relegated by the practitioner? The practices of the cultural stranger must somehow be justified (by the majority). Unless an unexpected behavior can be linked to culture (by the culturally competent practitioner), it may be interpreted simply as erratic,

[122] Gardiner H. London, Robert G. Mead, Jr., and Kathryn London, "A Guide for the Spanish Major," *Hispania* 38, no. 2 (May 1955): 132.

irrational, and unacceptable. The behavior (and the patient) may then be dismissed in good conscience.

The overlap between these assumptions and one discussed above (i.e., culture defines and restricts behavior) serves to promote a false sense of confidence when dealing with persons from other cultures. Practitioners who apply newly acquired cultural knowledge in the clinical setting may genuinely believe that they are fulfilling their duties and meeting the needs of their patients from differing cultural backgrounds.

To frame the problem in terms of a lack of cultural data—a lack of cultural competency—provides a very benign rationale for the conflicts that arise in the clinical setting. As I have argued above, these conflicts are regularly attributed to the intercultural miscommunication that stems from a lack of knowledge regarding the practices and traditions of other cultures.[123] Framing the problem in these terms limits the need for educators and practitioners to consider other important factors that contribute to the problems that are being encountered in clinical contact with persons from different cultures. In most of the literature on cultural competency, there is a lack of reflection on the impact (and misuse) of social power in these encounters. Practitioners are not invited to consider the ways in which a culturocentric perspective contributes to a negative evaluation of some of their patients. Racism, classism, heterocentrism go unaddressed.

[123] Knowledge deficits are occasionally the cause of inappropriate actions taken by professionals. On these occasions, the acquisition of essential information may remedy the situation. See Appendix A for a personal reflection on just such a situation.

Contact

The design of many training programs for cultural competency is reminiscent of a once popular model in sociology: the contact hypothesis.[124] The contact hypothesis (criticized by many current sociologists and psychologists) was an approach to reducing tensions between antagonistic social groups.[125] The goal of the contact hypothesis was to foster harmonious relationships between groups that were experiencing conflict. Ideally, according to psychologist Stuart W. Cook, such contact was to occur under the following five conditions:

- Participants from the two groups have equal status within the confines of the contact situation.
- The characteristics of outgroup members with whom contact takes place disconfirm the prevailing outgroup stereotype.
- The contact situation encourages, or perhaps necessarily requires, cooperation in the achievement of a joint goal.
- The contact situation has high 'acquaintance potential' (i.e., it enables individuals to get to know each other as individuals, rather than as stereotypical outgroup members).
- The social norms within and surrounding the contact situation favour 'group equality' and 'equalitarian intergroup association'.[126]

Yet, even when it is possible to arrange for contact experiences that meet these conditions, it is impossible to control for other negative factors. Yehuda Amir, a social psychologist, has observed that contact experiences (even those that meet the five conditions listed above) are not devoid of competition, tension, moral conflict between groups, and the lingering

[124] Gordon W. Allport, *The Nature of Prejudice* (Cambridge, MA: Addison-Wesley, 1954); and Stuart W. Cook, "Interpersonal and Attitudinal Outcomes in Cooperating Interracial Groups," *Journal of Research and Development in Education* 12, no. 1 (Fall 1978): 97-113.

[125] Miles Hewstone and Rupert Brown, "Contact Is Not Enough: An Intergroup Perspective on the 'Contact Hypothesis'," in *Contact and Conflict in Intergroup Encounters*, ed. Miles Hewstone and Rupert Brown (New York, NY: Basil Blackwell, 1986).

[126] Ibid., 4-5.

effects of the status of the groups within the larger society.[127] So, even when these conditions are met, systems of dominance are perpetuated and exacerbated by the contact experience, *outgroup* persons are stripped of their individuality, and groups remain in conflict.

Pertinent to my critique of cultural competency, these conditions are not met when medical students are placed into contact with patients from races or cultures different from their own. And, as Amir has argued, even if such conditions could be met, it remains unlikely that mere exposure or contact would be sufficient to foster the reflection necessary to reform deeply embedded attitudes and biases towards others. Whether students are exposed to another culture in an immersion program or through cultural descriptions published in guidebooks, contact is not enough.

If this is the case, and contact is insufficient for reducing or eliminating intergroup conflict, those experiences will be ineffective in fostering the reflection and discernment necessary to address the deeper social structures that contribute to racial disparities in access to health care. Brian Hennen, a physician and medical educator, acknowledging the limitations of many contemporary training programs, states, "Simply placing students in a community setting as part of the curriculum is not a sufficient response to the challenge of social accountability in medical education."[128] According to Brenda L. Beagan, a sociologist:

> A course intended to produce physicians able to work effectively across differences of race, culture, gender, sexual orientation, religion, and so on must explicitly address power relations. It must be about racism, not just cultural difference; it must be about homophobia and heterosexism, not just

[127] Ibid., 7.

[128] Brian Hennen, "Demonstrating Social Accountability in Medical Education," *Canadian Medical Association Journal* 156, no. 3 (February 1, 1997): 365-367.

> differences in sexuality; it must be about sexism and classism, not just gender differences and the health issues faced by the "the poor."[129]

Ultimately, neither social contact nor the accumulation of cultural knowledge (the staples most training programs in cultural competency) will be effective measures for preparing physicians and medical students for the work of identifying causes of racial disparities in health care and developing strategies in the hopes of reducing or eliminating those disparities.

Cultural Competency as an Individual Effort

The few authors who recognize that cultural competency requires reflection on social factors beyond the racial origins of patients often focus exclusively on the attitudes of the individual practitioner.[130] Increasingly, those attempting to incorporate the values of cultural competency into their daily practice are urged to acknowledge and identify their own biases and prejudices. This process is a step in the right direction and will receive more attention later in this project. However, many of these authors fail to connect the practitioners' biases and prejudices with attitudes shared and endorsed among members of their social context. According to medical anthropologist Linda Hunt:

> Health researchers, like everyone else, are subject to the influences of their society, their best efforts to be objective and neutral notwithstanding. Our

[129] Brenda L. Beagan, "Teaching Social and Cultural Awareness to Medical Students: 'It's All Very Nice to Talk about It in Theory, But Ultimately It Makes No Difference'," *Academic Medicine* 78, no. 6 (June 2003): 614.

[130] Derek M. Griffith et al., "Dismantling Institutional Racism: Theory and Action," *American Journal of Community Psychology* 39, no. 3-4 (June 2007): 382.

> society has a long legacy of stereotypes and prejudices about certain ethnic groups."[131]

Attitudes towards cultural strangers are very much a part of one's own cultural constitution. When these social trends go unexplored, they can be mistaken for objective information regarding a group or class of people. Such cultural influences can be overcome and they can evolve. Yet, to do so, one must first recognize that these perspectives are not objective ways to think about people of a certain class or race. Rather, they are the historically derived perceptions that continue to shape new generations and influence the design of social policy, judicial action, law enforcement, and clinical practice. To be effective, training for clinical practice with cultural strangers will be effective only when individuals are motivated to address collaboratively the many social structures that result in disparity in access to needed social and medical services.

William Vega states that current programming in cultural competency will not be effective in producing social or corporate change.[132] He asserts that focusing training opportunities—limited as they are—on individual practitioners serves only to temporarily partition them from larger organizational structures that are in need of change. By not providing follow-up opportunities, ongoing support, or resources for addressing organizational failings, even those participants who recognize the need for broader reform may feel overwhelmed or powerless to initiate meaningful conversations with superiors or effect systemic change. "Simply put," Vega states, "in the absence of (unambiguous) organizational support and commitment of resources—augmented by a clear strategy for

[131] Linda Hunt, "Health Research: What's Culture Got to Do with It?" *Lancet* 366, no. 9486 (August 20, 2005): 618.

[132] Vega, "Higher Stakes ahead for Cultural Competence," 449.

sustaining the infusion of new knowledge, training alone is unlikely to improve patient care."[133]

Harm can come to the patient when these many concepts are not properly understood. Physicians may associate learned cultural data with foreign-born individuals or persons who possess the physical characteristics of a particular racial minority. The patient's *culturalness* is then associated with traditionalism (tradition in the negative sense described above), and the patient is deemed unsophisticated or primitive. The patient's incapacity to understand modern medical technology and her inability to act in ways contrary to her culture may be assumed. Clinical care, then, may often be tainted by an unconscious effort to save the patient from herself. In the absence of an adequate understanding of how one has been conditioned to believe in a standard or a norm, one's relationship to the cultural stranger will suffer. Many of these conceptual flaws are evident in current training programs for cultural competency.

[133] Ibid.

Chapter 3: Current Practices

Despite the many professional and legislative mandates, most medical schools do not address culture or health disparities in their curricula. A 2000 study showed that only 8 percent of schools had specific courses in cultural matters as part of their curriculum.[134] Another article published that same year showed that less than one-third of residency programs addressed "multicultural medicine" and that "at least 14%" of residency programs lacked any mention of cultural practices in their curricula.[135] Yet another article reported findings from the 1999-2000 Liaison Committee on Medical Education Annual Medical School Questionnaire.[136] According to the data collected from the questionnaire, in 2000 only one in the 125 medical schools reviewed had a formal course dedicated to the exploration of cultural issues in health care.

In the absence of formal programs, cultural issues and health disparities may be presented as minor subtopics in the context of other courses or in electives.[137] Often, the claim is that the issues central to cultural competency and health disparities are integrated into the curriculum and that the relevant issues compose a longitudinal thread that is incorporated throughout the educational experiences of medical students and residents. Scholars have challenged the effectiveness of such approaches. Caroline Wachtler and

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[134] Flores, Gee, and Kastner, "Teaching of Cultural Issues in U.S. and Canadian Medical Schools," 452.

[135] Kathleen A. Culhane-Pera et al., "Multicultural Curricula in Family Practice Residencies," *Family Medicine* 32, no. 3 (March 2000): 171.

[136] Barbara Barzansky, Harry S. Jonas, and Sylvia I. Etzel, "Educational Programs in US Medical Schools, 1999-2000," *JAMA* 284, no. 9 (September 2000): 1114-1120.

[137] Warren J. Ferguson, "Developing Culturally Competent Community Faculty: A Model Program," *Academic Medicine* 78, no. 12 (December 2003): 1221; and Flores, Gee, and Kastner, "Teaching of Cultural Issues in U.S. and Canadian Medical Schools," 452.

Margareta Troein, both physicians and public health scholars, reviewed the training program for cultural competency at one medical school. Their observations are important as they could apply to any similar program in which the methods and expectations for training in cultural competency are not formally articulated. Wachtler and Troein state:

> Cultural competency is not clearly defined in the planned curriculum and the subject is not thematically presented in the taught curriculum. Instead, cultural competency training is present but hidden, 'integrated' in an unstructured way that is described differently by teachers and students. Inclusion of cultural competency in specific educational environments depends on time and interest. There is no verification that all students leave the medical programme with adequate skills and the knowledge required to take care of patients regardless of their background.[138]

Regardless of the format or the extent of the programming, it is difficult to deny that a change is occurring and that medical students and physicians have been given the task of becoming culturally competent—whatever that may be. Unfortunately, a review of the literature illustrates that many programs are burdened by the many conceptual flaws presented in the previous chapter (e.g., *culture* is understood as monolithic and static, naïve or primitive perspectives are attributed to cultural strangers, it is presumed that only racial minorities have culture, etc.).

Fortunately, there has been some evolution in how educators understand cultural competency. Some of the programs and resources that have been developed in recent years appear to endorse a patient-centered approach in which patients who are cultural strangers are invited to articulate their needs and concerns. Practitioners are encouraged to reflect upon the diversity that exists in human communication and they are asked to

[138] Caroline Wachtler and Margareta Troein, "A Hidden Curriculum: Mapping Cultural Competency in a Medical Programme," *Medical Education* 37, no. 10 (October 2003): 866.

consider how their own expectations and perspectives may contribute to miscommunication. In a few cases, practitioners are challenged to assess their own biases and discriminatory attitudes towards others. While these programs represent a vast improvement over the models that focus on the acquisition of cultural data, there is still an understanding that it is the cultural differences that are the problem. Although a few of these programs require that participants reflect on their own biases, there is still a reluctance to consider the broader social structures that contribute to disparities in health care. There is a lack of reflection on the number of cultural and racial minorities who, because of unjust policies and practices, are barred access to medical services. The physician who can effectively communicate across and through cultural differences will be of little use to the sick person who is never able to reach the clinic.

Cultural Competency in Medical Education

Many medical educators and advocates for cultural competency have reported on their efforts to prepare medical students and physicians to provide clinical care for cultural strangers. These reports provide valuable insight into the content of these programs and the variety of approaches that are currently being implemented. In many of these cases, however, very little is formally articulated regarding the content or goals of the educational activities and analysis of such programs proves very difficult. A selection of programs and resources will be presented and evaluated here. Many exhibit the conceptual flaws discussed in the previous chapter, but some reflect an evolution towards a patient-based approach.

The American Medical Student Association (AMSA). In 2003, AMSA began to test a pilot program: Achieving Diversity in Dentistry and Medicine (ADDM).[139] ADDM was a four-year project funded by the U.S. Department of Health and Human Services, HRSA, Bureau of Health Professionals, Division of Medicine and Dentistry. ADDM was designed to provide resources and guidance to the faculties at medical and dental schools who were interested in developing longitudinal curricular interventions in order to address issues relevant to clinical practice with cultural strangers. Arguing that the incorporation of cultural competency into medical education is important, the AMSA provides the following for those institutions interested in developing their curricula:

1. Strategies for preparing medical school faculty to teach cultural competency through integration;
2. A suggested curriculum outline for cultural competency that can be tailored to any school;
3. A look at ways to evaluate the efficacy of a culturally competent medical education and student/faculty performance within it;
4. Detailed methods for student instruction in cultural competency, based on existing curriculum type;
5. A blueprint for making cultural competency an integrated part of an institution.[140]

The AMSA reports that eleven institutions participated and implemented their curricular guidelines. Of these schools, five were allopathic medical institutions, three were schools of osteopathic medicine, and three were schools for dental medicine.[141]

Although the recommendations provided by AMSA emphasize the importance of reflecting on the impact of negative biases towards cultural strangers, a list of core

[139] American Medical Student Association, *Achieving Diversity in Dentistry and Medicine*, http://www.amsa.org/addm/#cult (accessed on January 23, 2008).

[140] Ibid.

[141] Ibid.

competencies recommends introducing students to the "folk illnesses and healing practices" of minority cultures.[142] This connection presumes that cultural minorities hold primitive beliefs regarding illness and disease. Further, the recommendations suggest that the authors believe that persons who can be identified with a particular culture will all share the same conceptions of health and treatment.[143]

The University of Texas Medical Branch (UTMB). In the School of Medicine at UTMB in Galveston, Texas, the faculty developed the Integrated Medical Curriculum (IMC).[144] Guided by the goals established by the AAMC, the faculty at UTMB identified a series of goals and objectives that are to be met throughout the curriculum. One of those stated goals is "Knowledge of the important non-biological determinants of poor health and of the economic, social, and cultural factors that contribute to the development and/or continuation of maladies."[145] However, there are no specific courses that treat these issues in the required curriculum.

Wake Forest University School of Medicine (WFUSM). The faculty at WFUSM developed a year-long elective course titled Culture and Diversity.[146] This was a pilot program and the faculty intended to use the experience to develop a four-year curriculum in multicultural medicine. The directors incorporated a variety of pedagogical methods into

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[142] American Medical Student Association, Cultural Competency Curricular Guidelines for Medical and/or Dental Schools (1994), 2.

[143] Ibid., 4.

[144] University of Texas Medical Branch, *The Integrated Medical Curriculum*, http://www.utmb.edu/cms_world/groups/external/@external/@026imo/documents/web_content/imo_095126.pdf (accessed on February 18, 2008).

[145] Ibid.

[146] Sonia J. Crandall et al., "Applying Theory to the Design of Cultural Competency Training for Medical Students: A Case Study," *Academic Medicine* 78, no. 6 (June 2003): 590.

the course: "Interactive lectures, videos, simulation, demonstration, role-plays, workshops, patient interviews (including interviews using interpreters), community-based service-learning, and online problem-based learning cases."[147]

Despite claiming to have been guided by a "broad definition of culture" that includes race, class, physical ability, and sexual orientation, one of the goals of the program at WFUSM was to introduce students to particular cultural beliefs regarding health and the influence these beliefs can have on clinical encounters.[148] For example, at the end of one session students were expected to be able to "discuss two important values held by American Indian populations."[149] Such a practice is an example of the presumption that cultural values are held in common by all persons who can be identified with a broad cultural designation. Further, although students were expected to know how to elicit information directly from the patient, students were also expected to be able to "describe medical beliefs, values, and behaviors, of population groups."[150] Expecting students to define the beliefs and practices of an entire population group might give those students the impression that eliciting information directly from patients is optional or unnecessary.

University of Colorado School of Medicine (UCSM). The faculty at UCSM developed the Hispanic Health Curriculum (HHC).[151] In addition to requiring students to participate in a cultural immersion experience, the HHC included "cultural competency exercises, videos of

[147] Ibid.

[148] Ibid., 591.

[149] Ibid.

[150] Ibid., 592.

[151] Ann O'Brien-Gonzalez, Maribel Cifuentes, and Julie Paranka, "Integrating the Care of Hispanic Patients into a Third-Year Clerkship," *Academic Medicine* 75, no. 5 (May 2000): 514-515.

positive and negative cross-cultural communication, and opportunities to practice culturally sensitive interview techniques and cultural genograms."[152]

The authors state that one goal of the curriculum was to introduce students to "Hispanic patients' common health problems."[153] Their commentary suggests a belief that persons who may be identified as Hispanic are genetically and physiologically homogenous and share the same susceptibilities to particular illnesses and diseases. Persons who live under similar environmental conditions may repeat recognizable health patterns, but it is not appropriate or helpful to conclude that all persons who may be identified as Hispanic will be exposed to the same environmental factors.

Maimonides Medical Center, Brooklyn, New York (MMC). In 1999, MMC faculty developed and administered an objective structured clinical examination (OSCE) designed to "instill cultural competency skills."[154] The OSCE included six stations that required residents to explore the diverse perspectives held by patients from various cultural and religious groups. Although the goals of the programs are described in terms of skill development, there is a clear expectation of knowledge acquisition as residents are introduced to common ethical *dilemmas* that occur when working with patients from other cultures (e.g., Jehovah's Witnesses and blood products, Muslim women and pelvic exams, or alternative healing practices that leave bruises on children).

In this report, there is no mention of challenging students to reflect on negative biases or prejudices towards particular social groups. There is an emphasis on the

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[152] Ibid., 514.

[153] Ibid.

[154] Lisa Altshuler and Elizabeth Kachur, "A Culture OSCE: Teaching Residents to Bridge Different Worlds," *Academic Medicine* 76, no. 5 (May 2001): 514.

acquisition of descriptive cultural data, particularly through the feedback from faculty. The assimilation of cultural knowledge is linked to the residents' ability to both recognize and respond when cultural practices complicate future clinical encounters.

Georgetown University School of Medicine (GUSM). At GUSM, cultural competency is incorporated into a required course dedicated to religious traditions in contemporary health-care settings.[155] The course description acknowledges the need for future practitioners to develop empathy and an awareness of attending to a patient's life circumstances that extend beyond the health-care setting. However, in the actual implementation of the course the majority of the time is spent in lecture settings where instructors (physicians and clergy) provide students with information regarding spiritual and cultural practices from around the world and how those practices may affect the delivery of health-care services.

Center for Immigrant Health at the New York University School of Medicine (CIH). The CIH offers a training program that consists of three to twelve contact hours. The program is organized into multiple sessions that last ninety minutes each. The goals of the program are: "1) enhancement of the cultural knowledge base and sensitivity of the staff, and 2) teaching of effective cross-cultural interviewing skills."[156] The program is described as a participatory experience that includes "didactics, role-plays and small group exercises."[157]

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[155] Georgetown University, *Religious Traditions in Health Care [A Course Syllabus]*, som.georgetown.edu/registrar/courses/1-rthc.doc (accessed on September 1, 2007).

[156] Center for Immigrant Health at the New York University School of Medicine, *Cultural Competence*, http://www.med.nyu.edu/cih/cultural/initiatives.html (accessed on August 13, 2006).

[157] Ibid.

Once again, there is an emphasis placed on the acquisition of cultural data. Such a practice, as I have argued, presupposes that cultural systems are fixed and definable. Further, the expectation that "three to twelve contact hours" would be sufficient for developing new communication skills or addressing health disparities is problematic.

Harvard Medical School (HMS). In addition to actual courses and programs in particular medical institutions, various agencies have developed resources that can be implemented in a variety of settings. The Culturally Competent Care Education Committee (CCCEC) at HMS developed the "Cross-cultural Education Primer."[158] In this document, the CCCEC articulates both goals and steps for preparing medical students to care for patients in cross-cultural situations. The goals include understanding the influence of cultural factors on health outcomes and learning the skills necessary for treating patients from diverse sociocultural backgrounds. The steps to culturally competent care include identifying the relevant cultural issues (e.g., communication styles, family dynamics, expectations, traditions, etc.), exploring the patient's understanding of her illness, making oneself aware of the patient's social context, and negotiating with the patient in order to reach the best possible outcome. Finally, recommendations are provided for when one must work with a language interpreter. Unlike other reflections on cultural competency in health care, the authors of the "Primer" affirm that the steps that are integral to clinical care that is culturally competent ought to be applied to all patients—but become especially important when patient and physician come from different social or cultural backgrounds.

[158] Culturally Competent Care Online Resource Center, *Cross-Cultural Education Primer*, http://medweb.med.harvard.edu/cccec/teaching/primer/_pdfs/CCCPrimer.pdf (accessed on March 1, 2008).

The content of this document reflects a shift from imparting cultural data to encouraging effective communication skills. The patient is identified as the appropriate source for information regarding her particular values and perspectives. However, as I have argued before, this approach may benefit only those cultural strangers who are able to overcome social and political obstacles and access medical services.

***Healing by Heart*.** In a book edited by Kathleen A. Culhane-Pera et al., case stories provide insight into the experiences of Hmong patients in American clinical settings.[159] Like the CCCEC developed by the faculty at the Harvard Medical School, this text is a resource for those who are interested in implementing training programs to foster the skills necessary for providing health-care services for patients who belong to cultural or racial minorities. This text is included here because it provides an example of an enlightened approach to addressing cultural issues in medical education: the inclusion of particular Hmong voices. The editors admit, "The cases are written from the biomedical perspective."[160] But it is the commentaries on the cases that the editors hold to be most important: "Most of the authors are Hmong. For the actual cases, the patient, a family member, or a traditional healer in the case wrote (or was interviewed by someone who wrote) a commentary from his or her intimate perspective."[161]

Although this text represents a positive development in cultural education for clinicians, the editors still found it necessary to provide a descriptive chapter on Hmong cultural practices and traditions. The editors are careful to note, "[W]hile general

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[159] Kathleen A. Culhane-Pera et al., eds., *Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers* (Nashville, TN: Vanderbilt University Press, 2003).

[160] Ibid., 4.

[161] Ibid., 5.

statements about culture are useful, they can become dangerous stereotypes if applied unconditionally."[162] Fortunately, what is perhaps more useful than the editors' caution against the dangers of stereotyping is the variety of cultural and social practices and attitudes that is depicted in the Hmong persons represented in the text (a variety which is not reflected in the definitive description of Hmong culture). For example, according to the editors, "Hmong men have more power and status than women."[163] But in one case story readers are introduced to Mai Neng Moua, a twenty-one-year-old Hmong college student. Readers learn that "Mai Neng's mother had always taught her to be independent and strong."[164]

I maintain my objection to the inclusion of cultural descriptions (regardless of the cautions that may be provided), and I question their validity and their usefulness. I also question the ethicality of attempts to define and describe other groups. I respect the care that was taken by the editors of this text to incorporate the voices of the cultural subjects (subjects who are often spoken *of* but not *with*), but I am concerned by the structure of the text. As much as Hmong voices are included, there still appears to be a privileging of the American voice and the biomedical perspective. Finally, the premise of this book is still that it is primarily cultural differences rather than oppressive social structures that contribute to health disparities.

This is not to say that this text does not provide a valuable contribution to the study of culture and medicine. With the guidance of a skilled and reflective facilitator, groups

[162] Ibid., 11.

[163] Ibid., 15.

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could be invited to consider the harms that arise when conflicting perspectives meet in the clinic. Despite the cultural description provided in the opening chapter, this text provides insight into the diversity of perspectives and values that may be held by persons who could be identified with the same cultural group. Finally, despite my concerns that it could have been implemented more effectively, the inclusion of Hmong voices provides a strong challenge and a positive model for attending to the voice of the patient.

Content Analysis. The training programs and resources for cultural competency that are presented above reflect a broad range in attitudes and content. A comparative analysis of training programs for cultural competency is complicated by the fact that each program functions in isolation without the influence or direction of a larger governing agency. Further, as various programs have invested in the development of their own curricula, copyrights and licensing fees limit one's access to the content.

Some of the programs are conducted in a classroom setting while others focus more heavily on activity-based learning activities. This sample was not intended to represent all training programs in cultural competency. These programs are, however, indicative of the general content and the range of designs that exist. In general, the topics that are addressed in the curricula of these various programs include:

- Specific cultural characteristics, beliefs, and practices of various groups
- The influence of cultural beliefs on health and health care
- The diversity of cultural expression
- The diversity of religious or spiritual expression
- The expectations of culturally competent practice
- The importance of empathy
- Effective communication strategies
- The importance of understanding the patient's perspective
- The proper procedure when working with a medical interpreter

Some of these programs provide the opportunity to integrate newly acquired knowledge with the development of clinical skills. Presumably, the range of pedagogical approaches allows for learning to occur at multiple levels and accommodate for the various learning styles of students. There remains, however, the assertion that it is cultural differences rather than oppressive social structures that lead to racial disparities in health care. This assertion is present in other aspects of cultural training and assessment for clinicians.

Learning Tools

Medical students are introduced to a number of mnemonic devices that serve as guides for physical exams and reviews of systems; these tools have been designed to help the practitioner remain mindful of key aspects of her training. For example, when exploring a patient's medical history, a medical student may learn to use a mnemonic device such as HISTORY which serves to remind the student to ask questions about hospitalizations, immunizations, sugar (diabetes), tumors/cancer, operations, a review of symptoms, and youth illnesses. Such tools serve to protect the patients by encouraging a thorough evaluation and fostering a standard practice when assessing patients.

In the pursuit of cultural competency, medical students and practitioners have been introduced to several mnemonic devices that are intended to guide them in eliciting information from cultural strangers. An analysis of these tools can be instructive if one considers the focus of these tools. What follows is a review of some of these mnemonic tools.

BATHE. This model was developed by Marian R. Stuart and Joseph A. Lieberman.[165] It emphasizes a mix of both key areas in the patient assessment and the attitude to be maintained by the medical professional. In gathering patient information, students are instructed to attend to four areas that have been identified as critical. The designers of this model hold that discussions in these areas are most prone to cross-cultural miscommunication. According to the model, when dealing with a patient from a cultural minority group, special attention should be given to these four areas: background, affect, trouble, and handling. Stuart and Lieberman claim that questions regarding the patient's *background* provide an opportunity for the practitioner to understand the context for the patient's visit. Asking the patient to describe their mood or *affect* provides affirmation for those feelings. When asked to discuss what is *troubling* them, it is expected that the patient will provide information regarding their symbolic understanding of their illness. And asking how a patient has been *handling* their situation provides the practitioner with information regarding the patient's level of functioning. The final *e* in the mnemonic device refers to an attitude of *empathy* which must be maintained by the practitioner and communicated to the patient. By showing empathy, it is hoped that the patient's feelings are validated and that the patient will experience support and encouragement from the provider.

CONFHER. In an article titled "Ethnicity and Nursing Practice," Carolyn Mae Fong, a nursing educator, introduces the CONFHER model.[166] Fong identifies communication style, orientation, nutrition, family relationships, health beliefs, education, and religion as the essential sites of cultural expression (and cross-cultural misunderstanding). *Communication*

[165] Marian R. Stuart and Joseph A. Lieberman, *The Fifteen Minute Hour: Applied Psychotherapy for the Primary Care Physician* (New York, NY: Praeger, 1986).

[166] Fong, "Ethnicity and Clinical Nursing," 1-10.

style refers to the languages used, nonverbal communication, and the influence of social customs. Attending to the patient's *orientation* includes determining the degree to which patient is rooted in her cultural identity and the level of acculturation experienced by the patient. A *nutritional* assessment of the patient will identify the patient's symbolic understanding of food as well as culturally defined dietary taboos. An effective assessment of the patient requires that the patient be understood in the context of her *family relationships*. Fong asserts that the practitioner will be well served by understanding the patient's family dynamics and decision-making practices. Eliciting information on *health beliefs* is necessary for determining if the patient is engaging in any alternative healing therapies that might be contraindicated or dangerous. Before instructing the patient in how to attend to her medical condition, the practitioner will need to understand the patient's learning style and *educational* background. These may be connected to the patient's economic and employment status. Finally, Fong asserts that the *religious* practices of the patients must be considered as distinct religious traditions will influence their adherents in the development of their preferences and the articulation of taboo.

ETHNIC(S). Originally designed by Steven J. Levin, Robert C. Like, and Jan E. Gottlieb (as ETHNIC), this mnemonic device was later expanded by Fred A. Kobylarz and John M. Heath who joined Like in further developing this tool for "ethnogeriatric education."[167] This model, like BATHE, addresses both essential areas that require special attention and steps to be taken by the practitioner. In assessing the patient, the physician should ask open-ended questions that elicit the patient's *explanation* of his or her medical condition. Physicians

[167] Fred A. Kobylarz, John M. Heath, and Robert C. Like, "The ETHNIC(S) Mnemonic: A Clinical Tool for Ethnogeriatric Education," *Journal of the American Geriatric Society* 50, no. 9 (September 2002): 1582-1589.

must also explore other *treatments* or home remedies that the patient may have tried before seeking medical attention. Directly connected to the use of alternative remedies, the developers of this model suggest that cultural minorities are more likely to enlist the services of alternative *healers*. It is important to know what these other individuals are doing (or have done) so as to limit potentially dangerous interactions and to find (if possible) ways to complement that work. At times, the developers caution, physicians may find that they are in conflict with the expressed desires of a patient who is a cultural stranger. In these situations, the physician will need to develop the skills and attitude necessary to *negotiate* with the patient to discover mutually acceptable solutions. Through negotiation, the physician and the patient can discuss and develop effective *interventions* in order to address the patient's illness or injury. In following this model, the physician is reminded of the importance of *collaboration* when working with patients who are cultural strangers. Finally, this model draws attention to the significance of the patient's *spiritual* practices. (This is the element that was added by the second team of developers.) The developers of this tool suggest that spiritual practices can influence how patients cope "with chronic illness, advance directives, and end-of-life care."[168]

LEARN. Elois Ann Berlin, a medical anthropologist, and William C. Fowkes, a physician, developed the LEARN tool.[169] In this model, medical students and physicians are challenged to

- *Listen* with sympathy and understanding to the patient's perception of the problem

[168] Ibid., 1585.

[169] Elois Ann Berlin and William C. Fowkes, Jr., "A Teaching Framework for Cross-Cultural Health Care," *Western Journal of Medicine* 139, no. 6 (December 1983): 934-938.

- *Explain* your perceptions of the problem
- *Acknowledge* and discuss the differences and similarities
- *Recommend* treatment
- *Negotiate* agreement[170]

In their presentation of this tool, Berlin and Fowkes acknowledge that expecting physicians to develop competency in the various aspects of another culture (or multiple cultures) is unrealistic. Their tool, they believe, will provide the means to communicate effectively with any patient regardless of cultural tradition or social class.[171]

When presented with any one of these tools in isolation from the others, one may initially accept that following such a pattern may indeed facilitate a conversation with a cultural stranger and serve to remind the practitioner of her duties that extend beyond diagnosis and treatment of symptoms and disease. However, when considered as a collection, one may recognize certain assumptions embedded within the tools. Several of these mnemonic devices indicate that one should expect a high degree of symbolic thinking from patients who are cultural minorities. There is a sense that all (and only) cultural minorities consult alternative healing practitioners and prefer alternative remedies.[172] In their reflections on these aspects of cultural differences, the designers of these tools imply that these alternatives are primitive and potentially dangerous.

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[170] Ibid., 934.

[171] Ibid., 938.

[172] By implication, it may be assumed that all white patients will prefer the services of physicians who practice Western, allopathic medicine. The steady increase of complementary healing traditions suggest otherwise. Such an assumption may result in physicians not asking white patients about alternative therapies and treatments. Given that a recent survey reported that two-thirds of all American adults use some sort of complementary or alternative therapy, physicians would be remiss to assume that white patients subscribe exclusively to allopathic treatment modalities. Patricia M. Barnes et al., "Complementary and Alternative Medicine Use among Adults: United States, 2002," *Seminars in Integrative Medicine* 2, no. 2 (June 2004): 59.

However, what is most striking is the general attitude that these mnemonic tools are designed to foster. It could be argued that the developers of these tools are calling for physicians to respect and care for their patients. As was stated by the developers of the Harvard Medical School "Primer," such practices (collaboration, negotiation, empathy, etc.) should be applied to *all* patients regardless of cultural practice, racial expression, or national origin. In effect, these tools are designed to promote a standard of care—a standard that clearly falls within the commonly accepted definitions of medical professionalism. However, by emphasizing that such a standard of care must be extended to cultural minorities, is there some subtle affirmation or tacit acknowledgement that certain social groups have been excluded from what is increasingly understood as professional medical care? If broader social structures are preventing cultural and racial minorities from obtaining quality medical services, will mnemonic devices be enough to reflect on and correct these larger problems?

Assessing the Skill Development of the Practitioner

Unlike other aspects of medical education, there has been very little effort made to evaluate the effectiveness of training programs for cultural competency.[173] The formal assessment tools that have been devised to measure the development of cross-cultural clinical skills are applied inconsistently. Further, a review of the literature exposes the reality that there is no consensus regarding "the essential content or definition of cultural competence, or about the best way to implement it."[174] Subsequently, the tools that have

[173] Macdonald, Carnevale, and Razack, "Understanding What Residents Want and What Residents Need," 445.

[174] Vega, "Higher Stakes ahead for Cultural Competence," 447.

been developed vary widely and provide data that cannot be compared from tool to tool. The three assessments that are evaluated here were chosen because they represent a range of approaches to the subject matter—as can be noted by the questions that are asked.

Cultural Competence Self-Assessment Questionnaire (CCSAQ). The CCSAQ was developed by the Portland Research and Training Center in response to "the growing body of literature promoting culturally competent systems of care."[175] The developers of this assessment tool claim that knowledge of other cultures is central to providing competent clinical care for cultural minorities. Linking cultural competency to health disparities, the developers state, "When culture is ignored, barriers to effective services may emerge."[176] The developers suggest that this assessment tool may help practitioners avoid common mistakes in clinical care with cultural strangers (e.g., culturally biased assessment procedures) by highlighting unwanted behaviors and identifying areas in need of professional development.[177] My analysis of this tool leads me to believe otherwise.

The CCSAQ assesses cultural competency in seven areas of clinical practice. In order to assess for *knowledge of communities*, the individual must respond to questions like "Do you know the greeting protocol within communities of color?" and "Are you able to describe the common needs of people *of all colors* in your community?"[178] The tool also assesses the individual's comfort with cultural strangers and her degree of *personal involvement* with cultural strangers. These questions include "Do you interact socially with people of color

[175] James L. Mason, *Cultural Competence Self-Assessment Questionnaire: A Manual for Users* (Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health, 1995), 1.

[176] Ibid., 3.

[177] Ibid., 9.

[178] Ibid., 21.

within your service area?" and "Do you attend cultural or racial group holidays or functions within communities of color?"[179] A practitioner's knowledge of local *resources and linkages* is measured with questions such as "Has your agency conducted or participated in a needs assessment utilizing providers in communities of color as respondents?"[180] *Staffing* practices are also assessed: "Are there people of color on the staff of your agency?"[181] Questions that evaluate *service delivery* include: "Do you use cultural references or historical accomplishments as a source of empowerment for people of color?" and "Do you dismiss patients who come late for appointments?"[182] An institution's *organizational policies* are assessed with questions such as "As a matter of policy, does your agency provide or facilitate transportation?" or " ... advocate for a better quality of life for persons of color in addition to providing services?"[183] Finally, the institution's commitment to *reaching out to communities* is measured by questions such as "Are people of color depicted on agency brochures or other print media?"

The questions that are designed to elicit the degree of cultural competency in an individual or agency betray a problematic understanding of culture. Several of the conceptual flaws presented in the previous chapter are evident in this tool. First and foremost, the questions consistently identify *persons of color* as the beneficiaries of clinical care that is culturally competent. By extrapolation, cultural competency is to be understood as a skill that must be developed by *white* health-care professionals on behalf of *persons of*

[179] Ibid.

[180] Ibid., 23.

[181] Ibid., 24.

[182] Ibid., 26.

[183] Ibid., 27.

color who alone have culture. This focus on *persons of color* also implies that cultural differences are congruent with differences in pigmentation. The phrasing of some of the questions suggests that the developers believe that discrete cultural groups exhibit uniform cultural expression. Further, the questions betray a negative view of cultural minorities: they possess primitive beliefs about health and healing, they live in poverty, they arrive late for appointments, and they have a poor quality of life. There is a conflation of cultural competency and racial diversity in the questions asking about the number *persons of color* that are employed by the institution (the presence of racial diversity in a workforce does not necessarily indicate positive intercultural or interracial relations). As a whole, this assessment is highly problematic and would provide very little guidance for an institution or an individual seeking to develop professional skills. Although not to the same degree, the tone of this assessment tool is reflected in many other tools.

Clinical Cultural Competency Questionnaire (CCCQ). The CCCQ was developed by Robert C. Like.[184] This assessment addresses six dimensions of cultural competency: *knowledge*, *skills*, *encounters*/*situations*, *attitudes*, *education and training*, and *impact*. The tool is described as a *needs assessment* and is designed to highlight areas where further training and development are necessary.

The first section measures the individual's knowledge from a variety of perspectives. Respondents are asked to indicate the degree to which they are knowledgeable of

[184] Robert C. Like, *Clinical Cultural Competency Questionnaire: Post-Training Version* (Newark, NJ: University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, 2001). This survey was developed by Robert C. Like, MD, MS, Professor and Director of the Center for Healthy Families and Cultural Diversity, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School. The CCCQ was used in a project titled, "Assessing the Impact of Cultural Competency Training Using Participatory Quality Improvement Methods," funded by the Aetna Foundation (http://www2.umdnj.edu/fmedweb/chfcd/aetna_foundation.htm). Quotations from this assessment tool appear here with permission.

"sociocultural characteristics of diverse racial groups," "sociocultural issues in geriatrics," and "ethnopharmacology (i.e., variations in medication responses in diverse ethnic populations)." In the section dedicated to skills, the individual is assessed for her competency in "greeting patients in a culturally sensitive manner," "prescribing/negotiating a culturally sensitive treatment plan," and "dealing with cross-cultural ethical conflicts." The third section is devoted to encounters/situations. Here the practitioner is asked to indicate her comfort level with "caring for patients from culturally diverse backgrounds," "interpreting different cultural expressions of pain, distress, and suffering," and "breaking 'bad news' to a patient's family first rather than to the patient if this is more culturally appropriate." In the section that addresses attitudes, respondents are asked about their perceptions of the connections between various factors (e.g., genetics, poverty, racism, etc.) and health disparities. Respondents are also asked to indicate the degree to which they are conscious of the racial and cultural stereotypes they may hold. The fifth section is an opportunity for respondents to report previous training in this area. And, finally, the sixth section measures the impact that previous training opportunities have had on the individual. This impact is assessed by asking the respondents whether or not they have taken advantage of resources to which they would have been exposed at previous training sessions.

Although the questions in this tool reflect some of the same conceptual errors that appear in the CCSAQ, the CCCQ is an improvement over the CCSAQ. Some of the strengths of this assessment include its attention to personal biases and prejudices and the need for the practitioner to reflect on her own culturally shaped values. One area in which this tool exceeds any of the tools or programs assessed above is the manner in which it challenges

participants to reflect upon discriminatory social factors that might contribute to health disparities. However, there are a number of questions that reflect a negative view of cultural minorities and a limited understanding of culture itself:

- *race* and *culture* appear to be interchangeable
- members of the same cultural groups will share the same personal characteristics
- members of minority cultural groups rely on primitive healing practices
- members of distinct cultural groups will react differently to certain medications
- deferring to cultural norms is emphasized over eliciting the personal preferences of the patient

Further, respondents are asked repeatedly to indicate the degree to which they can perform clinical tasks with *cultural sensitivity*. This concept is not defined in this particular document and is a nebulous concept at best. A more tangible indicator should be identified for the purposes of an assessment.

Cross-Cultural Adaptability Inventory (CCAI). The CCAI was developed by Colleen Kelley, a communications scholar and human relations consultant, and Judith Meyers, a licensed clinical psychologist.[185] According the authors, it "is a training instrument designed to provide information to an individual about his or her potential for cross-cultural effectiveness."[186] The tool is designed to be used in a number of ways. It can be implemented by an individual or it can be incorporated into a training event. The stated focus of the assessment is the individual's skill level in adapting to intercultural situations. It is not an assessment of accumulated cultural knowledge:

[185] Colleen Kelley and Judith Meyers, *CCAI: Cross-Cultural Adaptability Inventory* (Minneapolis, MN: National Computer Systems, 1995).

[186] Ibid., 1.

> The CCAI is not targeted to one particular culture; it is designed to be culture-general. The culture-general approach assumes that individuals adapting to other cultures share common feelings, perceptions, and experiences ... The culture-general approach addresses the universal aspects of culture shock and cultural adjustment.[187]

The tool is designed to illuminate areas in need of growth and development. The assessment is accomplished by means of a tool that is composed of fifty statements to which the individual must respond negatively or affirmatively. Responses to the question are plotted on a special template that highlights one's level of adaptability in the four dimensions that the authors have identified as critical to cross-cultural adaptability: emotional resilience, flexibility/ openness, perceptual acuity, and personal autonomy.[188]

The authors define emotional resilience as the capacity to maintain a positive outlook in the midst of ambiguity or hardship.[189] Some of the statements that evaluate emotional resilience include: "I can laugh at myself when I make a cultural faux pas" and "I can function in situations where things are not clear."[190] Flexibility/openness refers to the individual's ability to interact with persons who possess opposing ideas and values. The authors describe a person who is flexible/open as nonjudgmental and tolerant. As differences are the central focus of training programs in cultural competency, this could be an important indicator for one's capacity to engage patients of other cultures. This dimension is assessed using statements such as "I am not good at understanding people when they are different from me" and "When I meet people who are different from me, I

[187] Ibid.

[188] Ibid.

[189] Ibid., 13.

[190] Ibid., 14.

expect to like them."[191] Perceptual acuity refers to the degree to which the individual is attentive to verbal and nonverbal communication.[192] This aspect of cross-cultural adaptability is addressed by statements such as "I believe that all cultures have something worthwhile to offer" and "When I am with people who are different from me, I interpret their behavior in the context of their culture." [193] Finally, the personal autonomy scale measures the individual's dependence (or independence) on the affirmation of others. [194] This dimension is explored with statements like "I believe that all people, of whatever race, are equally valuable" and "My personal value system is based on my own beliefs, not on conformity to other people's standards."[195]

Ultimately, the authors believe that "a person who is universally adaptable is one who can adjust to any culture's idiosyncrasies."[196] The general focus of this assessment is on attitudes *about* interpersonal difference and not necessarily on knowledge regarding specific cultural differences. As such, this tool is more likely to get at the deeper issues of bias against intercultural differences than an assessment tool that measures the accumulation of cultural data. The role of bias and prejudice in health disparities is not adequately addressed by many training programs in cultural competency. This tool, however, is not without its shortcomings. One must question the validity of any practitioner's claims that she can "interpret [patients'] behavior in the context of their

[191] Ibid., 15.

[192] Ibid.

[193] Ibid., 16.

[194] Ibid., 17.

[195] Ibid.

[196] Ibid., 1.

culture." This particular value, as shaped by this tool, rests on the presumption that is possible to escape from one's perspective and accurately view the world from another subject's position. One's perspectives may change over time (especially through meaningful dialogue with others), but one can never take the perspective of another. One must also question that assertion that all persons who find themselves in culturally foreign situations will act in similar ways. Are there, in fact, "universal aspects of culture shock" that are experienced by all medical practitioners? The CCAI can be an effective tool for assessing a practitioner's ability to communicate effectively across and through cultural differences. It will not, however, foster any reflection on the broader political and social factors that contribute to health disparities.

Evaluating the Effectiveness of Training Programs

Nearly a decade ago, J. Emilio Carrillo, Alexander R. Green, and Joseph R. Betancourt, physicians heavily invested in addressing health disparities, criticized medical education for its failure to prepare medical students adequately for the challenging work of "providing quality care to socially and culturally diverse populations."[197] In light of this harsh criticism from Carrillo and his colleagues, and they are not alone in their assessment, it is difficult to explain why so little has been done to monitor the success (or failure) of training programs in cultural competency. Despite the abundance of tools that have been developed to measure the development of cultural competency in individual practitioners,

[197] J. Emilio Carrillo, Alexander R. Green, and Joseph R. Betancourt, "Cross-Cultural Primary Care: A Patient-Based Approach," *Annals of Internal Medicine* 130, no. 10 (May 18, 1999): 833.

there have been very few studies undertaken to evaluate the effectiveness of training programs and curricular innovations.[198]

In the absence of an authoritative body to govern the development of training programs for cultural competency, individual institutions have been free to design interventions as they choose. The lack of accountability has led to a wide range in both content and design. The resulting variety has confounded efforts to evaluate the many training programs that have been developed. This confusion is only compounded by evaluative efforts that lack any methodological rigor. Despite these deficiencies, the few studies that have been conducted to evaluate the effectiveness of training programs in cultural competency can provide important insights into the shortcomings of current practices. These evaluations, when taken together, serve to illuminate critical flaws in the design and methods of current efforts.

Absence of the Voice of the Patient. According to Scott Miyake Geron, an applied policy researcher, measures taken to assess cultural competency suffer from being "based on researcher-defined dimensions of cultural competency and do not include the client or care recipient's evaluation of the cultural competency of the care received."[199] In the absence of the patient's perspective, the cultural competence of the practitioner is evaluated in terms of self-reports made by the practitioners. Geron challenges the accuracy and validity of self-administered evaluations and suggests that other models of evaluation should be considered.[200] He refers his readers to an earlier work in which he and his

[198] Vega, "Higher Stakes ahead for Cultural Competence," 447; and Beach et al., "Cultural Competence," 357.

[199] Geron, "Cultural Competence: How Is It Measured? Does It Make a Difference?" 41.

[200] Ibid.

colleagues reflect on the value of incorporating the experiences of health-care consumers into the evaluation of medical services.[201] Advocating for a "direct approach," Geron discusses the positive effects of providing health-care recipients with the opportunity and the means "to address specific aspects of the care they receive."[202] Guided by rigorous research methods and criteria, this earlier project was one of the first to "systematically measure client satisfaction."[203] In his later work, Geron speculates on the possibility of developing similar assessment tools for patients whose health-care providers have completed training in cultural competency and emphasizes the need for doing so when he states, "It is inappropriate to base a judgment about a person's or provider's cultural competency without including input from the client or care recipient."[204] Although he does not articulate his position in these terms, it could be argued that Geron is advocating for a privileging of the voice of the patient in the process of evaluating and assessing medical services.

Emphasis on Observable Criteria. Certain training programs depend exclusively on observable criteria for evaluation of their effectiveness. These criteria include, but are not limited to, "the extent of board and staff diversity or written statements of support for diversity and cultural competency."[205] For example, health-care institutions, in an attempt to communicate a greater capacity to serve certain social groups and their commitment to

[201] Scott Miyake Geron et al., "The Home Care Satisfaction Measure: A Client-Centered Approach to Assessing the Satisfaction of Frail Older Adults with Home Care Services," *Journal of Gereontology: Social Sciences* 55B, no. 5 (September 2000): S259-S270.

[202] Ibid., S268.

[203] Ibid., S269.

[204] Geron, "Cultural Competence: How Is It Measured? Does It Make a Difference?" 41.

[205] Ibid., 42.

cultural competency, will describe their workforce as one that resembles the patient base. At UTMB, *diversity* is listed as a core value of the institution. This value is articulated as follows: "We are committed to employ and educate a health care work force whose diversity mirrors the population they serve."[206] In practical terms, what does this mean? Which aspects of the patient population are reflected by the hospital staff and faculty? Educational level? Income level? Religious affiliation? Insurance coverage? Or is the intent to reflect the physical characteristics? Skin tone, hair color, height, weight, or age? From an administrative perspective, how is this enacted? Does the institution hire and terminate faculty and staff based on the changing demographics of the patient population? And, ultimately, to what end? Is it assumed that cross-cultural miscommunication will be reduced if the hospital staff and faculty physically resemble the patients? Shared physical characteristics are not an indication of shared cultural practices or of effective communication.[207]

Lack of Integration. William A. Vega, a public health scholar, reports, "Most cultural competence programming has been limited to brief training sessions usually ranging from a few hours to a full day—far too short an exposure to impart clinical skills effectively."[208] Vega stresses that if training in cultural competency is expected to lead to a reduction in health disparities, then a greater commitment of resources and time will be necessary. As

[206] University of Texas Medical Branch, *Our Core Values*, http://www.utmb.edu/mission/# (accessed on April 8, 2008).

[207] UTMB is not alone in this emphasis on reflecting the community served. Laurie M. Anderson, an epidemiologist, and her colleagues implemented a systematic review of five interventions designed to promote cultural competency. In their final report, they state that "a culturally diverse staff that reflects the community served" is essential to fostering a culturally competent health-care center. Anderson et al., "Culturally Competent Healthcare Systems: A Systematic Review," 69.

[208] Vega, "Higher Stakes ahead for Cultural Competence," 447.

it stands, there is a dramatic incongruence between the stated goals and the level to which resources are dedicated for such an intervention. Vega warns that, with increased frequency, institutional commitments to cultural competency are nominal, at best. According to Vega, "[W]ithout mainstreaming cultural competence to gain organizational support, it will remain a primarily symbolic activity, too often peripheral to the real business of clinical care."[209] Given the numbers of medical schools that either do not include cultural issues in their curricula or relegate discussion of these issues to elective classes or special topic presentations, it can be of no surprise that attending to cultural differences is understood as an optional activity for physicians who are busy with the work of *real medicine*.

Limitations of Evaluative Efforts

Many of those who have evaluated training programs in cultural competency have contributed a great deal to the dialog on this issue. However, the evaluations themselves are often lacking as critical factors in training and education for cross-cultural clinical services go unexplored.

Social Influence. There is no evidence to show that efforts have been made to measure the effect of *social influence* on the medical students' learning experiences with regard to providing clinical care for cultural strangers.[210] Michael Wilkes, a physician and medical educator, and Bertram H. Raven, a psychologist, explore the ways in which the

[209] Ibid., 449.

[210] Michael Wilkes and Bertram H. Raven, "Understanding Social Influence in Medical Education," *Academic Medicine* 77, no. 6 (June 2002): 481-488.

actions and behaviors of senior members of the faculty can have negative consequences for medical students. According to Wilkes and Raven:

> Trainees are often at the bottom of a large hierarchy, a position that makes them susceptible to social influences that ideally are intended to shape them into compassionate physicians but that can also impede their professional development.[211]

The manner in which faculty members can influence students varies widely. Wilkes and Raven consider a range of methods that includes reward, coercion, and manipulation. Whether or not the faculty member is conscious of the influence her own behaviors have over the student, the student, motivated by a desire for a positive evaluation, may learn to reproduce undesirable practices and attitudes. It is possible, in order to conform to the practice of her superiors, that a student could begin to rely upon cultural and racial stereotypes.

Lack of Methodological Rigor. Eboni G. Price, a physician, and a team of researchers conducted an extensive survey of studies that evaluated the effectiveness of training in cultural competency for health professionals.[212] After analyzing sixty-four reports, the research team concluded that "the quality of evidence from interventions to improve cultural competence of health professionals is generally poor."[213]

The research team reports that few evaluations provide demographic characteristics of the individuals who participated in the training programs. Another flaw in many of the evaluations was a lack of comprehensive descriptions of the training programs themselves.

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[211] Ibid., 481.

[212] Eboni G. Price et al., "A Systematic Review of the Methodological Rigor of Studies Evaluating Cultural Competence Training of Health Professionals," *Academic Medicine* 80, no. 6 (June 2005): 578-586.

[213] Ibid., 583.

Control groups were rarely reported and steps were not taken to blind assessors to the identities of the participants. Finally, many evaluations focused on the self-reported changes in attitude but very few measured observable changes in behavior.

Lack of Assessment with Regard to Stated Goals. There is currently little evidence to suggest that evaluations of training in cultural competency have been designed to measure effectiveness in terms of the stated goals of training programs for cultural competency: the reduction in health disparities in both access to health care services and in health outcomes.

In 2006, Michele M. Carter (a psychologist) and colleagues published a study documenting the effectiveness of one particular training model at the Uniformed Services University (USU).[214] The evaluators found that while participants showed a greater understanding of particular cultural practices and cultural diversity in general, there was nothing to suggest that this program (or others like it) would translate "into better medial [*sic*] care."[215] While the authors do not explore the issue, they do raise the question of whether or not training in cultural competency has had any significant impact on race-based disparities in access to health-care services. This question is of great significance in light of the fact that so many proponents of cultural competency have consistently argued that it would in fact serve to reduce disparities.

These assessments and evaluations have focused primarily on problems in the design, implementation, and the evaluative methods used in training programs for cultural

[214] Carter et al., "Cultural Competency Training for Third-Year Clerkship Students," 1772-1778.

[215] Ibid., 1777.

competency that focus on the acquisition of cultural data about particular social groups. It is important to acknowledge, however, that many advocates for cultural competency have reflected upon the deficiencies of such an approach. Those individuals have begun to advocate for training in cultural competency that brings attention to the ways in which personal biases and prejudices (and the stereotypes one holds to be true) negatively effect communication with cultural strangers. In an attempt to move past descriptive lists and encyclopedic depictions of cultures, these individuals believe that attending to negative attitudes held by physicians will help alleviate racial disparities in health care.

It is not a foreign culture that is problematic in the clinical setting but the attitude that the physician has towards difference—an attitude that is shaped by her own social context. Jessica Gregg, an anthropologist, and Somnath Saha, a physician, state:

> [W]hile cultural differences may exacerbate the problem of differential access and discrimination, "culture" is ultimately not the central problem for the large segments of our population who live in unhealthy conditions, have limited healthcare access, and have little power to change the circumstances of their lives.[216]

Lauren Clark, Jeannie Zuk, and Julaluk Baramee, all nursing educators, argue, "Even if every [health-care professional] in the world was perfectly culturally competent, clients could still receive poor care (or no care) if structural changes reinforcing race and class disparities in health and health care are ignored."[217] Health disparities that coincide with perceived racial differences are a social issue. This is a question of justice, of ethics. If race-based health

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[216] Jessica Gregg and Somnath Saha, "Losing Culture on the Way to Competence: The Use and Misuse of Culture in Medical Education," *Academic Medicine* 81, no. 6 (June 2006): 544.

[217] Lauren Clark, Jeannie Zuk, and Julaluk Baramee, "A Literary Approach to Teaching Cultural Competence," *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society* 11, no. 3 (July 2000): 202.

disparities are to be reduced, deeper social structures must be critically examined. Carlos N. Molina, an artist and HIV/AIDS activist in New York City, states, "[L]os cursos de sensibilización cultural no son la respuesta. Aunque ... pueden ser de utilidad, pueden también ser usados para que agencias, programas, organizaciones e individuos ... esquiven su obligación con [las minorías culturales]."[218] Reflecting on his own experiences of participating in training program to promote *cultural sensitivity*, Molina argues that they provide "un servicio que en las mejores ocasiones es incompleto."[219]

Physicians and medical students should be challenged to reflect upon their own biases and consider the negative effects of believing theirs to be an objective and universal perspective. But most efforts to train for cultural competency draws attention away from the factors that are more likely at the root of the racial disparities in health care. Well-intentioned persons who participate in such training programs may sincerely believe that they have *done their part* to reduce health disparities by having learned about *susto*, coining, *curanderas*, or soul loss. Yet if a solution is to come, one must consider health disparities as they arise from a legacy of unjust race relations, an inequitable distribution of social power, and a distorted understanding of the ethical obligations one has to the one who is other. Cultural competency itself must be recognized as an function of the same oppressive forces that keep certain groups of persons from accessing needed health-care services. Further, the excluded and the silenced must be supported in making their own voices heard—reform efforts explored in the continued absence of the excluded simply

[218] Carlos N. Molina, "¿Sensibilidad Cultural o Inclusión?" *SIDAahora* August/September 1995, 33. Translation: Programming in cultural sensitivity is not the answer. Although ... it may serve some purpose, it may also be used by agencies, programs, organizations, and individuals ... to escape their obligations towards [cultural minorities].

[219] Ibid., 32. Translation: ...a service which even under the best conditions is incomplete.

replicate those same patterns of marginalization and dominance. These aspects appear to have eluded most who have sought to reform health disparities.

PART II: SOCIAL CRITICISM

Chapter 4: Race and Racism

Many scholars, while writing from the perspective that training in cultural competency will reduce health-care disparities, acknowledge that the research is limited. Romana Hasnain-Wynia, a health policy scholar, states, "It has been difficult to prove that cultural competence itself is related to high-quality care."[220] Arthur Kleinman, a psychiatrist and medical anthropologist, argues, "For all the talk of training practitioners to be culturally competent ... there is surprisingly little research demonstrating that culturally informed approaches affect outcomes."[221] These and other scholars are questioning the alleged connection between intercultural miscommunication and racially based health disparities. Either the research has simply not been done, or efforts to train physicians in the cultural practices of others simply have had no effect on health disparities. It is likely that both are true. This assessment is based on the unquestioned conflation of race and culture: training programs attend to *cultural traditions* in order to reduce disparities based on *race*. As I have shown, race is not synonymous with culture. Physical characteristics are not an indicator of the cultural resonance or dissonance between two persons. If health disparities predictably fall along lines of race—of physical characteristics—then relations between racial groups must be explored. An understanding of the historical development of racial categories and

[220] Romana Hasnain-Wynia, "Is Evidence-Based Medicine Patient-Centered and Is Patient-Centered Care Evidence-Based?" *Health Services Research* 41, no. 1 (February 2006): 6.

[221] Kleinman, "Culture and Depression," 952.

the legacies of interracial conflict are central to this issue. Interracial injustice must be explored conceptually from the perspective of social power. And, if race-based disparities amount to how a *we* treats a *them* then a critical understanding of otherness is essential. These three concepts—race, social power, and otherness—must be addressed in medical education if unjust allocations of medical services are to be remedied. Medical students and physicians must be challenged to reflect on these concepts and brought to a new consciousness of the social structures that prevent certain groups from accessing health-care services.

Brach and Fraser acknowledge that "the research literature has not been able to firmly rule out the confounders of education, literacy, and class as causes for racial and ethnic disparities."[222] These scholars, however, do not articulate why they suspect that these other factors may have a role to play in the exacerbation of health-care disparities. Tsveti Markova, a physician and medical educator, and Barbara Broome, a nursing educator, affirm that (as a result of the plurality and heterogeneity that exist within any and all cultures) attempts to learn the cultural practices of other groups are futile and that effective clinical care with cultural strangers will be possible only when physicians learn to competently elicit information from the patients themselves.[223] Yet they offer no insight or reflection on social factors that may negatively (and unconsciously) shape relations between physicians and cultural strangers. Although some scholars have recently begun to recognize that training physicians and medical students in the particular cultural practices of other groups is not an effective use of time or resources, most base this assessment on the

[222] Brach and Fraser, "Can Cultural Competency Reduce Racial and Ethnic Health Disparities?" 203.

[223] Tsveti Markova and Barbara Broome, "Effective Communication and Delivery of Culturally Competent Health Care," *Urologic Nursing* 27, no. 3 (June 2007): 239-242.

impracticality of learning another cultural tradition. Few (if any) have suggested that cultural competency (as it is popularly conceived) may never achieve the goals articulated by its proponents. Fewer still have considered the ethical questions of one (dominant) group deciding what is essential to and representative of another (minority) group's cultural practices. Further, there appears to be a shared reluctance to suggest in explicit terms that disparities in access to health-care services may result from racist, classist, and culturally elitist attitudes in individual practitioners and in the general society. According to Philomena Essed, "The dominant group claims that the problem is one of cultural difference, but it is more than this."[224] It is a rejection and a denigration of those identified as *different*.

In the first chapter I discussed the methods of certain training programs that incorporate reflections on how biases and stereotypes held by the practitioner can negatively influence the quality of the care provided to members of certain social groups. This is an important issue that must be considered, but the focus must be expanded beyond the biases held by the individual practitioner. Discrimination based on race is a societal phenomenon and must be considered from that perspective. There is a great deal of research to show that after other relevant factors have been considered, health-care disparities tend to cluster around patients of similar races or social classes. However, before I explore the concept of discrimination based on race (racism), I must first explore the concept of race.

[224] Philomena Essed, *Understanding Everyday Racism: An Interdisciplinary Theory*, vol. 2, Sage Series on Race and Ethnic Relations (Newbury Park, CA: Sage Publications, 1991), 203.

Race

Race is a concept that has come under heavy scrutiny in the last few decades.[225] From a scientific perspective, it is fairly widely accepted that race is not a biological category, but a socially constructed system of categorizing human beings.[226] According to Carl E. James, a professor of education:

> Insofar as race is socially constructed and a set of social relations, then racial identity ... "is not a stable, permanent, united center that gives consistent meaning in our lives. It too is socially and historically constructed, and subject to political tensions and contradictions."[227]

Racial categorization, while socially defined, is made on the basis of "physical criteria."[228] And, as a socially defined system, it is applied inconsistently and its application has varied widely over time. Nancy Krieger, a social epidemiologist, states, "The fact that we know what 'race' we are says more about our society than it does our biology."[229]

In 1999, the American Anthropological Association (AAA) issued a statement that described race in this way:

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[225] As I show in this chapter, *race* is a heavily contested method of categorizing human beings. Often, race is used interchangeably with *ethnicity*. Generally speaking, however, ethnicity is distinguished from race as ethnicity is a designation based on cultural identity and not on physical traits. However, from the perspective of social science, ethnicity, as a category, is even more highly contested than race. For that reason, I will make exclusive use of the term *race* (despite its own limitations). Appearances in this dissertation of the terms *ethnic* or *ethnicity* are the result of direct quotations from other sources.

[226] Joseph L. Graves, Jr., *The Emperor's New Clothes: Biological Theories of Race at the Millennium* (New Brunswick, NJ: Rutgers University Press, 2001); Luigi Luca Cavalli-Sforza, Paolo Menozzi, and Alberto Piazza, *The History and Geography of Human Genes* (Princeton, NJ: Princeton University Press, 1994); American Anthropological Association, "AAA Statement on Race," *American Anthropologist* 100, no. 3 (September 1999): 712-713; and Michael P. Banton, *Racial Theories* (Cambridge, UK: Cambridge University Press, 1998).

[227] Carl E. James, introduction to *Talking about Identity: Encounters in Race, Ethnicity, and Language*, ed. Carl E. James and Adrienne Shadd (Toronto, ON: Between the Lines, 2001), 3.

[228] Pierre L. van den Berghe, *Race and Racism* (New York, NY: John Wiley and Sons, 1967), 9.

[229] Nancy Krieger, "Does Racism Harm Health? Did Child Abuse Exist before 1962? On Explicit Questions, Critical Science, and Current Controversies: An Ecosocial Perspective," *American Journal of Public Health* 93, no. 2 (February 2003): 195.

> Race thus evolved as a world view, a body of prejudgments that distorts our ideas about human differences and group behavior. Racial beliefs constitute myths about the behavior of people homogenized into racial categories. The myths fused behavior and physical features together in the public mind, impeding our comprehension of both biological variations and cultural behavior, implying that both are genetically determined. Racial myths bear no relationship to the reality of human capabilities or behavior. Scientists today find that reliance on such folk beliefs about human differences in research has led to countless errors.[230]

Elsewhere in its statement, the AAA states that racial categories were developed and have been maintained in order to relegate certain groups of people to a low social status while privileging others with power and opportunity. Relevant to this dissertation, the AAA explicitly addresses the conflation of race and culture and insists that cultural practices, personal temperaments, and individual capacities are not genetically determined and are, therefore, independent of racial identification.[231]

Historically, such categorizations have been made based on physical features and characteristics. In its own statement on race, the American Association of Physical Anthropology declared:

> These old racial categories were based on externally visible traits, primarily skin color, features of the face, and the shape and size of the head and body, and the underlying skeleton.[232]

Despite the AAPA's statement that such an approach to race is outdated, the 2006 edition of *Mosby's Guide to Physical Examination* defines race in this same manner—almost verbatim.[233]

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[230] American Anthropological Association, "AAA Statement on Race," 713.

[231] Ibid.

[232] American Association of Physical Anthropology, "AAPA Statement on Biological Aspects of Race," 569.

As a social category, race has repeatedly been used to enforce oppressive relations between social groups. Yet, as a result, such acts of oppression have historically worked to strengthen bonds within those groups and to foster greater identification with the group. Ultimately, despite social conventions, geneticists and anthropologists agree that there is but one human race. There may great variety in physical expression, but human beings belong to one biological category.

The Ambiguity of Race

As socially defined categories, official racial designations in the United States have varied extensively in the last century. A review of the questionnaires used by the United States Bureau of the Census in its decennial survey serves to illuminate the ongoing struggle to define racial categories.[234] How the federal government chose to categorize residents of the United States often reflected the major political issues and social agendas of the time. In 1790, the census bureau divided people into Free White and Slave.[235] As offspring of Free White and Slave persons began to be born, a new category was developed, and the 1860 census questionnaire listed three options for racial identity (referred to as *color*): White, Black, and Mulatto.[236] In 1870, Chinese and Indian were added as racial categories.[237] But,

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[233] Henry M. Seidel et al., *Mosby's Guide to Physical Examination* (St. Louis, MO: Mosby Elsevier, 2006), 40.

[234] In addition to the census, these categories are also used in the promotion and enforcement of civil rights and in data collection and analysis by social scientists.

[235] Jason G. Gauthier, *Measuring America: The Decennial Censuses from 1790 to 2000* (Washington, DC: Bureau of the Census, 2002), 5.

[236] Ibid., 13.

[237] Ibid.

in 1890, the population was divided into eight racial classifications.[238] In addition to White, Chinese, Japanese, and Indian (i.e., Native American), four categories applied to Black or partially Black members of the population. Black, Mulatto, Quadroon, and Octoroon were used to label individuals based on their degree of Black ancestry.[239] This focus corresponded to the prevailing race relations following emancipation—especially in the southern United States. Of major concern to many was the preservation of the White race. This preoccupation with documenting the differences between Black and White persons was most poignantly characterized by instructions that were given to enumerators for the 1890 census: persons with "any trace of black blood" were to be distinguished from the White segment of the population (regardless of their physical traits).[240]

In the twentieth century there were frequent revisions of the official list of racial classifications. In 1900, the census bureau had done away with the various categorizations for Black persons and all persons with "any trace" of Black ancestry were reported as Black.[241] But in 1910, Mulatto was reintroduced as a means to categorize persons of mixed racial ancestry while Black was retained to identify those who were "fullblooded negroes."[242] In 1930, Black became Negro, and the list of racial classifications was expanded and the category Mexican was added.[243] Yet, beginning in 1940, enumerators were

[238] Ibid., 22.

[239] United States Bureau of the Census, *200 Years of U.S. Census Taking: Population and Housing Questions, 1790-1990* (Washington, DC: US Government Printing Office, 1989), 36.

[240] Ibid.

[241] Gauthier, *Measuring America*, 36.

[242] Ibid., 48, 58.

[243] Ibid., 59.

instructed to classify Mexicans as White.[244] Similarly, in 1960, enumerators were instructed to classify Asian Indians as "other" and to write "Hindu" in the space provided on the data card.[245] In 1970, Hawaiian and Filipino were added to the list of categories on the census questionnaire. Additionally, Latin American descent was introduced as a separate question and no longer needed to correspond with one's racial category.[246] By 1980, Korean, Vietnamese, Guamanian, Samoan, Eskimo, and Aleut had also been added. Black was once again used, but Negro remained as an alternative title for this category.[247] No changes were made in the list of racial categories for the 1990 or 2000 census. However, an interesting change was made to the instructions for the 2000 census. For the first time, respondents were permitted to identify as many racial categories as they desired.[248]

Despite the growing consensus that racial categorization is not scientifically sound, the practice continues to shape both research efforts and policy development. As David R. Williams, a sociologist, states, "Definitions of race in the biomedical sciences and public health continue to view race as reflecting underlying genetic homogeneity."[249] This confusion has also been observed in the epidemiological literature of the twentieth century.

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[244] Ibid., 64.

[245] The inclusion of Hindu as a racial classification was likely an effort to avoid confusion as the term Indian was already being applied to the Native American population. However, as Hinduism is a religious tradition (one that could be adhered to by anyone—regardless of physical traits), this is a clear example of the conflation of race and culture.

[246] Gauthier, *Measuring America*, 77. The addition of Latin American descent as a separate category had a significant impact on certain individuals. Some individuals from Mexico who possessed strong indigenous features had once been categorized as Mexican. Later, these same persons were categorized as White. Finally, with the inclusion of this new question, they would be categorized racially as Indian (with the new question indicating their Mexican descent). For individuals who had internalized the racial hierarchy, this was a difficult transition.

[247] Ibid., 84.

[248] Ibid., 100.

[249] David R. Williams, "Race and Health: Basic Questions, Emerging Directions," *Annals of Epidemiology* 7, no. 5 (July 1997): 324.

A study conducted on representative essays published in the *American Journal of Epidemiology* resulted in a list of racial labels that were inconsistently applied.[250] The scholars who executed the study also observed inconsistencies in the very understanding of race and in the means by which race was determined in potential research subjects.

The ambiguity and inconsistency are significant. Persons with origins from distinct Asian countries were categorized separately, in acknowledgment of their unique cultural and linguistic heritages. Yet, despite the equally diverse linguistic and cultural traditions, persons who could trace their origins to various European counties were all categorized into a single, monolithic category: white. A similar pattern has been applied to those identified as black despite the reality that not all persons with black features trace their origins to the same geographical area. This inconsistency, coupled with the constant revisions made to the list of racial categories, illustrates the subjectivity with which racial categories are determined as attempts to define clear racial categories have consistently failed.

Disagreement over the Use of Race as a Social Category

Race, as a biological concept, has been rejected by most scientific authorities. Race, as a social category, has been problematic, inconsistent, and reflective more of the social attitudes of the dominant group than of actual observable physical differences in the subjects of arbitrary racial labels. For these reasons, there has been a movement to abandon racial categories in scientific and public health endeavors. Others, however, insist

[250] Camara Phyllis Jones, Thomas A. LaVeist, and Marsha Lillie-Blanton, "'Race' in Epidemiologic Literature: An Examination of the *American Journal of Epidemiology*, 1921-1990," *American Journal of Epidemiology* 134, no. 10 (November 1991): 1079-1084.

that racial categories and physical differences between groups must continue to be addressed.

From the perspective of health care, some argue that certain inherited physical traits are directly relevant to health and predispose certain groups to certain risks. Krieger addresses how the biology of pigmentation has a direct relationship to certain skin-related disorders when she writes:

> Whether or not racism existed, people with lighter vs darker skin (i.e., less vs more dispersed melanosomes) would be at higher risk of malignant melanoma, given sufficient exposure to sunlight (and especially bad sunburns before puberty).[251]

From a sociological perspective, many scholars argue that abandoning all references to physical traits shared by certain groups would not end discrimination based on those traits. In fact, it would only hamper efforts to address and correct it.

The work of Williams is especially useful on this point. In a recent essay published in *Annals of Epidemiology*, Williams articulates six reasons for not abandoning racial constructs.[252] First, Williams addresses the differences in power and status that are ascribed to various racial groups. Despite society's best efforts, there is a strong correlation between socioeconomic status and certain racial categories. Williams argues that abandoning racial categories would result in the denial of these power differentials and limit one's ability to interrupt these patterns of correlation.

[251] Krieger, "Does Racism Harm Health?" 195.

[252] Williams, "Race and Health," 323-333.

Second, Williams states, "racial categories have historically reflected racism."[253] He contends that racial categorization was often motivated by racist ideologies of superiority and inferiority. Racial categories functioned to impose and maintain that hierarchy. By tracing the pattern of racial oppression in the United States, Williams contends that abandoning racial categories could result in the denial of this history of oppression and its repercussions into the future.

Next, Williams argues that racial categories have been instrumental in organizing American society. According to Williams, "Attitudes and beliefs about racial groups have been translated into policies and societal arrangements that limited opportunities and life chances of stigmatized groups."[254] Understanding the current racial disparities in access to health care, employment, and education requires an acknowledgment of how race has functioned in the past and how it continues to shape policies and influence practices.

Williams's fourth reason revolves around legislation regarding and protections for racial minorities. He claims that federal, state, and local governments have acted to rectify discrimination based on physical characteristics. Minority status, he insists, is a label conferred exclusively on those groups who have historically been the victims of negative prejudice and bias. Williams is concerned that lifting the racial labels that correspond with shared physical characteristics will further hinder vulnerable populations who have benefitted (although perhaps only in limited ways) from legislative protections. According to Williams, such an approach would eliminate those benefits and undermine civil-rights

[253] Ibid., 325.

[254] Ibid.

statutes. These protections include, but are not limited to, voting rights, discrimination in the work place, access to education, access to housing, and small business lending.[255]

The fifth reason appears to stem from a somewhat fatalistic view of human interaction. Williams, turning to psychosocial scholarship, suggests that "in-group favoritism and out-group discrimination" are to be expected in social encounters.[256] He explains, "There appears to be a deep human tendency for individuals to value their own group over others and to demonstrate favoritism towards their group."[257] As he believes this to be an inevitable social practice, Williams states that understanding the effects of racial identity is essential to both identifying and responding to this discriminatory practice.

One flaw in this particular reason is the lack of exploration for how individuals identify their in-group. It appears that Williams believes that the only way human beings can identify their group identity is by comparing skin color and other physical characteristics. While this tendency to prefer one's own in-group may occur, as it is described in the literature there is no reason to believe that individuals could not be socialized to expand their conception of their in-group.

Finally, Williams claims that it is unlikely that racial labels will disappear because they have been instrumental in the formation of personal identity. This process serves as a point of connection with others who have been exposed to "common experiences, including discrimination and segregation in residential and occupational contexts."[258] As the solidarity

[255] Suzann Evinger, "How Shall We Measure Our Nation's Diversity?" *Chance* 8, no. 1 (Winter 1995): 8.

[256] Williams, "Race and Health," 326.

[257] Ibid.

[258] Ibid.

that develops through this process can be beneficial, individuals and groups are likely to continue to claim racial labels despite efforts to abandon such categories.

While I agree with many of Williams's points, I am puzzled by the circularity of his final point. Racial identity, he claims, is forged partially by the shared experiences of discrimination and oppression. Therefore, he holds, racial categories must not be eliminated. However, if social progress were to lead to the reduction (if not elimination) of racially based oppression, would not this phenomenon identification through shared suffering be diminished (or disappear) as well?

Racism

Much of the discussion above has included references to the concept of *racism*. Williams succinctly defines this social phenomenon when he writes, "racism refers to an ideology of superiority that justifies social avoidance and domination of groups defined as either genetically or culturally inferior."[259] Williams and T. D. Rucker expand this definition and acknowledge that racial discrimination influences how a community "differentially allocates societal resources to human population groups."[260] Krieger adds that in oppressive race relations, the dominant group seeks to "adversely restrict, by judgment and action, the lives of those against whom they discriminate."[261] Yet missing from both of these definitions is a direct assessment of the manner in which racism is an exercise of power—specifically the power of one group over another group of persons.

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[259] Ibid., 325.

[260] David R. Williams and T. D. Rucker, "Understanding and Addressing Racial Disparities in Health Care," *Health Care Financing Review* 21, no. 4 (Summer 2000): 76.

[261] Krieger, "Does Racism Harm Health?" 195.

Several decades ago, Michel Foucault, a philosopher and historian, was exploring these same issues from a unique perspective: "What in fact is racism? It is primarily a way of introducing a break into the domain of life that is under power's control: the break between what must live and what must die."[262] The purpose of racism, according to Foucault, is to fragment society and to classify some races as good and others as inferior. He articulates the mindset that drives racism when we states, "If you want to live, the other must die."[263] The attraction of racism, he argues, is that it allows one to defend oneself (and one's group) in the name of biology. Racism avoids the rhetoric of war by hiding behind the rhetoric of nature:

> The more inferior species die out, the more abnormal individuals are eliminated, the fewer degenerates there will be in the species as a whole, and the more I—as species rather than individual—can live, the stronger I will be, the more vigorous I will be. I will be able to proliferate.[264]

From a racist perspective, bad and inferior races must be eliminated from society so that society may flourish. In this view of the world, the very health and wellbeing of the dominant class is secured by eliminating the other. When racism shapes the society, killing the racial and cultural others is understood as eliminating a biological threat.

Many who can be identified with the dominant class may take offense at this line of thinking. Many will seek to exonerate themselves and, possibly, illustrate how they engage in positive and respectful interracial relations. Others will scoff at Foucault's extreme language regarding murder. Racism, however, is not always enacted in such extreme ways.

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[262] Michel Foucault, *Society Must Be Defended*, ed. Mauro Bertani and Alessandro Fontana, trans. David Macey (New York, NY: Picador, 2003), 254.

[263] Ibid., 255.

[264] Ibid.

Foucault states: "When I say 'killing,' I obviously do not mean simply murder as such, but also every form of indirect murder: the fact of exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on."[265]

Racism is at its most effective when it goes unnoticed. And on the occasions that it is challenged, racial discrimination must be defended by being shown to be a reflection of the *natural order*. The philosopher Lawrence Cahoone states:

> The process [of racism] must itself be covered up so that the hierarchy can be *assumed inherent* in the nature of the phenomena, rather than a motivated construction. Thus, the privileged term's actual dependence on the demoted other, and on the process of semiotic construction, must be, as already noted, *repressed*.[266]

The privileged group (race) must repeatedly construct and present itself in ways that distinguish it from its definition of the nonprivileged group. And the definition of the nonprivileged group must reinforce the concept of those groups as "*intrinsically* lacking the properties of the privileged group."[267]

The Experience of Racism

The AAPA, in addressing the struggles faced by those who attempt to foster fruitful relations between persons of differing racial origins, has stated, "Obstacles to such

[265] Ibid., 256.

[266] Lawrence E. Cahoone, introduction to *From Modernism to Postmodernism: An Anthology*, ed. Lawrence E. Cahoone (Cambridge, MA: Blackwell, 2003), 11.

[267] Ibid.

interaction have been social and cultural, not biological."[268] Pointing to the civil rights movement of the 1950s and 1960s, some may choose to believe that such attitudes have been lost to the distant past. Unfortunately, this is simply not so. In 1994, a high-school principal in east-central Alabama attempted to prohibit mixed-race couples from attending a school-sponsored social function.[269] In 2006, a story of racial discrimination at another southern high school received national attention. In Jena, Louisiana, a black high-school student triggered months of court proceedings, civil rights protests, and media attention when he sat in the shade of a tree traditionally reserved for white students.[270]

Racism has been formalized by leaders who allowed personal prejudices to shape their policies and practices and by scholars whose research and teachings were influenced by the social codes of the time. Urie Bronfenbrenner, a psychologist, was heavily criticized for his theories of racially based intellectual inferiority in black students. He opposed integrated classrooms, saying:

> In many American communities the enlightened leadership, both Negro and white, and their supporters operate on the tacit assumption that once the Negro child finds himself in an integrated classroom with a qualified teacher and adequate materials, learning will take place, and with it the deficiencies of the American Negro, and the judgments of inferiority which they in part encourage, will be erased.[271]

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[268] American Association of Physical Anthropology, "AAPA Statement on Biological Aspects of Race," 570.

[269] Bob Herbert, "The Prom and the Principal," *New York Times*, March 16, 1994.

[270] Richard G. Jones, "In Louisiana, a Tree, a Fight and a Question of Justice," *New York Times*, September 19, 2007.

[271] Urie Bronfenbrenner, "The Psychological Costs of Quality and Equality in Education," *Child Development* 38, no. 4 (December 1967): 910.

A more overt form of racial discrimination was embodied by the Jim Crow laws, now banned, that prohibited black persons from accessing services, facilities, and benefits that were reserved for white persons.

More often, racial discrimination is officially prohibited by governing authorities but is "sanctioned by custom or practice."[272] These forms of discrimination, justified by any number of religious, personal, political, or philosophical ideologies, can go unrecognized and prove more difficult to address. Regardless of the form of discrimination, it is present at all levels of society. According to Krieger, "These include the state and its institutions (ranging from law courts to public schools), nonstate institutes (e.g., private sector employers, private schools, religious organizations), and individuals."[273] Racial discrimination operates simultaneously at multiple levels in any institution. Derek Griffith, a clinical community psychologist, and his colleagues define these levels as *extraorganizational*, *intraorganizational*, and *individual*.[274] According to their theory, extraorganizational discrimination occurs when agencies, institutions, and even nations interact negatively with each other as a result of race-based prejudices. From the intraorganizational perspective, discrimination may be perpetuated by the unchallenged assumptions held by the institutional leadership. Official policies and unofficial practices, while *legal*, may serve to perpetuate systems of racial dominance. At the individual level, interpersonal relations can be negatively affected by negative beliefs and attitudes towards certain races.

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[272] Nancy Krieger, "Discrimination and Health," in *Social Epidemiology*, ed. Lisa F. Berkman and Ichiro Kawachi (New York, NY: Oxford University Press, 2000), 39.

[273] Ibid., 40.

[274] Griffith et al., "Dismantling Institutional Racism: Theory and Action," 384.

Everyday Racism

Social scientists are challenging the mistaken belief that America has evolved past a racialized view of society. Patricia G. Devine, a social psychologist, and her colleagues conducted several studies in the early 1990s. Their findings indicated that individuals who intellectually distance themselves from racial prejudice will often behave in ways that indicate latent prejudice.[275]

According to Charles Ridley, a psychologist and educator, it is bias in its covert forms that presents the greatest danger. Going unseen, these acts of discrimination are less likely to be addressed and corrected.[276] Essed addressed this blindness to racial discrimination in her exploration of *everyday racism*.[277] According to Essed, everyday racism is expressed in what some choose to call voluntary housing segregation. Reflecting on the appeal of "Caucasian traits," Essed also considers how there appears to be greater visibility and broader acceptance of nonwhite entertainers, models, and politicians who have relatively light complexions.[278] Another expression of everyday racism is the manner in which the media "create, preformulate, and reinforce" stereotypes of nonwhite persons as criminals.[279] A recent example of this practice was observed in the media coverage during the days and weeks after Hurricane Katrina. Hazel Markus, a psychologist, states, "Blacks caught on camera taking goods out of stores were routinely said to be 'looting' ... while

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[275] Patricia G. Devine et al., "Prejudice with and without Compunction," *Journal of Personality and Social Psychology* 60, no. 6 (June 1991): 817-830.

[276] Charles R. Ridley, *Overcoming Unintentional Racism in Counseling and Therapy: A Practitioner's Guide to Intentional Intervention* (Newbury Park, CA: Sage, 1995).

[277] Essed, *Understanding Everyday Racism*.

[278] Ibid., 217.

[279] Ibid., 222.

white people doing the exact same thing were said in captions to be looking for food or supplies."[280]

Impact of Racism on Self-Perception

Models of racial inferiority and superiority can have countless effects on those deemed inferior in such systems. Perhaps one of the most devastating is what happens when judgments of inferiority are internalized by those who are oppressed or excluded. Internalized racism has been defined as:

> Acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth. It is characterized by their not believing in others who look like them, and not believing in themselves. It involves accepting limitations to one's own full humanity, including one's spectrum of dreams, one's right to self-determination, and one's range of allowable self-determination, and one's range of allowable self-expression. It manifests as an embracing of "whiteness" (use of hair straighteners and bleaching creams, stratification by skin tone within communities of color, and "the white man's ice is colder" syndrome); self devaluation (racial slurs as nicknames, rejection of ancestral culture, and fratricide); and resignation, helplessness, and hopelessness (dropping out of school, failing to vote, and engaging in risky health practices).[281]

The American Anthropological Association addressed this internalization of racial prejudice in its statement on race when it concluded, "How people have been accepted and treated within the context of a given society or culture has a direct impact on how they perform in

[280] Andrea Orr, "Hurricane Katrina Discussion Raises More Questions Than Answers on Race, Class," *Stanford Report*(November 16, 2005), http://news-service.stanford.edu/news/2005/november16/katrina-111605.html.

[281] W. Michael Byrd and Linda A. Clayton, "Racial and Ethnic Disparities in Healthcare: A Background and History," in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, ed. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson (Washington, DC: National Academies Press, 2003), 524.

that society."[282] And reflecting on the experience of growing up in a Chinese immigrant community, Ben R. Tong writes:

> The damage wrought by living behind the stereotype is not limited to individual egos. The Chink mentality is also actively imposed by its chief adherents on the impoverished and destitute of Chinatown.... With this kind of thinking, community leadership is discouraged from emerging and problems continue to be denied and covered up.[283]

The philosopher Carles Taylor argues, " [The] refusal [of equal recognition] can inflict damage on those who are denied it.... The projection of an inferior or demeaning image on another can actually distort and oppress, to the extent that the image is internalized."[284]

In reviewing legislation that would directly affect immigrants from Latin American countries, Laura Padilla, a professor of law, traces a pattern by which Latin American immigrants "sabotage rather than support" other immigrants in similar situations.[285] Padilla shows that Latin American immigrants consistently voted in favor of legislation that would eliminate services in Spanish, bring harsher punishments for undocumented immigrants, and end affirmative action. She includes nonlegislative examples of the same practice. For example, she cites a case in which a "predominantly Latino school board" fired two Hispanic teachers for teaching "Chicano history" to a predominantly Hispanic group of students.[286] Padilla is convinced that these are the direct result of an internalization of the negative

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[282] American Anthropological Association, "AAA Statement on Race," 713.

[283] Ben R. Tong, "The Ghetto of the Mind: Notes on the Historical Psychology of Chinese America," *Amerasia Journal* 1, no. 3 (November 1971): 23.

[284] Charles Taylor, "The Politics of Recognition," in *Multiculturalism: Examining the Politics of Recognition*, ed. Amy Gutman (Princeton, NJ: Princeton University Press, 1994).

[285] Laura Padilla, "'But *You're* Not a Dirty Mexican:' Internalized Oppression, Latinos, and Law," *Texas Hispanic Journal of Law and Policy* 7, no. 3 (Fall 2001): 74.

[286] Ibid., 64.

stereotypes that are regularly applied to persons of Hispanic descent and an attempt to identify more closely with the dominant racial group.

Internalizing racial discrimination has a unique but equally devastating effect on those persons who identify (or are identified) as biracial or multiracial. Historically speaking, the majority of persons who identify as Mexican are the descendants of both the indigenous peoples of the area now encompassed by Mexico and the American Southwest and its Spanish colonizers. For some, an internalization of social scorn for *indios* has resulted in a rejection of those aspects of their heritage and a preference for identifying with their European ancestry. This attitude is often adopted in an attempt to elevate one's social position and to claim a certain level of social authority. Norma Alarcón, a women's studies scholar, describes the experience of many Mexican and Mexican-American women when she reflects on "the rejection and denial of the dark Indian Mother as Indian which have compelled women to often collude in silence against themselves."[287]

Impact of Racism on Health

Racial disparity exists across the entire spectrum of goods and services available in contemporary society. Racial minority status consistently corresponds with low-wage jobs, substandard primary and secondary educational institutions, and low-quality housing. That it is also present in access to health care is considered by many to be most egregious. Martin Luther King, Jr., is often quoted as having said, "Of all forms of inequity, injustice in health care is the most shocking and inhumane."[288]

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[287] Alarcón, "Chicana Feminism," 252.

[288] Martin Luther King, Jr., (National Convention of the Medical Committee for Human Rights, Chicago, IL, March 25, 1966). Quoted in Griffith et al., "Dismantling Institutional Racism: Theory and Action," 381.

Racial disparities in access to health care may be receiving increased attention today; however, they are not new. Byrd and Clayton trace a pattern that goes back for centuries.[289] Their work shows a consistent pattern in which the first European settlers used English models to establish a health-care system based on race. In the early years of this country, there were already "separate and unequal tiers of 'health' and health systems for blacks, the poor, and Native Americans."[290] Although the legal status of slavery, and thus of those who identified (or were identified) as black, would change, this multitier system of health care would remain. The authors state that subsequent waves of immigrants were relegated to the lowest tiers of the health-care system. Irish-Catholics, Chinese, Italians, Eastern European Jews, Japanese, Mexicans, Puerto Ricans, and various Caribbean groups have all suffered the results of having to seek medical care from substandard public hospitals, dispensaries, and institutions providing charity care. Byrd and Clayton claim that the coincidence of advances in medical technology and the decline of infectious disease and mortality in racial minorities is simply that, a coincidence. Racial disparities in clinical care did not decline because medical science advanced. Instead, the authors point to social projects that directly contributed to the improved health of racial minorities (e.g., sanitation and programs established to provide milk and drinking water).[291] According to Byrd and Clayton, racial minorities have been "segregated and isolated from the mainstream health system and systematically excluded from health professions training."[292]

[289] Byrd and Clayton, "Racial and Ethnic Disparities in Healthcare," 455-527.

[290] Ibid., 467.

[291] Ibid., 472.

[292] Ibid.

The historical record of racial discrimination in access to health-care services has made a significant impact on some groups whose members are less likely to place their trust in health-care professionals. In research studies, racial minorities have suffered at the hands of researchers who devalued them because of their minority states. The legacy of the "Tuskegee Study of Untreated Syphilis in the Negro Male" has left some African-American persons wary of medical professionals.[293] Another case involved Mexican-American women who were made part of a research study on contraceptives without their informed consent.[294] This lack of trust combined with the perpetuation of structures that directly and indirectly impede certain groups from accessing much needed clinical care contribute directly to the disparities that are receiving renewed attention by researchers.

The documentation of research on current racial disparities in access to health care is endless. The data consistently show that "racial and ethnic minorities have less access to health care than does the white, non-Hispanic majority."[295] Researchers who conducted a study on implicit racial bias report that "most nonblack physicians demonstrated some degree of bias favoring whites over blacks."[296] These disparities are evident in a number of diseases and health conditions. In 2001, the National Center for Health Statistics reported

[293] Centers for Disease Control and Prevention, *U.S. Public Health Service Syphilis Study at Tuskegee*, http://www.cdc.gov/tuskegee/timeline.htm (accessed on April 8, 2008).

[294] Patricia E Stevens and Pamela K. Pletsch, "Informed Consent and the History of the Inclusion of Women in Clinical Research," *Health Care for Women International* 23, no. 8 (December 2002): 809.

[295] Darrell J. Gaskin and Catherine Hoffman, "Racial and Ethnic Differences in Preventable Hospitalizations across 10 States," *Medical Care Research and Review* 57, no. S1 (November 1, 2000): 85.

[296] Alexander R. Green et al., "Implicit Bias among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients," *Journal of General Internal Medicine* 22, no. 9 (September 2007): 1235-1236.

data on the correlation of health and racial identity.[297] This comprehensive report indicates that Mexican-Americans have a higher rate of uncontrolled high blood pressure, black Americans have a higher death rate from diabetes, and Hispanic Americans are more likely not to have a consistent source of care. Marsha Lillie-Blanton, a public health scholar, and her colleagues state, "Blacks generally fare worse than whites in infant mortality ... Latinos fare worse than whites in terms of health insurance coverage."[298] Persons who identify as black have a higher chance of developing and dying from lung cancer and are less likely to receive optimal care.[299] Black persons are more likely than white persons to develop multiple risk factors for coronary artery disease but are less likely to be referred for invasive cardiac procedures.[300] Research shows that the physician's decision to recommend cardiac catheterization may be influenced by racial bias. According to Kevin Schulman and his colleagues:

> We found that the race and sex of the patient affected the physicians' decisions about whether to refer patients with chest pain for cardiac catheterization, even after we adjusted for symptoms, the physicians' estimates of the probability of coronary disease, and clinical characteristics.[301]

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[297] National Center for Health Statistics, *Healthy People 2000 Final Review* (Hyattsville, MD: U.S. Public Health Service, 2001).

[298] Marsha Lillie-Blanton et al., "Race, Ethnicity, and the Health Care System: Public Perceptions and Experiences," *Medical Care Research and Review* 57, no. S1 (November 1, 2000): 232.

[299] Talmadge E. King, "Racial Disparity in Rates of Surgery for Lung Cancer," *New England Journal of Medicine* 341, no. 16 (October 14, 1999): 1231.

[300] Lynne C. Einbinder and Kevin A. Schulman, "The Effect of Race on the Referral Process for Invasive Cardiac Procedures," *Medical Care Research and Review* 57, no. S1 (November 1, 2000): 162.

[301] Kevin A. Schulman et al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," *New England Journal of Medicine* 340, no. 8 (February 25, 1999): 623.

The status of insurance coverage, a significant factor in accessing health care, also corresponds with racial categories. Alan Monheit and Jessica Vistnes, both health economists, present evidence that "the gap in private employment-related coverage and uninsured rates between white males and Hispanic males" continues to expand.[302] What often compounds these issues is that both the minority that is affected and the majority that is better positioned to effect change are ignorant of these disparities.[303]

However, in the absence of self-reported data that explicitly indicate racial bias as a factor in allocating health-care services, it is not possible to state in absolute terms that societal prejudices against certain racial groups are the reason for these disparities. Yet racial disparities do exist in health care even after accounting for other confounding environmental factors. In a publication that presents the research and recommendations of the Institute of Medicine, this troublesome phenomenon is defined as "racial or ethnic disparities in the quality of healthcare that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention."[304] Referring to the extensive research that has been done in this area, the authors report that such disparities are evident in the quality of cardiovascular care, the application of standard diagnostic tests in cancer, and the administration of analgesics. The authors also refer to studies that indicate that African Americans with HIV "are less likely than non-minorities to receive antiretroviral therapy, prophylaxis for pneumocystic pneumonia, and protease inhibitors."[305] These (and

[302] Alan C. Montheit and Jessica Primoff Vistnes, "Race/Ethnicity and Health Insurance Status: 1987 and 1996," *Medical Care Research and Review* 57, no. S1 (November 1, 2000): 32.

[303] Lillie-Blanton et al., "Race, Ethnicity, and the Health Care System," 232.

[304] Smedley, Stith, and Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 3-4.

[305] Ibid., 5.

other) manifestations of racial disparity in health care correspond with higher mortality rates for racial minorities.

Some researchers have chosen to focus on specific outcome indicators so that comparisons may be made between racial groups. Darrell Gaskin and Catherine Hoffman, both public health scholars, focused their research on the incidence of hospitalization for what are commonly considered preventable conditions. They reasoned that such hospitalizations are likely the result of limited access to primary care services in the early stages of easily preventable conditions. Their review of discharge data from ten states showed that Hispanic children, working-age African American adults, and African American and Hispanic elderly patients were more likely to be hospitalized for preventable conditions than were their white peers. In their work, Gaskin and Hoffman were careful to control for other, potentially confounding factors like insurance coverage, socioeconomic status, and the accessibility of primary care services. They make a point of noting, "Even among persons within the same insurance classification, disparities by race persist."[306] A clear example is provided when they show that racial disparities exist even among economically comparable Medicare patients. In preparation for critics who may desire to discredit their data as anecdotal, the authors repeatedly show how their findings correspond with the results of many other similar studies.

This type of data is significant for a number of reasons. First, while it is not concrete and irrefutable evidence of intentional racial discrimination, there is clearly a trend. Second, with regard to those who advocate for socialized medicine or national programs to extend

[306] Gaskin and Hoffman, "Racial and Ethnic Differences in Preventable Hospitalizations across 10 States," 101.

health insurance to everyone, these data suggest that racial disparities in access to health care would persist. Finally, at present (and likely into the foreseeable future) certain social groups are receiving substandard health care.

Beyond the clinic, racial bias shapes social structures and practice in ways that directly contribute to impoverished health in racial minorities. Krieger identifies four of these community factors (in addition to a fifth factor that she describes as "inadequate or degrading medical care").[307] First, she states that segregation in residential areas and occupational opportunities can lead to poorer nutrition. Several other studies support her assertion that the availability of nutritious food items is diminished in predominantly racial-minority neighborhoods. Second, residential segregation can often expose racial minorities to unhealthy and harmful living conditions. Third, the mere anticipation of discrimination can lead to distrust and anxiety. And, finally, alcohol, tobacco, and junk food are more heavily marketed in racial-minority neighborhoods. According to the Center on Alcohol Marketing and Youth at Georgetown University, when compared to all American youth, black youth were exposed in greater numbers to advertising for beer, ale, and distilled spirits.[308]

La Verdad sin Voz

Concerns raised regarding racial bias in clinical care may be dismissed by many who believe themselves to be enlightened individuals whose judgments and actions are not influenced by the racial identity of the other. Yet, as I have argued, racism is a social

[307] Krieger, "Does Racism Harm Health?" 196.

[308] Center on Alcohol Marketing and Youth, *Exposure of African-American Youth to Alcohol Advertising, 2003 - 2004: Executive Summary* (Washington, DC: Georgetown University, 2006), 5.

construction that functions simultaneously at many levels in society. An individual who believes that her judgments and actions are genuinely free from racial bias still functions within a society in which this is not the case. Her freedom may be constrained more than she is willing or able to recognize.

La Verdad sin Voz is a fictionalized account of actual events that took place in the early 1970s in Mathis, Texas.[309] Alejandro Morales, the author, takes artistic liberty with the life and death of Dr. Fred E. Logan, Jr. Morales learned of the events when a colleague referred him to an article in a national news magazine.[310] The one-page article was the only source material Morales used for the novel.[311] It was not until later that he would find himself with the opportunity to visit Mathis, Texas.

Logan was a white osteopath who served as the director of the Office of Economic Opportunity Migrant Health Program in Mathis, Texas.[312] Logan quickly established himself as an ally to the Mexican community and provided services to those who otherwise would not have had access to medical care. Logan's wife is quoted in the original news article: "They almost could never pay ... Once, right after he [Logan] started, I discovered he hadn't billed anyone for weeks and I just gave him hell because we were starving."[313] Guadalupe Salinas, a lifelong resident of Mathis, recalls how the Mexican community in Mathis had never had anyone to tend to their medical needs the way that Logan did.[314] Salinas

[309] Alejandro Morales, *La Verdad sin Voz* (Mexico City, México: Joaquín Morales, 1979).

[310] Alejandro Morales, interview by J. Ernest Aguilar, March 28, 2008.

[311] "Death of an Anglo," *Newsweek* July 27, 1970, 21.

[312] "Doctor Is Killed in Scuffle," *Corpus Christi (TX) Caller*, July 13, 1970.

[313] "Death of an Anglo," 21.

[314] Guadalupe Salinas, interview by J. Ernest Aguilar, April 20, 2008.

comments that while Logan's work endeared him to the Mexican community, many white members of the community openly despised him for what was doing. Beyond his medical office, Salinas reports that Logan regularly engaged in efforts to improve the living conditions of individuals and families in the Mexican community. Salinas states that close to the time of his death, Logan began a campaign to be elected to the school board in order to improve the educational conditions for Mexican children. Many members of the white community, reports Salinas, were opposed to Logan's election to the school board and feared losing the control they had over the Mexican community. Logan was not the first health-care professional who attempted to improve the living conditions for the Mexican-American community in Mathis. According to the original article that inspired Morales's novel, "There was no doctor in Mathis who regularly treated the Mexican-American poor when Fred Logan Jr. arrived on the scene back in 1966. The last to try had been harassed out of town by local Anglos."[315]

Logan, it could be said, was not invested in perpetuating the racially dominant model that has been discussed above. To the contrary, many believe that he was strongly committed to reversing that pattern—at least in one small town. Many of his contemporaries, however, did not share his ideology.

On Saturday, July 16, 1970, after an evening of drinking at a local restaurant, Logan was arrested for shooting blanks from a pistol in the parking lot. His actions were reported to the county sheriff's office, and Logan was taken into custody by San Patricio County Deputy Sheriff Eric Bauch—"a law officer particularly disliked by the Mexican-Americans."[316]

[315] "Death of an Anglo," 21.

[316] Ibid.

Deputy Bauch claims that there was a struggle in which he shot and killed Logan. However, the events of Dr. Logan's death remain somewhat mysterious. Of primary concern to investigators were the inconsistencies between Deputy Bauch's report of the incident and the report issued by James H. Sisson, the county medical examiner.[317] Others have commented, "There was no explanation of why the deputy, who is a good deal taller than the doctor, could not subdue a drunken man without shooting him dead."[318] It is believed by many Mathis residents, including Guadalupe Salinas, that Logan was killed in order to terminate the aid and support being offered to the Mexican-American community.

In an outpouring of grief by the Mexican-American community, Logan's casket was carried in a public procession and buried—"the first Anglo ever to be laid to rest in Mathis's *chicano* graveyard."[319] Salinas, however, did not participate in the public demonstrations. He reports that his employment would have been terminated had he chosen to lend his public support to the cause growing up around Logan's death.

Morales, whose work has been criticized for not being historically accurate, insists that it was not his intention to provide a documented history of Logan's death. As a writer committed to raising consciousness regarding the experience of Mexican-Americans, Morales's intention was to tell an important story. Morales reports that the story has "haunted" him in the years since its original publication. While in London for an academic conference, Morales met a married couple from Corpus Christi, Texas (a city approximately forty miles from Mathis). The man was the physician on duty when Dr. Logan's dead body

[317] "Doctor Is Killed in Scuffle."

[318] "Death of an Anglo," 21.

[319] Ibid.

was taken to the hospital. Sometime after that, while in Corpus Christi for another conference, Morales traveled to Mathis and introduced himself to people whom he met. Morales explains that many Mathis residents were still troubled by the events surrounding Logan's death. Additionally, Morales learned that Logan's work with the Mexican-American community had divided the city. Many were grateful for the services he provided. Others, however, expected that Logan's work would serve only to encourage more Mexican-American persons to come to Mathis—something many in the community did not want. In Morales's assessment, Dr. Logan had upset the *status quo*.

Vulnerability

Racial discrimination is an oppressive practice that affects its targets in multiple ways. There is the initial insult and disrespect, the loss of access to services and goods, and the damage to self-esteem. Further, targets of racially based oppression are often systematically stripped of the social power necessary to address these wrongs and effect change. Subsequently, they are left vulnerable to ongoing abuse.

What does it mean to refer to a person or a population as vulnerable? Currently, there is no consensus amongst public health scholars on what criteria constitute *vulnerability*. But, at the most basic level, vulnerability is the state of being susceptible to harm—to be at risk. One can be susceptible to any number of harms: physical injury, disease, exploitation, or loss. Vulnerability is a fluid quality that all human beings possess in degrees, and it is a quality that is itself open to change across time within the same person. Historically, vulnerable groups have been those with limited political, economic, or social power.

Leiyu Shi and Gregory D. Stevens, both public health scholars, recognize the difficulty of defining vulnerability and draw on the work of Lu Ann Aday, a social scientist. Shi and Stevens chose to identify distinct groups within American society that exhibit vulnerability.[320] These groups include racial minorities, the uninsured, the poor, individuals who cannot communicate in English, and the poorly educated. While their list contains a number of other groups (e.g., physically disabled, HIV+, the mentally ill, etc.), it is not difficult to see how some racial minorities could be identified with many of the descriptions presented above. Such overlap of subsets of the population is not unique and is the focus of the work by Shi and Stevens. For the purposes of their work, they trace the impact of three of these subsets: race, economic status, and health insurance.

Shi and Stevens' reflection on the interrelatedness of vulnerability factors is important to consider. They provide a simplified model that demonstrates the interconnectedness between the three factors they have chosen to highlight (see Illustration 1).[321] The model makes clear that the experience of vulnerability in one category can easily lead to experiences of vulnerability in another, and then another. It is, potentially, a self-perpetuating cycle passed from generation to generation. Their generic model (see Illustration 1) can be understood in the following way:

1. Social exclusion from educational resources can leave racial-minority students at a disadvantage when seeking higher education.
2. The lack of higher education frequently limits employment opportunities to low-wage jobs.
3. Such employment venues regularly do not provide workers with health benefits.

[320] Leiyu Shi and Gregory D. Stevens, *Vulnerable Populations in the United States* (San Francisco: Jossey-Bass, 2005), 1.

[321] Ibid., 81.

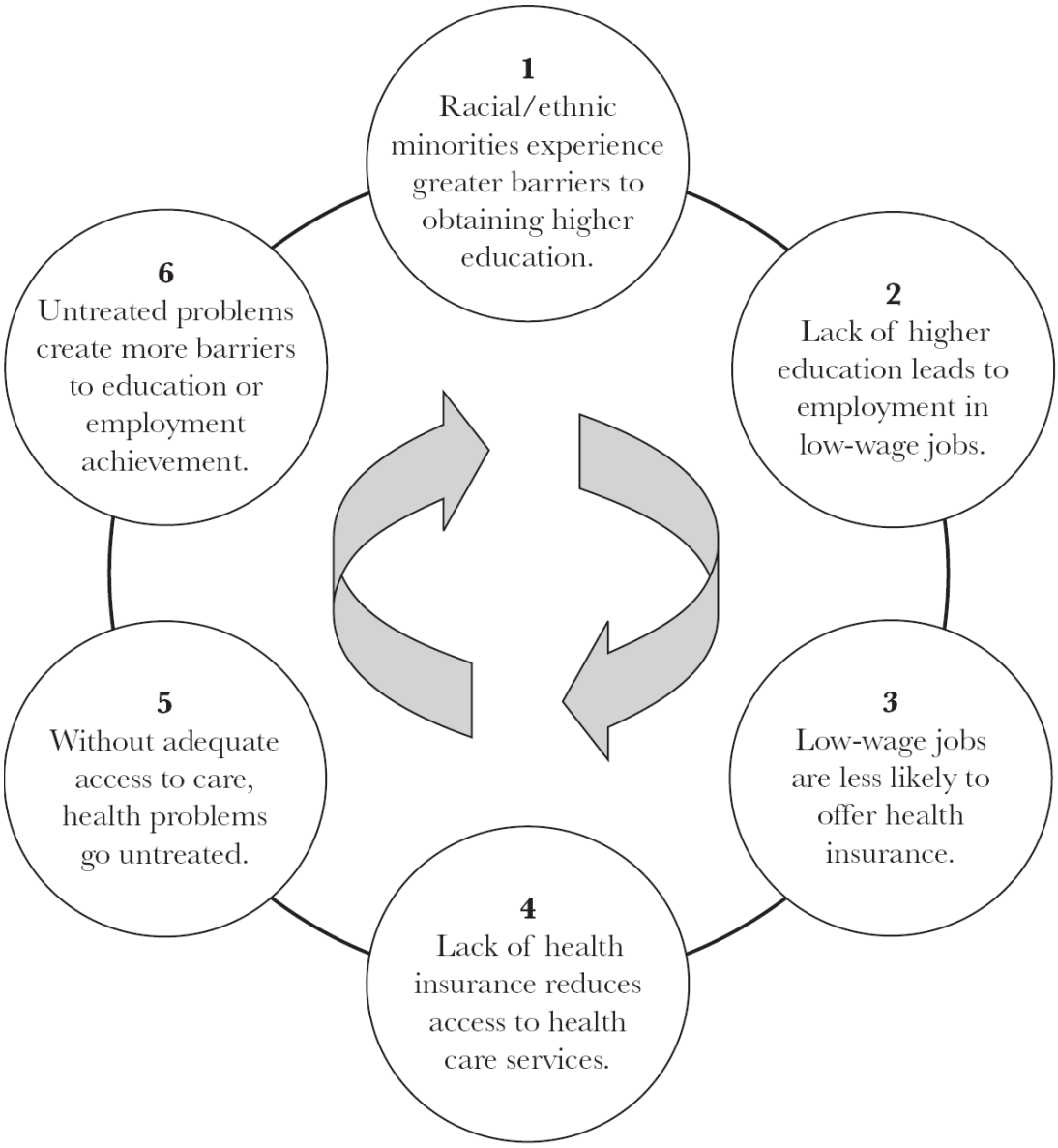

Illustration 1: Cycle of Vulnerability[322]

4. High-quality health care is generally inaccessible to those who do not have health insurance and, as a result, they are left exposed to illnesses that regular, skilled preventative clinical care would have prevented.
5. As a result, workers without health insurance are more likely to miss days of work and students will miss days from school; moreover, in

[322] Ibid.

the absence of regular care, easily treatable illnesses can be allowed to develop into major health threats.

6. Children who go untreated for serious illnesses face problems in their education and development, which leads back to the first point in this list.

Unaddressed, such interconnectedness of risk factors can have significant and ongoing impact on the health status of an already vulnerable population.

Rise in Disparities

The trend to cite U.S. Census Bureau data, previously criticized in this dissertation, may have some merit after all. The data suggest that more persons who are likely to be marginalized based on physical characteristics will be entering American society. What is needed, instead of presentations and handbooks that attempt to define these new cultural groups, is an improved understanding of the ways in which social power is expressed between groups.

There can be a great deal of resistance and discomfort that is expressed when racism is mentioned in an academic setting (or nearly any public setting). Racism has been wished away to a distant past. Whether it is a sense of guilt, anger, or shame, it can be challenging to engage a group in conversation on the topic of race relations and the history of racism. Yet, given the data and theories I have presented in this chapter, it would be difficult to argue effectively that race and a legacy of hostile race relations have not contributed to disparities in access to health-care services. Despite the discomfort that one may experience when challenged to reflect upon race-based injustice, race and racism must be explored and understood if those disparities are to be addressed. However, a deeper

understanding of race relations will require reflection on the exercise of social power and control. For, as Didi Khayatt, an educational theorist, states, "Racism is not about colour, it is about power. Racism *is* power. It is not only a recognition of difference, but also the explicit emphasis on difference to mediate hierarchy based on colour, ethnicity, language, and race."[323] Drawing from the work of several theorists, I will explore social power and how it functions. This analysis is especially relevant to an understanding of the (possibly) unintended effects of cultural competency in medicine.

[323] Didi Khayatt, "Revealing Moments: The Voice of One Who Lives with Labels," in *Talking about Identity: Encounters in Race, Ethnicity, and Language*, ed. Carl E. James and Adrienne Shadd (Toronto, Canada: Between the Lines, 2001), 81.

Chapter 5: Social Power

Training materials in cultural competency repeatedly construct cultural minorities as naïve, irrational, primitive, and dependent upon authority. In response, the responsible and ethical physician is to accommodate these limitations when necessary, but enlighten wherever possible. As I have alluded to in the previous chapters, what is masked here is the power wielded by the dominant majority over racial minorities. This power is expressed in (at least) three ways:

- the dominant majority defines the cultural parameters of the cultural stranger;
- the dominant majority decides that *culturally appropriate* care is what cultural strangers need; and
- race-based disparities in health care become a legitimate area of inquiry only when the dominant majority decides so.

The work of philosophers, historians, and literary scholars will be particularly illuminating on the role of social power in race-based disparities in access to health-care services.

In this chapter I will present an argument for understanding cultural competency as a system (regardless of the intention of the designers) of defining, silencing, and controlling racial minorities. Edward Saïd, a literary theorist and cultural critic, addresses this pattern in his seminal text, *Orientalism*.[324] In his work, he specifically addresses the way in which Western European academics, under the guise of advancing knowledge, defined and

[324] Edward W. Saïd, *Orientalism* (New York, NY: Vintage Books, 1994).

controlled the identities of Orientals, inhabitants of the Middle Eastern countries.[325] Saïd states:

> A text purporting to contain knowledge about something actual ... is not easily dismissed. Expertise is attributed to it. The authority of academics, institutions, and governments can accrue to it, surrounding it with still greater prestige than its practical successes warrant. Most important, such texts can *create* not only knowledge but also the reality they appear to describe. In time such knowledge and reality produce a tradition, or what Michel Foucault calls a discourse, whose material presence or weight, not the originality of a given author, is really responsible for the texts produced out of it.[326]

Similarly, as a discourse, cultural competency systematically produces both the *other* in the clinic and her proper relation to standard medical practice.

Power and Discourse

In the work of Michel Foucault, a French philosopher and historian noted for his critical study of various social institutions, there is no single monolithic definition for *power*. Power is not the crown, the president, the police, the physician, or the military. Each of these (and all persons) may participate in power, but they are not power. Further, power, according to Foucault, is neither negative nor positive. It is a value-neutral phenomenon. Its application, however, can have positive or negative results. Ultimately, Foucault understands power as it is expressed in the production of discourse. Simultaneously, discourse can be "both an instrument and an effect of power, but also a hindrance, a

[325] In the European academy of the mid-20th Century, *Orient* traditionally referred to the area known as the Middle East, as opposed to the (now out of favor) American application of the term to identify countries such as China, Japan, Thailand, etc. In the United States, the term *Asian* has gained favor as a label intended to be less Eurocentric (the term *orient* developed from the Latin word for *east*).

[326] Saïd, *Orientalism*, 94.

stumbling block, a point of resistance and a starting point for an opposing strategy."[327] *Discourse* is the domain in which knowledge is formed, and knowledge defines what comes to be known as *truth*. With regard to truth, then, power is expressed in one's capacity and freedom to participate in the discourse by which that truth is named. Cultural competency can be understood as a process by which a truth is articulated by the medical profession about cultural and racial minorities. In the process, those minority groups are stripped of the power to participate in that discourse and the production of certain truth about them.

In Foucauldian usage, *discourse* is not synonymous with language. Discourse is a system that orders human society's perception of the world. Foucault states, "We must conceive of discourse as a violence which we do to things, or in any case as a practice which we impose on them; and it is in this practice that the events of discourse find the principle of their regularity."[328] An example of the development and acceptance of this regularity is provided by Foucault when he shares an experience of reading an essay by Jorge Luís Borges titled "El Idioma Analítico de John Wilkins" ("The Analytical Language of John Wilkins").[329] Each society, Foucault contends, develops its own models for classifying and organizing the natural world. The order of that structure becomes regularized within a particular society and comes to be regarded as *true*. Yet, when one is introduced to the organizational models of another society, the inconsistencies between discourses become evident. In Borges's

[327] Michel Foucault, *The History of Sexuality: An Introduction: Volume I* (New York, NY: Vintage Books, 1990), 101.

[328] Michel Foucault, "The Order of Discourse," in *Untying the Text: A Post-Structuralist Reader*, ed. Robert Young (London, UK: Routledge, 1981), 67.

[329] Michel Foucault, *The Order of Things: An Archaeology of the Human Sciences* (London, UK: Tavistock, 1970), xvi.

essay, animals are organized in way that would be quite unfamiliar to most. In his essay, Borges refers to a

> cierta enciclopedia china que se titula *Emporio celestial de conocimientos benévolos*. En sus remotas páginas está escrito que los animales se dividen en (a) pertenecientes al Emperador, (b) embalsamados, (c) amaestrados, (d) lechones, (e) sirenas, (f) fabulosos, (g) perros sueltos, (h) incluidos en esta clasificación, (i) que se agitan como locos, (j) innumerables, (k) dibujados con un pincel finísimo de pelo de camello, (l) etcétera, (m) que acaban de romper el jarrón, (n) que de lejos parecen moscas.[330]

Foucault's fascination with Borges's discovery (or literary invention—there is some debate on the source of this text) is the degree to which it differs from anything devised by a *modern* society in the current age.[331] Such a model for categorizing animals seems very wrong, or at least absurd. A contemporary American reader, steeped in the seven-tier taxonomy (i.e., kingdom, phylum, class, order, etc.), might find the model of the *Celestial Emporium* amusing, but it would have no scientific merit. That judgment, according to Foucault, is shaped by the discourse to which the American reader has been exposed. Discourse shapes and limits our experience. Discourse defines our values and understanding of truth. Foucault concludes his reflections on Borges's essay by stating:

> In the wonderment of this taxonomy, the thing we apprehend in one great leap, the thing that, by means of the fable, is demonstrated as the exotic

[330] Jorge Luís Borges, *El Idioma Analítico de John Wilkins*, http://www.ciudadseva.com/textos/teoria/opin/borges3.htm (accessed on March 1, 2008). Translation: [A] certain Chinese encyclopedia titled *The Celestial Emporium of Benevolent Knowledge*. In its remote pages, it is written that animals are to be divided into (a) belonging to the Emperor, (b) embalmed, (c) trained, (d) pigs, (e) sirens, (f) fabled, (g) stray dogs, (h) included in this classification, (i) crazed, (j) innumerable, (k) drawn with a very fine camel hair brush, (l) *et cetera*, (m) that have just broken a water jar, (n) that from a distance look like flies.

[331] There has been speculation as to whether or not the *Emporio celestial de conocimientos benévolos* actually existed and, if it did exist, whether it was regarded as a poetic invention or a scholarly text. Regardless of its origins or its purpose, its usefulness in Foucault's reflection is clear.

> charm of another system of thought, is the limitation of our own, the stark impossibility of thinking *that*.[332]

The constraining nature of discourse is where Foucault focuses his reflections on discourse. According to Foucault, "Discursive practices are characterized by the delimitation of a field of objects, the definition of a legitimate perspective for the agent of knowledge and the fixing of norms for the elaboration of concepts and theories."[333] Discourse limits the range of acceptable behavior and speech. In order to be identified as an authority on a particular subject, one must consciously function within the constraints of that discourse. To do otherwise is to place oneself outside the sphere of legitimate authority. When one is outside of the discourse, one is without power.

Familiarity with a discourse, however, may not be enough to be granted authority and power in that discourse. Features within discourse are designed to bestow or deny authority, to grant or to refuse permission to speak. Foucault refers to these as "internal rules, where discourse exercises its own control."[334] Foucault identifies these rules as *commentary*, *the author*, *disciplines*, and *the rarefaction among speaking subjects*. When commentary is made on a text created by another, the commentary serves to reinterpret the text and bestow upon it a new status within the discourse. "Commentary," says Foucault, "gives us the opportunity to say something other than the text itself, but on condition that it is the text itself which is uttered and, in some ways, finalized."[335] In

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[332] Foucault, *The Order of Things*, xvi.

[333] Michel Foucault, *Language, Counter-Memory, Practice: Selected Essays and Interviews*, ed. Donald Bouchard, trans. Donald Bouchard and Sherry Smith (Ithaca, NY: Cornell University Press, 1977), 199.

[334] Michel Foucault, *The Archaeology of Knowledge: And the Discourse on Language*, trans. A.M. Sheridan Smith (New York, NY: Pantheon, 1972), 220.

[335] Ibid., 221.

commenting, then, the one making the commentary establishes herself as an authority in the discourse, as well.

When Foucault identifies the author as an internal rule for controlling discourse, he is not referring to the originator of the text. Instead, the author is "the unifying principle in a particular group of writings or statements, lying at the origins of their significance, as the seat of their coherence."[336] The author is the principle that brings a degree of synthesis to a body of work by drawing them together under a central idea or theme. Occasionally, the only unifying principle that can found within a collection of texts will be the actual composer herself and Foucault allows for this as what unifies the texts may derive from the lived experiences of the composer. In these cases, it is only when the life of the composer is considered that a consistency may be found within seemingly disparate texts.

Subject knowledge, according to Foucault, is divided into disciplines. The organization of these disciplines provides the basis for the third of the rules that exercise control from within discourse itself. Foucault argues that "disciplines constitute a system of control in the production of discourse, fixing its limits through the action of an identity taking the form of a permanent reactivation of the rules."[337] Disciplines exercise their control over discourse by limiting the knowledge that can be counted as legitimate within that discipline.

Finally, the rarefaction (or the limitation) among speaking subjects is yet another way in which discourse exercises a certain degree of control. As Foucault states, "None may enter into a discourse on a specific subject unless he has satisfied certain conditions or if he

[336] Ibid., 222.

[337] Ibid., 225.

is not, from the outset, qualified to do so."[338] By restricting who may speak, restricting what is spoken is also accomplished. By restricting what is spoken, discourse functions to promote a set of beliefs, values, or ideas that can go uncontested. Uncontested, at least, by any voice found to be authoritative within the discipline. This provides a certain degree of protection within a discourse.

Understanding discourse is essential to understanding the knowledge of a community: how do we know what we know? There is no single authoritative discourse. Instead, there are a number of overlapping discourses that compete for hegemony, each creating their own versions of truth and establishing its own selective criteria for bestowing legitimacy. By studying discourse, one comes to understand the source, the development, and the purpose of certain knowledge. The definitions of suffering and success are set by the dominant discourse. Femininity and masculinity are discursive constructs. The value of youth or agedness is established by discourse. Further, each of these categories is open to reinterpretation or redefinition as resistance succeeds in transforming the relevant discourse. When one understands discourse, it becomes possible to understand the meaning of *truth* as it is ascribed to knowledge. Finally, in studying discourse, one is exposed to the exercise of power within a community: "Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it."[339]

Cultural competency is deeply embedded in a discourse that defines the proper relations between perceived racial groups. This discourse establishes the dominant group

[338] Ibid.

[339] Foucault, *History of Sexuality: Volume I*, 101.

and privileges them with the authority to benevolently assist those presumed to be primitive, traditional, and culturally bound—the voiceless members of society. From their position of privilege, the dominant group believes it is fitting that it should define other groups. The structure of the relevant discourse then serves to legitimize its judgments regarding the identities, needs, and preferences of cultural minorities.

Power and Resistance

Power is a central component of Foucault's work. In Foucauldian terms, however, power is not synonymous with violence or force. Instead, it is the relationship between persons that influences behavior, actions, and thought. Power is expressed in how the will of the other person is directly constrained by the exercise of power. Power is present at every level of society and in every relationship. Power, while value neutral, can be exercised as dominance over another person or a group of persons. Power, in Foucault's thought, is intimately connected to knowledge: "It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power."[340]

Foucault consistently rejects the idea that power resides in individuals who exercise that power over the powerless. Power cannot be possessed. "Power," Foucault argues,

> must by [*sic*] analyzed as something which circulates, or rather as something which only functions in the form of a chain. It is never localized here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net like

[340] Michel Foucault, "Prison Talk," in *Power/Knowledge: Selected Interviews and Other Writings: 1972-1977*, ed. Colin Gordon (New York, NY: Pantheon, 1980), 52.

> organisation ... Individuals are the vehicles of power, not its points of application.[341]

Individuals are the site where power is expressed, but it is done in ways that are not always visible. Power, Foucault argues, works in hidden ways.[342] In response to the hidden nature of power, one must engage in the inquiry necessary to discover the unseen ways in which power is manifested, negotiated, and resisted.

Just as power and knowledge are inseparable in Foucault's thought, so too are power and resistance: "Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power."[343] Here Foucault emphasizes that there is experience outside of the dynamic power. Power is always everywhere and resistance is always a part of it. Resistance, or freedom from repressive forms of power, is made possible by knowledge. The prominent place of resistance in Foucault's understanding of power and knowledge is significant. The constant presence of resistance creates the space necessary for that which is different or that which is other (from the dominant group) to make its voice heard.

Power over Bodies

Power is power over the very body of the other. Bodies are observed, assessed, controlled, defined, explained, and punished. Foucault describes this power over bodies as

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[341] Michel Foucault, "Two Lectures," in *Power/Knowledge: Selected Interviews and Other Writings: 1972-1977*, ed. Colin Gordon (New York, NY: Pantheon, 1980), 98.

[342] Michel Foucault, "Power and Sex: Discussion with Bernard-Henri Levy," in *Michel Foucault: Politics, Philosophy, Culture: Interviews and Other Writings: 1977-1984*, ed. Lawrence D. Kritzman (Londong, UK: Routledge, 1988), 119.

[343] Foucault, *History of Sexuality: Volume I*.

biopower.[344] It allows for the control of entire populations and is the foundation of the modern political state. Biopower is evident in the "explosion of numerous and diverse techniques for achieving subjugation of bodies and control of populations."[345] The control that is exerted over individuals and populations through the exercise of biopower is secured by drawing attention to any number of threats to human survival. From this perspective, a regulated body is a protected body, even if it is not a free body. The state can exercise tremendous power over the population, for example, by referring to the threat of terrorist activities, the influx of undocumented immigrants, or the depletion of natural resources.

Perhaps the most important tool in enacting power over the body of the other is a concept that has already been discussed: normativity. According to Foucault,

> [W]e can say that there is one element ... which will make it possible to control both the disciplinary order of the body and aleatory events that occur in the biological multiplicity ... the norm. The norm is something that can be applied to both a body one wishes to discipline and a population one wishes to regularize.[346]

The philosopher Alexander Nehamas, reflecting on the work of Foucault, states:

> [Foucault] argued that our conception of what we are like as individuals or "subjects" depends essentially on expelling and controlling whole classes of people who do not fit the categories that the Enlightenment developed to establish what it would count as "normal."[347]

[344] Ibid., 140.

[345] Ibid.

[346] Foucault, *Society Must Be Defended*, 253.

[347] Alexander Nehamas, "Subject and Abject: The Examined Life of Michel Foucault," *The New Republic* 208, no. 7 (February 15, 1993): 30.

This passage emphasizes the violence that can be wrought when a society unreflectively operates under an assumption of a standard or a norm. The other is the one who falls short of the ideals represented by the norm and may, therefore, be forced to conform or be excluded. Very often, when groups or persons are understood as other, perceived differences and distances are magnified. This exaggerated view becomes the justification for treating those groups or persons differently, a treatment that regularly results in exclusion from general society and its goods.

The Body

Bill Ashcroft, Gareth Griffiths, and Helen Tiffin, all literature scholars, are engaged in the study of postcolonial literatures. *Postcolonial literature* is generally defined as the literature that is written in a formerly colonized society and usually attends to issues of social or cultural change, exploitation, and alienation. The body is often approached as a locus of these issues—the body is where the violence is done and experienced. Ashcroft, Griffiths, and Tiffin state:

> The 'difference' of the ... subject by which s/he can be 'othered' is felt most directly and immediately in the way in which the superficial differences of the body and voice (skin colour, eye shape, hair texture, body shape, language, dialect or accent) are read as indelible sign of the 'natural' inferiority of their possessors.[348]

Although postcolonial literary theory, by definition, generally concerns itself with the struggles faced by persons living in postcolonial societies, the insights and perspectives are

[348] Bill Ashcroft, Gareth Griffiths, and Helen Tiffin, introduction to Part X, "The Body in Performance," in *The Post-Colonial Studies Reader*, ed. Bill Ashcroft, Gareth Griffiths, and Helen Tiffin (London, UK: Routledge, 1995), 321.

illuminative for any social context in which sections of the population are singled out for inferior treatment. Racism, as Didi Khayatt stated, is about power and not about color. As a practice of exclusion and dominance, racism is based on perceived differences between physical bodies. How those physical differences are perceived as cultural, social, and moral differences is of immediate concern to the practice of medicine. Too often, as has been shown, negative attitudes towards those differences are deeply enmeshed in the discourse of cultural competency in medicine. In turn, instead of improving services for certain segments of the population, those groups are stripped of the right and dignity of defining their own sense of who they are. Ashcroft, Griffiths, and Tiffin continue:

> The body, too, has become the literal site on which resistance and oppression have struggled, with the weapons being in both cases the physical signs of cultural difference, veils and wigs ... symbols and literal occasions of the power struggles of the dominator and dominated for possession of control and identity.[349]

This struggle is also about control *over* identity. How the body functions in this debate has been addressed by countless other scholars from a wide variety of perspectives.

Judith Butler, a philosopher, argues that the body itself is the product of discourse: "There is no reference to a pure body which is not at the same time a further formation of that body."[350] Academic and professional investigations and projects that study the bodies of others succeed in defining and constructing those bodies. Cultural strangers who are described in training materials for cultural competency are created by those descriptions. Further, the very notion of a singular, corporate *body* (e.g., the black body, the lesbian body,

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[349] Ibid., 322.

[350] Judith Butler, *Bodies That Matter: On the Discursive Limits of 'Sex'* (London, UK: Routledge, 1993), 10.

the aged body) is a discursive construction that can contribute to the essentializing of human experience and the negation of difference. There is not *one* body, but a multitude of bodies—each with its own perspective, its own directions, and its own story. Norma Alarcón argues that one significant way in which bodies are defined is in terms of the (arbitrary) sociopolitical categories of race.[351] The bodily experiences of individuals of different races and cultures will vary extensively as a result of the sociopolitical discourse that either elevates or denigrates their bodies.

Mariam Fraser and Monica Greco, both sociologists, open their introduction for a collection of essays on the body by quoting Alfred North Whitehead (a mathematician who became a philosopher), "No one ever says, Here I am, and I have brought my body with me."[352] Their point in doing so is to emphasize the point that the *I* and the *body* are inseparable.[353] This appears to be an observation of something quite obvious. However, Fraser and Greco claim that in many sociocultural studies and analyses the *body* is strangely absent, at least conceptually. Only in recent decades has social theory turned to the body as a subject deserving of its own study. Fraser and Greco claim, "The body has become a crucial site for rethinking the scope and the limits of the social scientific imagination."[354] Anatomists and biologists, of course, have studied the body in detail. However, the sociological, cultural, and political implications of the body have been, until recently,

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[351] Alarcón, "Chicana Feminism," 250.

[352] Alfred North Whitehead, *Modes of Thought* (Cambridge, MA: Cambridge University Press, 1938), 156; quoted in Mariam Fraser and Monica Greco, ntroduction to *The Body: A Reader*, ed. Mariam Fraser and Monica Greco (London, UK: Routledge, 2005), 1.

[353] For the purposes of these discussions, Fraser and Greco (and I) are addressing the common experience in the physical world. They (and I) are setting aside the religious and metaphysical beliefs and claims that suggest that one can leave (and possibly return to) one's body.

[354] Fraser and Greco, introduction to *The Body,* 2.

neglected. Fraser and Greco recognize this absence in the Cartesian split between the mind and the body: "Corporeal events might have an impact on processes of thinking, but the final product—thought 'itself,' with its concomitant relations of meaning—was to be valued precisely insofar as it was *dis*embodied."[355] The legacy of this dualism is a preference for pure thought that has not been corrupted by the physical. In objection to this preference for pure thought, Fraser and Greco quote the work of Steven Shapin, an historian and sociologist of science, who states, "To tell the truth, I have never seen a 'disembodied idea,' nor, I suspect, have those who say they study such things."[356] Any social criticism, then, must include reflection on how people's very bodies are being affected in the current system and how those same bodies might fare differently in a different (evolved?) social context. Patients' bodies are affected by more than disease and illness.

Elisabeth Grosz, a philosopher, traces the absence of the body in social theory to long before René Descartes. Grosz reflects on the perception of the body in the ancient Greek academy. "Plato," Grosz explains, "sees matter as a denigrated ad [*sic*] imperfect version of the Idea."[357] Tracing the influence of this early thought, Grosz considers how the physical body is represented in Western religious traditions and philosophy—including Cartesian dualism. She then considers the influence of this dualism on current research practices and identifies three lines of investigation that, according to her, show traces of Cartesian thought.

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[355] Ibid., 6.

[356] Ibid.

[357] Elizabeth Grosz, "Refiguring Bodies," in *The Body: A Reader*, ed. Mariam Fraser and Monica Greco (London, UK: Routledge, 2005), 47.

Grosz states that in the first line of investigation, the body is both objectified and universalized. She claims that both in the natural sciences and in the humanities the body is studied as a physical object that is decontextualized, existing like any other object in the natural world. Although in different ways, Grosz claims that both "ignore the specificity of bodies in their researches."[358] When the body's specificity is disregarded, any understanding of how bodies are socially and politically constructed is lost. The second line of investigation attends only to the body's instrumentality. The body is of value only in that it can enact the will of the noncorporeal (and superior) consciousness and "as an instrument, or tool, it requires careful discipline and training."[359] The interpretation of body as instrument feeds social structures that permit the strong to dominate the weak for the purposes of extracting physical labor from their bodies. The discipline and order that the strong place upon the bodies of the weak are understood as benevolent and charitable. In the absence of the influence of the strong, the weak (it is believed) would live in the chaos that results from being unable to control their own bodies—their own instruments. Finally, in the third line of investigation, the body serves only to signify the inner consciousness of the person: "A mode of rendering public and communicable what is essentially private (ideas, thoughts, beliefs, feelings, affects)."[360] In this model, the body (the bodily experience) of the person has no influence on the construction of that person's thoughts or beliefs. By this reasoning, one's lived experience, one's social, political, and economic

[358] Ibid., 39.

[359] Ibid., 50.

[360] Ibid., 51. This should not be confused with Lévinas's *face*. The face, in Lévinas, does not refer to the physical face, but to the presence of the person; the point of contact between the same and the other.

context, have no effect on the *true* self. In understanding the other, according to this perspective, these factors may (and should) be ignored.

Whose Bodies Matter? In the Christian scriptures, there is a particularly well-known story regarding a miraculous feeding of a large crowd with only a handful of fish and a few loaves of bread. At the conclusion of the story, the reader learns that "those who ate were about five thousand men, not counting women and children."[361] This passage reflects the normative state of humanity for that time and that place. The *normative* human being was an adult male (belonging to that cultural group). All others were either incomplete or distorted versions of that norm. Butler explores the question of the normativity of the body.[362] She argues that the normativity of maleness (and gender itself) is a cultural construction designed by those in power—those who define the discourse. Bodies, Butler insists, cannot be understood apart "from the regulatory norms that govern their materialization and the signification of those material effects."[363]

What one perceives when one looks upon another (another's body), Butler argues, is dictated by the discourse in which one is steeped. The value of the person is interpreted in terms of their physical presentation—their body. And some bodies matter, and some bodies do not. The legitimacy of the relative value of different bodies is accepted as a naturally occurring reality. Only with adequate reflection, only by attending to the power relations behind the *truth* can one come to understand how one has been influenced to

[361] Matthew 14:21 (New American Bible).

[362] Butler, *Bodies That Matter*.

[363] Ibid., 2.

value one body over another. This is not to imply that there are no differences between bodies, but that the value attached to those differences is culturally constructed.

When one encounters another body, one encounters an *other*. How one treats that *other* is a question of ethics, morality, and justice. How one treats that other must also be understood in terms of the hegemonic forces that define acceptable attitudes towards difference.

The rhetoric of cultural competency not only reflects and imposes how the dominant class views other groups of people, but, as a discourse, it has the cumulative effect of creating those groups and shaping how they come to view themselves. By reaching the level of discourse, cultural competency enjoys the authority of the medical profession, medicine's governing bodies, and even state legislation. Such authority allows for the ongoing control of the identity, needs, desires, and the very bodies of the racial and cultural stranger. Saïd directly addresses this when he states, "Knowledge of subject races ... is what makes their management easy and profitable; knowledge gives power."[364] Because of Saïd's conviction that such expressions of power can serve to "obliterate [the other] as a human being," he was determined (quoting the words of Marxist cultural critic Raymond Williams) to articulate an academic and intellectual call for an "'unlearning' of 'the inherent dominative mode.'"[365]

Race-based disparities in access to health care are disparities that result from power structures that dictate how the bodies of others are valued (or not). These same power

[364] Saïd, *Orientalism*, 36.

[365] Ibid., 28.

relations have formed the practice of cultural competency. As an expression of the same oppressive power that limits health-care services for racial minorities, cultural competency is an unreasonable choice for a remedy to the situation. Any attempt to address health disparities will require exploration of and reflection on the discursively conditioned responses to otherness and how that discourse may need to be revised. In the next chapter, I will draw upon the work of philosophers, cultural critics, and narratologists. Their work on otherness—and the proper posture to be taken before the other—are essential to any attempt to correct race-based disparities.

Chapter 6: Responding to the Other

The practice of medicine is rooted in one of the most basic of human experiences: responding to the needs of the other. This ethical call to respond to the needs of the other is deeply embedded in nearly every religious or spiritual tradition and is the basis for social service agencies, volunteer networks, and civic organizations. In medicine, individuals rigorously prepare themselves to provide the care, insight, and services needed for the countless others who will enter the clinic in search of relief, aid, or comfort. Yet it would appear that there are others who are simply *too other*.

Cultural competency has been upheld as a remedy for the an observed pattern in which certain others (those of particular racial and social groups) are barred access to health-care services. Or, if they are able to access the services they need, they are subjected to clinical care of substandard quality. For some time, many have held that this disparity in the quality of clinical care is the result of the challenges that arise when physicians encounter patients who are very different from themselves. When the patient is too much of an other, it is suggested, the lack of a mutual perspective leads to misunderstandings between physician and patient that negatively affect the quality of care that is provided.

This assumption raises several questions. Is the degree of otherness really the issue? Can there be an other who is more easily understood, known, defined? Does the degree of difference really matter—ought there be a standard that governs one's response to all who are other? Who is the other? How much of the distance between the physician

and the patient is rooted in actual, discernible difference? And how much of it is constructed and placed upon the other?

The Other and the Self

Emmanuel Lévinas, a noted philosopher, addresses the proper posture to be taken before the other. Motivated by a belief that Western philosophy has consistently suppressed the other, Lévinas reflects on a practice of meeting the other that is governed by high ideals: obligation, humility, and service.[366] Some may find Lévinas's expectations for interpersonal relationships too idealistic for clinical encounters between patient and physician. Yet the same could be said of many ethical or moral codes. His work is something to which one should aspire even if one never quite accomplishes all that Lévinas asks. Further, even if Lévinas's ideals are unobtainable, his reflections are pertinent to the practice of medicine and provide a strong foundation for engaging the other who is one's patient. His theories on the ethical significance of alterity have been applied to dilemmas and questions in disciplines ranging from geography to health care.[367] In the past decade, a number of scholars within nursing and medicine have begun to recognize the work of Lévinas as an important foundation for an ethical practice of healing.[368] Per Nortvedt, a medical educator, argues,

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[366] Emmanuel Lévinas, *Totality and Infinity: An Essay on Exteriority*, trans. Alphonso Lingis (Pittsburgh, PA: Duquesne University Press, 2007), 302.

[367] Clive Barnett, "Ways of Relating: Hospitality and the Acknowledgement of Otherness," *Progress in Human Geography* 29, no. 1 (February 2005): 5-21.

[368] Michelle Clifton-Soderstrom, "Levinas and the Patient as Other: The Ethical Foundation of Medicine," *Journal of Medicine and Philosophy* 28, no. 4 (August 2003): 447-460; Maria de Lourdes Campos Hames et al., "A Alteridade como Critério para Cuidar e Educar Nutrizes: Reflexões Filosóficas da Prática," *Revista Brasileira de Enfermagem* 61, no. 2 (March-April 2008): 249-253; Craig A. Irvine, "The Other Side of Silence: Levinas, Medicine, and Literature," *Literature and Medicine* 24, no. 1 (Spring 2005): 8-18; Arthur

> Levinas' transcendental argument for an ethics of responsibility supports some core values of individualized care, values that are essential to health care. The ethics of Levinas provides a foundational support for many of the essential intuitions in health care, what it means to be addressed by vulnerabilities and the importance of a sensitive receptivity towards the other person.[369]

According to Mirelle Lavoie, a nursing educator, Lévinas's work has much to offer those who seek to enhance their capacity to provide sound clinical care:

> [Lévinas] taught us what *s'occuper de l'autre* (to take care of the other) really means and made sure that we fully respect the humanity emanating from the other's face. Such responsibility is proper to each and every one of us, whether healthcare professionals or not [and] to all those ... who want to be caregivers, that is to say attentive to a person in order to assist her in the particularity and singularity of her life.[370]

Philosopher Francis Dominic Degnin argues, "Emmanuel Levinas would ... call on all of us to be witnesses to the unbalanced, violent treatment of society's most vulnerable members as they seek healthcare."[371] And anthropologist Arthur Kleinman, invoking the work of Lévinas, argues that attending to the suffering that is particular to a specific patient is at the moral center of medicine.[372]

Lévinas's extensive work on the ethics of the relationship between the other and oneself is rooted in a non-indifferent love for the other that is not motivated by an

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Kleinman and Peter Benson, "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It," *PLOS Medicine* 3, no. 10 (October 2006): 1673-1676; Mirelle Lavoie, Thomas De Koninck, and Danielle Blondeau, "The Nature of Care in Light of Emmanuel Levinas," *Nursing Philosophy* 7, no. 4 (October 2006): 225-234; and Per Nortvedt, "Levinas, Justice and Health Care," *Medicine, Health Care, and Philosophy* 6, no. 1 (March 2003): 25-34.

[369] Nortvedt, "Levinas, Justice and Health Care," 28.

[370] Lavoie, De Koninck, and Blondeau, "The Nature of Care in Light of Emmanuel Levinas," 233.

[371] Francis Dominic Degnin and Donna J. Wood, "Levinas and Society's Most Vulnerable: A Philosopher's View of the Business of Healthcare," *Organizational Ethics* 4, no. 1 (Spring/Summer 2007): 79.

[372] Kleinman and Benson, "Anthropology in the Clinic," 1675.

expectation of reciprocity. Yet his reflections on the other are difficult to trace as, in the original French, he uses more than one word and regularly (but inconsistently) uses capitalization to make even further distinctions. Adriaan T. Peperzak, a philosopher and a frequent commentator on the work of Lévinas, addresses this when he acknowledges the difficulty in attempting

> ... to solve the rendering of *Autre*, *autre*, *Autrui*, and *autrui*, Lévinas' use of which is not always consistent. Among Lévinas scholars it has become a convention to reserve "the Other" with a capital for all places where Lévinas means the human other, whether he uses *Autrui*, *autrui*, *autre*, or *Autre*. This convention has many inconveniences, however. For example, it cannot show the difference between *Autre*, when it is used to refer to God and when it refers to the human other.[373]

Despite these difficulties, Lévinas's insights into the proper relationship to the other are insightful and an essential element of any reflection on how best to respond to the other (i.e., the cultural stranger) who seeks medical services.

With regard to encounters with human others, Lévinas locates this encounter in the face (*visage*) of the other. It is in the face of the other that one accesses the other. For Lévinas, however, the face is not the physical face situated upon one's head. The face is the personification of the human other. As the face is not an object, it is unknowable in the ways that one can have knowledge of objects perceived with one's senses. The face of the other "is not 'other' like the bread I eat, the land in which I dwell, the landscape I contemplate."[374] Lévinas emphasizes the separateness of the face of the other from one's self (which Lévinas calls the *same*) when he states, "[T]he Other enters into relation while

[373] Adriaan T. Peperzak, "Preface," in *Emmanuel Levinas: Basic Philosophical Writings*, ed. Adriaan T. Peperzak, Simon Critchley, and Robert Bernasconi (Bloomington, IN: Indiana University Press, 1996), xiv.

[374] Lévinas, *Totality and Infinity*, 33.

remaining *καθ'αύτό*, where he expresses himself without our having to disclose him from a 'point of view,' in a borrowed light."[375] The significance of the other is not dependent on social standards, civil laws, religious practices, or personal merit. The face (and, therefore, the other) has significance because it exists. The other must be respected as other—separate from the same. If the other becomes the object of one's knowledge, then the other is reduced to that which is contained in one's knowledge. What one can know is not and can never be the other. From this perspective, the other cannot be known or possessed by the self and exceeds any impressions that the same may form of the other.[376] Lévinas elaborates on this point when he argues that knowledge of an other is only possible as a result of "proximity, of sociality that does not lead back to ontology, and is not based on experience of being and in which meaning is not defined formally, but by an ethical relation to the other person in the guise of responsibility to him or her."[377]

The relationship of the same with the other is the very location of ethics. This relationship is articulated by Lévinas:

> A calling into question of the same—cannot occur within the egoist spontaneity of the same—is brought about by the other. We name this calling into question of my spontaneity by the presence of the Other ethics. The strangeness of the Other, his irreducibility to the I, to my thoughts and my possessions, is precisely accomplished as a calling into question of my spontaneity, as ethics.[378]

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[375] Ibid., 67. Transliteration: k*ath auto*. Translation: by himself.

[376] Ibid., 50.

[377] Emmanuel Lévinas, *Outside the Subject*, trans. Michael B. Smith (Stanford, CA: Stanford University Press, 1994), 93.

[378] Lévinas, *Totality and Infinity*, 43.

It is a relationship that is carried out in dialogue and conversation.[379] This conversation should not be understood in terms of the verbal exchange between two persons who engage in social discussion, rather it is the expression of the ethical call and response which motivates the same to respond to the other.[380]

The foundation of this discourse is what Lévinas calls the "first word," a concept rooted in the Hebrew scriptural tradition. For Lévinas, the other's "primordial expression" to the same is: "you shall not commit murder."[381] The face is not a rival or an opponent, an obstacle to be overcome, or an unknown to be defined. Instead, Lévinas explains, "The face opens the primordial discourse whose first word is obligation."[382] It is from this understanding of the ethical relationship between the same and the other that Lévinas is able to say, "There is here a relation not with a very great resistance, but with something absolutely *other*: the resistance of what has no resistance—the ethical resistance."[383]

Lévinas's other not only demands not to be killed, but also obliges the same to offer welcome, gift, and hospitality. Further, this ought to be done with "full hands" extended to the one who demands in her need.[384] Once again drawing from the Hebrew scriptures, Lévinas characterizes the other in need: "The Other who dominates me in his transcendence is thus the stranger, the widow, and the orphan, to whom I am obligated."[385]

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[379] Ibid., 39.

[380] Ibid., 262.

[381] Ibid., 199.

[382] Ibid., 201.

[383] Ibid., 199.

[384] Ibid., 205.

[385] Ibid., 215.

The same is responsible both to and for the other. That is to say, the same must respond to the other when the other calls, and the same must provide for the other in her need.

Lévinasian ethics apply only to the same. The obligation to respond to the needs of the other is an obligation of the same and not of the other. "The intersubjective space," claims Lévinas, "is not symmetrical."[386] The other is not indebted to the same in any way for the services and care provided by the same. Lévinas does not dispense the other from the obligations of ethics, yet he maintains that when one engages in ethical deliberation one must focus on one's own work. One is obliged to be responsible to the other without any expectation of reciprocity. Lévinas allows for the possibility that the other may ultimately have the same obligations, but, "reciprocity is *his* affair."[387] The resulting asymmetry of this relationship leaves the same in a "position of being such that the Other counts more than myself."[388] Lévinas's work on reciprocity is particularly applicable to clinical medicine. In many ways, the practice of medicine is an endeavor that is undertaken without an expectation of reciprocity. Physicians cannot expect that their patients will return the care and attention that the physicians provide to the patient.

In clinical practice, Craig A. Irvine, a philosopher and clinical educator, observes that there is a hostility towards otherness, to that which cannot be known, defined, and controlled.[389] Medicine, he states, is "driven by the need to *identify* everything under the 'category of the medical,' from large-scale environmental structures to the most intimate

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[386] Emmanuel Lévinas, "Time and the Other," in *The Levinas Reader*, ed. Seán Hand (Oxford, UK: Blackwell, 1989), 48.

[387] Emmanuel Lévinas, *Ethics and Infinity*, trans. Richard A. Cohen (Pittsburgh, PA: Duquesne University Press, 1985), 98.

[388] Lévinas, *Totality and Infinity*, 247.

[389] Irvine, "The Other Side of Silence," 13.

structures of the body."[390] Lévinas's approach to the other is distorted when physicians reduce the patient—the other—to the physical body on the examination table. Physicians articulate scientific and clinical knowledge about the body and mistakenly believe that they have come to know everything that there is to know about the whole person.

In formulating a response to racial disparities in health care, there can be no mystery why physicians would develop programs by which they could come to know and define persons from other cultures in the way that they have been trained to know pathologies and drug therapies. Lévinas's challenge to those engaged in cross-cultural clinical practice is to recognize in the patient (the cultural stranger) the same obligations that are owed to all others. The cultural stranger is not more of an other because of the differences between the patient and the physician. Lévinas addresses this when he states:

> [The] differences between the Other and me do not depend on different "properties" that would be inherent in the "I," on the one hand, and, on the other hand, in the Other, nor on psychological dispositions which their minds would take on from the encounter.[391]

The patient is the face of the other to the physician because she is not the physician. And, as other, Lévinas holds that she has meaning for the physician: "In social relations the real presence of the other is important.... The presence of the Other (*Autre*) is a presence that teaches us something."[392] Attempts to define and control the cultural stranger are attempts to grasp that which is beyond one's reach. The only ethical response is to enter the conversation with the other, the patient, the cultural stranger, and in that discover her

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[390] Ibid.

[391] Lévinas, *Totality and Infinity*, 215.

[392] Emmanuel Lévinas, "The Transcendence of Words," in *The Levinas Reader*, ed. Seán Hand (Oxford, UK: Blackwell, 1989), 148.

needs and respond with "full hands." Murder, dominance, appropriation of the other will always fail. Particular others (specific human beings) may be killed or controlled, but there will always be the infinitely other that the self cannot reach. But, Lévinas argues, "the extermination of living beings" does not eliminate or even diminish otherness.[393]

Lévinas's development of an ethics of engaging the other is extensive and has influenced the work of many scholars. As I have shown, there has been a resurgence of interest in his work—particularly for the important insights that can be gained for ethical clinical practice. For this reason, I have drawn extensively from his theories and ideas. However, Lévinas was neither the first nor the last to have considered the ethical nature of one's relation to the other**,** especially in clinical medicine.

The physician-patient relationship has been at the forefront of bioethics for some time. The work of other philosophers has been brought to bear on the ethics of clinical medicine. Immanuel Kant's theories have shaped current thinking on patient autonomy.[394] David Hume's theories on justice have been applied to proposals for health-care reform and reflections on professionalism in medicine.[395] And the work of John Rawls has been used to provide a "theoretical framework for international bioethics."[396]

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[393] Lévinas, *Totality and Infinity, 198*.

[394] Barbar Secker, "The Appearance of Kant's Deontology in Contemporary Kantianism: Concepts of Patient Autonomy in Bioethics," *Journal of Medicine and Philosophy* 24, no. 1 (February 1999): 43-66; Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge, UK: Cambridge University Press, 2002), 83-86.

[395] Larry R. Churchill, "Looking to Hume for Justice: On the Utility of Hume's View of Justice for American Health Care Reform," *Journal of Medicine and Philosophy* 24, no. 4 (August 1999): 352-364; Loretta M. Kopelman, "Help from Hume Reconciling Professionalism and Managed Care," *Journal of Medicine and Philosophy* 24, no. 4 (August 1999): 396-410.

[396] Robert Baker, "A Theory of International Bioethics: Multiculturalism, Postmodernism, and the Bankruptcy of Fundamentalism," *Kennedy Institute of Ethics Journal* 8, no. 3 (September 1998): 231.

Many contemporary bioethics scholars, some of them theologians, have reflected on one's responsibility to the other. According to Edward Langerak, strangers are not threats but opportunities to enter into mutually vulnerable relationships. These relationships, far more complex than rule-governed contracts, demand the continued engagement and exploration of each other's particular needs and gifts. Langerak holds that interactions with others "must include respect for their status ... as choice-makers, as *hearers and givers* of reason, as *ends-in-themselves*."[397]

Courtney S. Campbell addresses the influential role of language in health care. He reflects on the manner in which power relationships are established by the very choice of vocabulary. "Inequality and dependency may be imbedded" in the language that is used to describe the relationship between patient and practitioner—or any two persons or groups.[398] Campbell cautions against philanthropic or benevolent activity that is unreflective of the potential harm that can be inflicted upon the recipient other. Critical of classical forms of philanthropy, he asserts that the unreflexive benefactor will generally perpetuate power relationships with herself in the superior position. In an effort to counter this destructive pattern, Campbell challenges the reader to contemplate the utter (yet generally denied) interdependence into which all are born and by which all are nurtured. This social reality ought to be understood in terms "of community rather than inferiority, of unity rather than a division into superiors and subordinates."[399]

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[397] Edward Langerak, "Duties to Others and Covenantal Ethics," in *Duties to Others*, ed. Courtney S. Campbell and B. Andrew Lustig (Dordrecht, Netherlands: Kluwer Academic Publishing, 1994), 104.

[398] Courtney S. Campbell, "Gifts and Caring Duties in Medicine," in *Duties to Others*, ed. Courtney S. Campbell and B. Andrew Lustig (Dordrecht, Netherlands: Kluwer Academic Publishers, 1994), 181.

[399] Ibid., 192.

David Tracy unrepentantly criticizes contemporary North-American social practices in which "[w]e find ourselves culturally distanced from those 'others' we have chosen both to ignore and oppress."[400] According to Tracy, the proper relationship to the other is one of solidarity. Solidarity, he argues, is essential to social transformation.[401] For there to be solidarity, Tracy (like Lévinas) argues against attempts to reduce or totalize the other. Efforts to totalize the other arise from the belief that one can know the other and that one's knowledge of the other is accurate and complete: "Anything different, other, alien must clearly be untrue and impossible."[402]

Generalized or Concrete Other

Lévinas and others provide a theoretical framework from which to consider the *nature* of one's relationship to the *other*. Seyla Benhabib, a philosopher and political scientist, reflects on the practical implications of two approaches to the other. First, Benhabib addresses the shortcomings of a theoretical construct she refers to as the *generalized other*.[403] Benhabib's generalized other is the stranger reduced to those qualities shared by all humankind. One's duty to the generalized other is to acknowledge in her "the same rights and duties [one] would want to ascribe to [one]self."[404] Within this paradigm, one's moral dignity arises exclusively from universally held traits and needs, and relationships are governed by the principles of obligation and entitlement. The emotional

[400] David Tracy, *Plurality and Ambiguity* (New York, NY: Harper and Row, 1987), 7.

[401] Ibid., 113.

[402] Ibid., 100.

[403] Seyla Benhabib, *Situating the Self: Gender, Community, and Postmodernism in Contemporary Ethics* (New York: Routledge, 1992), 158.

[404] Ibid.

content of these relationships is constituted by feelings of respect, worthiness, and dignity.[405] Benhabib criticizes this model for making all differences irrelevant and, subsequently, eliminating all need for dialogue. Rather than individuals struggling to be in relationship with each other, Benhabib suggests that there can be only an "empty mask that is everyone and no one."[406] Approaching someone as a generalized other has the cumulative effect of stripping them of their humanness, reducing them to nonpersons.

In contrast to the *generalized other,* Benhabib advocates for attending to the *concrete other*. Within this model, individuals are engaged according to their "specific needs, talents, and capacities." Interpersonal distinctions, rather than a source of conflict that must be eliminated, serve to enrich all of the participants. Rather than in rights language, the concrete other is addressed in terms of friendship and love. Here it is "not only your *humanity* but your human *individuality*" that is affirmed and brought into dialogue and, ultimately, known.[407] In establishing the recognition of individual differences as a value, Benhabib proceeds to articulate a framework in which recognition may occur by way of meaningful dialogue.

Relevant to my argument, Benhabib's *generalized other* is reminiscent of those who have suggested that an effective response to racial disparities would be to treat everyone exactly the same. According to that suggestion, the patient's cultural, social, religious, and economic realities are irrelevant. Physicians need only to be guided by the *evidence*, the physical symptoms and, in all like cases, prescribe identical remedies. Critical of such an extremist and misguided understanding of evidence-based medicine, Trisha Greenhalgh, a

[405] Ibid., 159.

[406] Ibid., 161.

[407] Ibid., 159.

physician and medical educator, states, "The evidence based approach to clinical decision making is often incorrectly held to rest on the assumption that clinical observation is totally objective and should, like all scientific measurements, be reproducible."[408] Such an approach neither addresses the social structures that prevent individuals from being identified as equals nor allows for responsible clinical practice. Further, there is no recognition of the patient's lived experience of discrimination and how that can have negative influences on her health. However, if the patient, regardless of her racial origin, is approached as a concrete person with needs, views, and fears that are unique to her, the medical encounter is more likely to lead to outcomes deemed effective by both parties. This is not to suggest that the patient's cultural or racial identities are irrelevant, but only that such identities must be understood as part of how the patient defines herself and can be understood only as they are articulated by the patient. The physician must humbly acknowledge the limits of her knowledge and insight. How culture and race influence a patient's experience, therefore, must come from the patient and not be imposed by the physician. Further, such a model allows for reflection on and response to the patient's experience of marginalization and exclusion.

Defining the Other

Training programs in cultural competency have been developed with the stated intention that clinical care will be enhanced when providers have the opportunity to learn more about the practices and needs of various cultural and racial groups—practices and

[408] Trisha Greenhalgh and Brian Hurwitz, "Why Study Narrative?" in *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, ed. Trisha Greenhalgh and Brian Hurwitz (London, UK: BMJ Books, 2004), 249.

needs that are presented as being radically *other* and different from that of the provider. But who developed these cultural profiles? And who decided what sort of clinical care was best for cultural minorities? There is no evidence to suggest that these others, the intended beneficiaries of clinical care that is culturally competent, have ever been consulted. Racial and cultural minorities have not been invited into the dialogue or been given the opportunities to shape or critique training programs that are intended to benefit them. There is also no indication that patients from cultural minorities have all articulated a desire for clinical care that is culturally competent (or sensitive, or specific). Generally, it is members of the dominant majority who have defined the needs of the other—subsequently, they have defined the other herself. The unstated claim is that they have come to know the other in ways that Lévinas states are impossible.

In the words of Linda Martín Alcoff, a philosopher and women's studies scholar, "In both the practice of speaking for as well as the practice of speaking about others, [one is] engaging in the act of representing the other's needs, goals, situation, and in fact, *who they are*."[409] Given this pattern, viewed particularly from a Foucauldian understanding of social power, cultural competency, as a discourse, can be interpreted as an exercise of power that only exacerbates the dominance and control held by the majority over those identified as racial minorities, as other. The legitimate knowledge about other cultures is determined by the dominant group just as only authorized speakers may give voice to the values of cultural competency. The racial minority, having been identified as other, becomes the silent,

[409] Linda Martín Alcoff, "The Problem of Speaking for Others," *Cultural Critique* 20 (Winter 1991-1992): 9.

passive, and indirect object of reform, but never an actualized subject contributing to that reform. Her perception of herself is irrelevant.

In a criticism of anthropology that is relevant to the current state of cultural competency, Trinh T. Minh-ha, a professor of women's studies and rhetoric, states, "The conversation ... is, therefore, mainly a conversation of 'us' with 'us' about 'them.'"[410] Trinh continues:

> A conversation of "us" with "us" about "them" is a conversation in which "them" is silenced. "Them" always stands on the other side of the hill, naked and speechless, barely present in its absence. Subject of discussion, "them" is only admitted among "us," the discussing subject, when accompanied or introduced by an "us."... It impels "them" to partake in the reduction of itself and the appropriation of its otherness.[411]

Cultural competency is undeniably focused on an *us* that provides for a *them*, for an *other*. One clear danger, as described above, is that training and services may be based on a false notion of who the other is, an understanding rooted exclusively in the desires and the imagination of the majority.

Speaking for the Other

Speaking for others is a widely criticized activity. Alcoff reports that a strong current within feminism maintains that "speaking for others is arrogant, vain, unethical, and politically illegitimate."[412] Although not always coming to the same conclusion, anthropologists and other social scientists have also reflected on the appropriateness of

[410] Trinh Thi Minh-ha, *Woman, Native, Other: Writing Postcoloniality and Feminism* (Bloomington, IN: Indiana University Press, 1989), 65.

[411] Ibid., 67.

[412] Alcoff, "Problem of Speaking for Others," 6.

speaking for others. To varying degrees most have concluded that there is always some danger in speaking for others. Clifford Geertz is skeptical of the practice of dividing "humanity into those who know and decide and those who are known and are decided for."[413] Further, he is critical of "scholars who have so long regarded themselves as the native's friend, and still think they understand him better than anyone else, including perhaps himself."[414] Gloria E. Anzaldúa, a feminist writer, poet, and scholar, personalizes this concern in an untitled poem when she writes of the fear experienced by an Hispanic woman, "the fear that she's the dreamwork inside someone else's skull."[415]

Alcoff raises two specific concerns. First, she contends that the speaker's social location has an unavoidable and significant impact on what she may say. Who one is and to whom one is speaking may, in many cases, be more important than what is said. The very validity of what one says may be judged exclusively in terms of the social relations of the interlocutors. Second, when those in a privileged social location speak for a group that is less privileged, there is the danger of "increasing and reinforcing the oppression of the group spoken for."[416] In the absence of responsible reflection, the advocate will (knowingly or otherwise) act from a particular understanding of the proper order of society that privileges her. Such an understanding may be influenced by racist tendencies, imperialist

[413] Geertz, *Available Light*, 95.

[414] Ibid.

[415] Gloria E. Anzaldúa, *Borderlands: La Frontera: The New Mestiza*, ed. Gloria E. Anzaldúa and Cherríe Moraga (San Francisco, CA: Spinsters/Aunt Lute, 1987), 43.

[416] Alcoff, "Problem of Speaking for Others," 7.

attitudes, and conceptions of gender that effectively maintain the silence of the nonprivileged.[417]

Gayatri Chakravorty Spivak, a literary scholar and theorist, addresses the social position of the nonprivileged (she uses the tem *subaltern*) and asks the question: "What must the elite do to watch out for the continuing construction of the subaltern?"[418] Spivak reflects on her use of the term *subaltern* when she states:

> I like the word "subaltern" for one reason. It is truly situational. "Subaltern" began as a description of a certain rank in the military. The word was used under censorship by Gramsci: he called Marxism "monism," and was obliged to call the proletarian "subaltern." That word, used under duress, has been transformed into the description of everything that doesn't fall under strict class analysis.[419]

In her essay "Can the Subaltern Speak?" Spivak repeatedly draws the reader's attention to the experience of poor women living in postcolonial societies. However, her cautions and her insights are applicable to relationships with racial minorities in clinical care. In answer to her own question, Spivak insists that while the subaltern may speak or resist, the hegemonic discourse is deaf to her voice.[420] The role of the advocate, then, is to "complete the speech act" on behalf of the one who has been discursively silenced.[421] This work must be done with an awareness of the damage that can be inflicted on the marginalized person

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[417] Ibid., 26.

[418] Gayatri Chakravorty Spivak, "Can the Subaltern Speak?" in *Marxism and Interpretation of Culture*, ed. Cary Nelson and Lawrence Grossberg (Urbana: University of Illinois Press, 1988), 294.

[419] Gayatri Chakravorty Spivak, "Negotiating the Structures of Violence," in *The Post-Colonial Critic: Interview, Strategies, Dialogues*, ed. Sarah Harasym (London: Macmillan, 1990), 141.

[420] Gayatri Chakravorty Spivak, "Subaltern Talk: Interview with the Editors," in *The Spivak Reader: Selected Works of Gayatri Chakravorty Spivak*, ed. Donna Landry and Gerald MacLean (New York, NY: Routledge, 1996), 289.

[421] Spivak, "Can the Subaltern Speak?" 292.

by the very act of helping. In offering assistance, one claims the position of power necessary to render aid. Spivak argues: "In seeking to learn to speak to (rather than listen to or speak for) the historically muted subject of the subaltern ... the postcolonial intellectual *systematically* 'unlearns' ... privilege."[422] In doing otherwise, efforts to provide assistance may succeed only in exacerbating the problems that racial minorities already face when trying to access health-care services.

Many professionals who have invested in cultural competency will insist that they have engaged in the work of learning and teaching (and defining) other cultures with the best of intentions. They will argue that their mission has been to improve the lives of cultural minorities and not subjugate them to further acts of violence or discrimination. Intention, however, is not enough. Lévinas states, "We are thus responsible beyond our intention. It is impossible for the regard that directs the act to avoid the nonintended actions that come with it."[423] In the absence of adequate reflection, benevolent acts may lead to unanticipated and undesirable outcomes.[424]

Edward W. Saïd adds his own perspective on the act of speaking for others. He argues that such practices lead directly to a false and overexaggerated sense of the distance between oneself (or one's society) and the other. Speaking to the divisions that are constructed between societies, Saïd states, "The line ... is less a fact of nature than it is a fact of human production, which I call imaginative geography."[425] He does not dispute that

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[422] Ibid., 295.

[423] Emmanuel Lévinas, "Is Ontology Fundamental?" in *Emmanuel Lévinas: Basic Philosophical Writings*, ed. Adriaan T. Peperzak, Simon Critchley, and Robert Bernasconi (Bloomington, IN: Indiana University Press, 1996), 4.

[424] Gayatri Chakravorty Spivak, *In Other Worlds* (London, UK: Routledge, 1998), 249.

[425] Edward W. Saïd, "Orientalism Reconsidered," *Cultural Critique* 1 (Autumn 1985): 90.

there are cultural differences. However, he insists that such differences are the product of social development and not biological variation. The descriptions of various cultures and societies (as in the case of training materials for cultural competency) are received by the majority as true and accurate. Yet, according to Saïd, as representations, these texts reflect far more. He states, "we must be prepared to accept the fact that a representation is *eo ipso* implicated, intertwined, embedded, interwoven with a great many other things besides the 'truth,' which is itself a representation."[426] Critical of those who conflate text and reality, Saïd states, "It is a fallacy to assume that the swarming, unpredictable, and problematic mess in which human beings live can be understood on the basis of what books—texts—say; to apply what one learns out of a book literally to reality is to risk folly or ruin."[427] Spivak is equally averse to approaching literary texts as transparent windows into the lives of actual people. She insists that subaltern studies "is not the reduction of real life to the page of a book."[428] To approach texts in this way, according to Saïd, is to possess a "*textual* attitude." Yet he acknowledges that in certain situations a textual attitude may be favorable.

One such situation "is when a human being confronts at close quarters something relatively unknown and threatening and previously distant."[429] The example he provides is that of a guidebook used for travel in unknown territory. Although not addressed in his own work, one could extrapolate from this example and envision ways in which literary texts could serve as guides for a safe, somewhat removed reflection on the nature of

[426] Saïd, *Orientalism*, 272.

[427] Ibid., 93.

[428] Spivak, *In Other Worlds*.

[429] Saïd, *Orientalism*, 93.

relationships between social groups. Saïd would certainly agree that using texts to categorically define all racist persons would be equivalent to using texts to define all persons from a single culture or society (and equally irresponsible). Perhaps, however, using texts as guides for forays in the domain of social oppression may prove useful and appropriate. This theory will be explored in greater detail in subsequent chapters.

Finally, Saïd (whose sentiments are echoed by Trinh) warns against treating racial minorities as voiceless objects to be studied as though they were exclusively responsible for the conflict that is being experienced. Instead, Saïd argues that when tensions arise between groups care must be taken to study all participants in the conflict—including the ones conducting the study.[430] Therefore, instead of identifying skills and behaviors that are deemed culturally competent, a deeper understanding of relations (whether of one's self or one's society) to the *other* is necessary. Second to that understanding is the need to explore how efforts to assist the other, however benign, may actually perpetuate models of dominance and exclusion. Although scholars from many different disciplines, particularly literary theorists and philosophers, have explored these issues, such an exploration is generally lacking in discussions and training materials for cultural competency and racial disparities in health care.

Advocating for the Other

Despite the many cautions against speaking for the other, Alcoff warns that retreating from all acts of speaking for others would result in the complete loss of advocacy. Such a retreat, guided by an intellectual understanding of the dangers of speaking for

[430] Saïd, "Orientalism Reconsidered," 90.

others, is likely to develop "into a narcissistic yuppie lifestyle in which a privileged person takes no responsibility for her society whatsoever."[431] Further, remaining silent is never an ethically or politically neutral activity as it permits the perpetuation of social structures of dominance and marginalization. Those who historically have been silenced may never find the leverage they need to make their own voices heard. How then, does one navigate between the need for advocacy and the dangers of speaking for others? Turning to the work of Spivak, Alcoff contends that one may neither retreat from opportunities to speak for the oppressed, nor may one presume to authentically represent their experiences. Instead, according to Spivak, one must foster opportunities for *speaking to* in which a new understanding may be achieved by all participants.[432]

Spivak juxtaposes the theories of Foucault and Gilles Deleuze as she considers the ramifications of representation. The disenfranchised, one can argue, are in need of someone with the discursive authority to speak on their behalf so that systems of exploitation can begin to be dismantled. As nonprivileged, powerless, voiceless individuals, how else might their needs and desires be expressed in places of power and influence? The purpose of bringing the theories of Foucault and Deleuze into dialogue is to draw attention to the ways that political or intellectual representation of the oppressed (by well-intentioned persons) can result in the continued silencing of the already marginalized. According to Spivak, both Foucault (despite the strength of his intellectual work considered

[431] Alcoff, "Problem of Speaking for Others," 17.

[432] Ibid., 23.

above) and Deleuze formulate gross overgeneralizations when they speak of *the oppressed*.[433]

Spivak's point is that political representation has much more in common with artistic representation than it often realizes or acknowledges. The political representative substitutes herself for those she is representing. On their behalf, she speaks in political settings. As an advocate, she articulates their needs and experiences. However, unlike the artist, Spivak points out, the political representative can forget (or deny) that what she presents in various political fora is not the actual people for whom she speaks. Her words are an artistic rendition of those persons on whose behalf she is advocating. The artist is keenly aware that the configurations of oils on a canvas are not the actual bowl of fruit sitting in her studio. With a hammer and chisel in hand, the sculptor creates an image (however realistic) that is separate and apart from the original object (or idea). When the political representative forgets that she does the same, she becomes part of the very system of marginalization that she is seeking to overturn.[434]

Spivak uses the example of widow-sacrifice (*sati*) in British colonial India. Spivak suggests that both opponents and proponents of this practice succeeded in silencing the voice of the women at the center of the issue. By condemning the practice of widow-sacrifice, the British authorities created a case of "White men saving brown women from brown men."[435] Objections were raised by many Indians who advocated for preserving

[433] Spivak, "Can the Subaltern Speak?" 272-274.

[434] Ibid., 276-278.

[435] Ibid., 297.

Indian tradition and cultural identity. They argued: "The women actually want to die."[436] Spivak argues that both positions legitimized each other as "one never encounters the testimony of the women."[437]

From a distance, one may regard the actions taken by British authorities as virtuous and admirable. One may believe that although the widow's voices were ignored, they were, at least, kept alive. In engaging in this sort of thinking, one fails to acknowledge or denies the personal and social violence that is committed by silencing a person or a group of persons. It is not difficult to connect this to the work done by American health-care professionals who have silenced cultural and racial minorities by defining them and speaking for them. To paraphrase Spivak, in the rhetoric of cultural competency, one never encounters the testimony of the cultural stranger.

This is not to say that one should never speak on behalf of another. One of Spivak's reasons for drawing Foucault and Deleuze into her reflection is to criticize them for their abdication of their intellectual responsibilities. Foucault and Deleuze, wary of disempowering others by speaking for them, refused to do so. Instead, they insisted that oppressed subjects must always speak for themselves as only they can "speak, act, and know *for themselves*" what their needs are.[438] This, Spivak believes, denies the political structures that prevent certain voices from being heard. She insists that representation is necessary. However, it must be representation that is mindful of the possibilities of further

[436] Ibid.

[437] Ibid.

[438] Ibid., 276.

violence. If the representative believes that her words are the authentic expression of the ones for whom she speaks, she will have done them a disservice.

When one fails to understand the ethical nature of standing before and responding to the other, violence is often the result. Not all violence is intentional. Benign motivations and laudable intentions, when executed from a place of ignorance, can bring harm to those who were intended to benefit most. In the rhetoric of cultural competency (a concept that has reportedly been developed as a remedy to unjust practices), ignorance of the proper, ethical posture to be taken before the other has led to flawed scholarship and violence, however unintended.

A Need to Respond

States and institutions may enact laws and policies that prohibit discrimination based on race (or on other factors), but discrimination, as an expression of oppression and dominance, is likely to continue. Although racial discrimination has received a great deal of attention in this dissertation, other social groups also suffer from discriminatory practices (some of which are sanctioned by state and federal governments). Discrimination is based upon, but is not limited to, physical gender, gender expression, sexual orientation, age, ability, and economic class. Discrimination, in all its many forms, must be addressed at every level. Presently, with regard to health care, discrimination has been shown to have lasting negative effects on those who are the targets of exclusion and marginalization. Health-care professionals have an obligation to recognize and address these problems, but to do so in ways that promote justice and do not perpetuate models of dominance. Advocates and promoters of cultural competency, as a loose collection of models and

practices, may have had the best of intentions. Unfortunately, the majority of programs that have been developed to instill cultural competency in physicians succeed only in further stripping cultural and racial others of their social power. The concepts that undergird much of the programming in cultural competency are too steeped in the dominant social discourse. As practiced by most, cultural competency will not lead to justice for cultural and racial others. Something else is needed.

According to the American College of Physicians, "when barriers diminish care for a class of patients because the patients themselves are less capable of self-representation, physicians must advocate on their behalf for equitable treatment."[439] However, how this is done must be carefully considered. Before racial disparities and discrimination can be addressed, there must first be a recognition of one's duplicity, however unconscious, with social structures that reflect models of racial inferiority, superiority, dominance, and exclusion. Physicians, medical students, medical educators, must all recognize how they may knowingly or unknowingly contribute to the elevation of those barriers. Further, as Spivak warns, any attempts at advocacy on behalf of those who have been excluded from the general goods of society must be undertaken with a consciousness of the potential (or inevitable) harms that can be inflicted on those for whom one advocates—by the very act of speaking for them.

Judith Andre, a philosopher working in bioethics, challenges faculties at medical schools to attend to the important concept of *moral vision*.[440] According to Andre, the

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[439] American College of Physicians, "Position Paper: Ethics Manual: Fourth Edition," *Annals of Internal Medicine* 128 (1998): 583.

[440] Judith Andre, "Learning to See: Moral Growth during Medical Training," *Journal of Medical Ethics* 18, no. 3 (September 1992): 148-152.

ability to see includes reflection upon both the strengths and weaknesses of institutions. Such moral reflection can lead to institutional change—even if only incrementally. However, in order for one to respond, states Andre, "[O]ne must first recognise that a conflict exists."[441] Unfortunately, a study on the recognition of discrimination showed that those who are able to perceive "discrimination at the societal level often fail to perceive it within their own environment where, in fact, they are better able to make changes."[442] Although the researchers were specifically studying gender-based discrimination, their findings are relevant to this dissertation. In their conclusion they state, "Discrimination can be seen at a glance in aggregated figures, but may not be seen at all when the information trickles in."[443] This insight is especially important when designing programs and curricula. Gloria Anzaldúa argues, "Perception is an interpretive process conditioned by education."[444] How educational programs address or avoid the issues of discrimination and bias will directly affect the availability and the quality of services provided to racial and cultural minorities who are currently experiencing debilitating disparities. Some training programs for cultural competency do include statistics on racial disparity. However, in and of itself, familiarity with the data does not necessarily translate into the ability to recognize these disparities in one's immediate environment. Understanding not only how one has failed to see, but how one has been blinded by one's circumstances is necessary.

[441] Ibid., 148.

[442] Faye Crosby et al., "Cognitive Biases in the Perception of Discrimination: The Importance of Format," *Sex Roles* 14, no. 11/12 (1986): 638.

[443] Ibid., 645.

[444] Anzaldúa, *Making Face, Making Soul = Haciendo Caras*, xxi.

Finally, even when there are those who do recognize the effects of racism, their insights and perspectives are often systematically delegitimized. Criticized for speaking for others, members of the dominant group often have their views categorically disqualified based on the idea that they, as a result of their station, are incapable of understanding the experiences of oppressed persons. Yet Tim Libretti, a literature scholar who regularly addresses issues of class and race, states:

> [Alejandro] Morales [author of *La Verdad sin* Voz] suggests it is not necessary to face a particular oppression in order to fight against that oppression, any more than it is necessary to be destitute in order to fight against poverty, that many people who do not experience a particular form of oppression can learn to identify with those who do and can be enlisted as allies in a common struggle.[445]

This capacity is especially important when one considers how members of oppressed groups are discredited based on the assumption that they are not capable of objectively understanding the situation. Any information that they may provide is deemed unreliable as a direct result of partiality.[446] In the case of white-black relations, Essed reports that black persons are often accused of "oversensitivity to racism."[447] This is a clear of example of Foucault's *rarefication* of speakers. In this case, dissenting voices are, to use Foucault's language, *rarefied* and the system of discrimination is protected.

For physicians to address disparities in health care, there will need to be an understanding of how power functions in social relations and how the exercise of that

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[445] Tim Libretti, "Forgetting Identity, Recovering Politics: Rethinking Chicana/o Nationalism, Identity Politics, and Resistance to Racism in Alejandro Morales's *Death of an Anglo*," *Post Identity* 1, no. 1 (Fall 1997): 86.

[446] Essed, *Understanding Everyday Racism*, 273.

[447] Ibid.

power is often inequitable. Medical students and physicians will need, as Andre has suggested, to learn to see: to see the injustice that pervades our society, to see their complicity in that injustice, to see patients as unknowable, unique individuals to whom they are nonetheless accountable, to see how well meaning reform efforts can often perpetuate violence. Yet most medical school curricula reflect the same limited understanding that has been criticized here. Further, few programs have been designed specifically to foster the type of social consciousness, moral reflection, and advocacy necessary to effect meaningful change.

PART III: SOCIALLY CONSCIOUS MEDICINE

Chapter 7: Learning to Take Social Action

Training programs in cultural competency have focused on the cultural differences that have developed over time between various human societies. It is regularly asserted by advocates of cultural competency that these differences lead to misunderstandings between physician and patient. These misunderstandings are identified as a central cause for race-based disparities in access to and quality of health-care services. This connection (among cultural differences, intercultural misunderstanding, and race-based health disparities) is commonly asserted but never substantiated. It is a theory that has remained untested, unproven. Yet it is a theory that continues to guide efforts to reform medical education. Studies have been conducted to measure the effectiveness of training programs in cultural competency. These studies, however, are limited by both faulty design and limited understanding of the greater issues at hand. Reports on the effectiveness of training in cultural competency rely almost exclusively on the self-assessments performed by participants in the training programs. Further, these studies have not been designed to measure a central tenet of the cultural competency argument: cultural competency leads to the reduction of race-based health disparities. This is a gross oversight. It is unlikely, however, that any such studies would reveal that the assimilation of cultural data by physicians leads to the reduction of race-based disparities in health care. Unfortunately, as

long as race-based disparities are addressed from the perspective of cultural differences, other possible avenues for addressing this problem may never be explored.

Race-based disparities in health and medical care are a social issue. Any solution will require social action. Before acting, however, medical students and health professionals will need to become conscious of the complex set of issues that intersect in the lives of those who are excluded from the medical services and forced to fend for themselves at the edges of society. This is not to say that the cultural practices of patients are insignificant. How culture influences perceptions of and responses to illness must be understood. Learning to listen to the patient and to privilege her account of her own experience will be an important step.

Cultural Humility

Cultural practices, beliefs, and traditions will undeniably influence how some patients express their understanding of their health and shape how they interact with the health-care practitioner. Further, cultural influences can shape how one understands oneself in relation to one's family and to one's society. To pretend otherwise is to deny the variety of cultural practices that have developed in time across human society and the importance of these practices in the lives of their adherents. To deny, or to attempt to *correct*, beliefs that are inconsistent with one's own can have detrimental effects. Judith Lee Kissell, previously introduced for her reflections on Sudanese kinship practices, states:

> What may be at stake among the Sudanese is a view of the world that establishes for each person her role in the world, her economic well-being,

> the protections owed to her by neighbors and friends, whom she should honor when they die, how she should relate to the earth.[448]

What is needed, instead, is an approach to medical education that would

> help prepare [medical students and physicians] for the uncertainty and ambiguity they will have to face as professionals in clinical practice by exposing them to ways of knowing other than the "[p]ositivist epistemology of practice" of professional training in general and of medical training in particular.[449]

Practitioners will meet patients with whom they are unable to communicate because of a language barrier. Practitioners will find themselves in situations where the incongruity between their own culturally shaped expectations and the culturally influenced preferences of the patient will result in irresolvable conflict. Practitioners may feel compelled to rescue their patients from beliefs and perceptions they deem primitive. Curricular interventions that depend upon mastering the cultural data of another group will not be effective in resolving these conflicts and may only make matters worse. Instead of focusing on teaching cultural data to medical students, medical educators should develop programs to instill a respectful, humble attitude in that student and future practitioner. Such an attitude would rest upon a better understanding of the nature of knowledge. Jerome Bruner, a psychologist, whose work will be explored in greater detail later in this dissertation, holds that human beings construct their understanding of reality in terms of stories—narrative.[450] Human knowledge, Bruner insists, is inherently narrative. What one

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[448] Kissell, "Suspended Animation," 526.

[449] Ayelet Kuper, "Literature and Medicine: A Problem of Assessment," *Academic Medicine* 81, no. 10 Suppl. (October 2006): S131.

[450] Jerome Bruner, "The Narrative Construction of Reality," *Critical Inquiry* 18, no. 1 (Autumn 1991): 4.

knows to be true is a narrative construction of reality. Further, and particularly applicable to the argument for a posture of humility before cultural strangers, Bruner argues, "[N]arrative constructions can only achieve 'verisimilitude.'"[451] That is to say, one's knowledge of the world and one's relationship to it can only ever approach likelihood or probability. Writing on *narrative humility*, Sayantani DasGupta, a physician and clinical educator, states, "[W]e cannot ever claim to comprehend the totality of another's story, which is only ever an approximation for the totality of another's self."[452] Absolute truth and incorrupt knowledge are not possible. DasGupta continues, "One very literal aspect of narrative humility is the fact that the patient's story, at least initially, belongs entirely to him."[453] Accepting this requires a degree of humility that is not often appreciated.

By developing an attitude of cultural humility, physicians would be better situated to identify and respond to the needs of the patient—the person—in front of her.[454] Melanie Tervalon and Jann Murray-García, both physicians, delve deeply into the role of humility in cross-cultural clinical encounters. They warn against the false security that can develop in those who make a point to learn the cultural values and practices of another group. Tervalon and Murray-García provide the following case (taken from their experience) as an example:

> 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

[451] Ibid.

[452] Sayantani DasGupta, "Narrative Humility," *Lancet* 371, no. 9617 (March 22, 2008): 980.

[453] Ibid.

[454] Howard Brody and Linda M. Hunt, "Moving Beyond Cultural Stereotypes in End-of-Life Decisions," *Annals of Family Medicine* 71, no. 3 (February 2005): 430.

> 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.[455]

To avoid situations such as this, the authors argue that health-care practitioners must be challenged to address the attitudes they hold towards cultural strangers. Citing research in race-based health disparities, the authors assert, "[A] lack of cultural competence in clinical practice reflects not a lack of knowledge, but rather the need for a change in practitioners' self-awareness and a change in their attitudes towards diverse patients."[456] Ultimately, Tervalon and Murray-García challenge practitioners to develop a sense of humility before the patient who is a cultural stranger.[457] Cultural humility, they suggest, would demand that interviews, interventions, and assessments be focused on the patient's lived experience (as she is able to report it) and not on the knowledge that the practitioner thinks she already has about the patient because of the patient's perceived race, class, or culture. In this model, physicians must come to understand that cultural differences exist *between* themselves and their patients—differences are not qualities possessed by the patients who are cultural strangers. The culturally humble physician will need to reflect on the power imbalance that exists between her and the patient (regardless of the cultures of those present). The sense of humility is evident in the authors' claim that "only the patient is uniquely qualified to help the physician understand" the social, cultural, and political

[455] Melanie Tervalon and Jann Murray-García, "Cultural Humility versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education," *Journal of Health Care for the Poor and Underserved* 9, no. 2 (May 1998): 118-119.

[456] Ibid., 119.

[457] Ibid., 120.

context of her experience.[458] The physician, then, must humbly accept the limits of her knowledge and understanding and come to value the experience of the patient over her own. As opposed to the mastery that is presumed in cultural competency, cultural humility challenges the practitioner to begin a lifelong practice of self-reflection. This reflection, according to Tervalon and Murray-García, is essential to the regular development of "mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations."[459] Howard Brody, a physician and medical ethicist, and Linda M. Hunt, a medical anthropologist, expand on the work of Tervalon and Murray-García when they state that physicians "should be sensitive to the arbitrariness of their own cultural beliefs."[460] Brody and Hunt argue that clinical encounters become problematic when the physician imposes her own (culturally influenced) values on her patient: "Effective cross-cultural care in this setting requires a willingness to learn each patient's preferences and to negotiate mutually acceptable alternatives."[461]

The Limits of Humility

An attitude of humility is certainly essential to respectful and effective clinical care. An abiding awareness that the patient is an *other* who can never be completely known or defined would require that the physician recognize the patient as a collaborator in the clinical encounter and not merely the passive recipient of the physician's medical expertise. Such an approach may indeed improve certain clinical encounters for some racial minorities,

[458] Ibid., 121.

[459] Ibid., 123.

[460] Brody and Hunt, "Moving Beyond Cultural Stereotypes in End-of-Life Decisions," 429.

[461] Ibid.

but humility will not be enough. It is likely that a certain amount of miscommunication or conflict at this level, does, in fact, contribute to health disparities between persons from various cultural groups. However, intercultural miscommunication is not the only factor in health disparities—or even the most influential. Medical educators, therefore, must consider these two (related and overlapping) issues separately. As has been shown, race-based disparities are the fruit of deeply engrained social and cultural practice. It is not enough, therefore, to create space (in the clinic) for the expertise and the voice of the patient in the examination room. It is also necessary to fix one's professional attention beyond the clinic, to see the widespread social structures of oppression, and to respond. Tervalon and Murray-García broach this subject as they acknowledge the disparity of social power that exists between physicians and patients, "particularly the poor."[462] However, they do not, in the context of this short article, explore the manner by which to instill such social awareness in medical students and practitioners.[463] And yet, it is essential to learn to see how one (even one who might otherwise think herself firmly opposed to racial prejudice and oppression) can unknowingly embody and enact those same oppressive forces. Clifford Geertz, an anthropologist, argues that if physicians and patients (particularly patients from oppressed social groups) "are to confront one another in a less destructive way (it is far from certain ... that they actually can) they must explore the character of the space between them."[464] Learning the patient's story is essential. Coming to terms with one's own story is

[462] Tervalon and Murray-García, "Cultural Humility versus Cultural Competence," 120.

[463] Ibid.

[464] Geertz, *Available Light*, 83.

crucial. But, without understanding society's story—the space in between—meaningful change will not be possible.

Socially Conscious Medicine

Rudolph Virchow is often remembered as the father of pathology and credited with orienting the practice of medicine, in the late 1800s, towards the social determinants of health. Virchow is noted for having stated that the "physician was the natural advocate for the poor."[465] For Virchow, medicine had to be practiced in a manner that addressed the ways in which social and economic factors influenced health, and medical practitioners had to work to change those factors that prove most egregious.

In addition to educational models that promote humility in the face of the cultural, religious, familial, and personal frameworks of the patient, medical students and physicians would also benefit from educational models that draw attention to the societal structures that contribute to race-based disparities in access to health care. Over a century after the challenges articulated by Virchow, a document issued collaboratively by three internal medicine federation asserts that medicine must be practiced in ways that promote social justice:

> The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on

[465] Sam Safavi-Abbasi et al., "Rudolf Ludwig Karl Virchow: Pathologist, Physician, Anthropologist, and Politician," *Neurosurgical Focus* 20, no. 6 (2006): E3.

> race, gender, socioeconomic status, ethnicity, religion, or any other social category.[466]

This work requires individual and communal reflection. Further, moral discernment is not a purely intellectual enterprise. As Ronald A. Carson, a medical ethics and humanities scholar, states, "Discernment is personal in that it engages the person of the interpreter, not the intellect alone, but the imagination too—heart as well as head."[467] Unfortunately, when the personal aspect of medical discernment is not attended to, medical students and physicians are left "without guidance when they find they *do* have feelings, reactions, biases."[468] Curricular interventions that will help medical practitioners become "critically aware of their own social location, their own emotions, their own impacts on the situation" are needed.[469] Social power must be attended to. Attention must be drawn to the ways in which well-intentioned relief efforts can perpetuate models of dominance and exclusion. Health-care professionals will need to be encouraged to explore how their own lack of reflection, their own acceptance of the *status quo*, is a political act that serves to preserve unjust practices.

In order to address health disparities in a responsible manner, educational interventions that foster greater insight, vision, discernment, and commitment to justice will need to be developed. The practice of socially conscious medicine requires a deeper understanding of race and race relations, and the arbitrary, political, and manipulative nature of racial designations. Socially conscious medicine requires that one explore and

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[466] "Medical Professionalism in the New Millenium: A Physician Charter," Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine, *Annals of Internal Medicine* 136, no. 3 (February 2002).

[467] Ronald A. Carson, "Interpretive Bioethics: The Way of Discernment," *Theoretical Medicine* 11, no. 1 (March 1990): 55.

[468] Beagan, "Teaching Social and Cultural Awareness to Medical Students," 613.

[469] Ibid.

reflect upon the manner in which knowledge is constructed (and defended) for the purposes of maintaining power over persons. Further, the practitioner of socially conscious medicine must reflect upon her ethical duties to the other and how racial politics and social discourses of power have effectively served to distort that most basic ethical relationship of indebtedness to the other.

What is needed is a model of education that contributes to the medical student's transformation from learner as absorber of data to learner as interpreter and agent of change. Further, such a transformation must also be a transformation of how one identifies one's values, a transformation of perspective, a transformation of purpose, a transformation of the self, and a transformation of society. Social accountability in medicine, Beagan asserts, may only be achieved when students and physicians are encouraged "to promote reflection upon attitudes, beliefs, and biases; to develop skills for critical self-awareness; and to develop understanding of power and privilege."[470] Such an approach will be rooted in effective models of adult education and enrich efforts to train medical students in the skills necessary to *read* their patients, themselves, and their society in the fullest context possible. From this perspective, medical education ought not aspire to cultural competency. Cultural humility may contribute to better patient-doctor encounters. But, ultimately, if health disparities are to be properly addressed, medical students and physicians must be encouraged to develop a social consciousness.

[470] Ibid., 614.

Thinking in Action

Paul Haidet, a physician and health-services researcher, studies various dimensions of the doctor-patient relationship. In his research, he draws attention to one particular aspect of that relationship: improvisation. Drawing comparisons between medical communication and jazz music, Haidet reflects on the creative aspects of medical practice.[471] Haidet identifies three dimensions of communication: "(1) as an act, (2) as a trait, and (3) as an event."[472] Communication as an act, according to Haidet, requires the work of creating space for the other, the patient. The patient needs her own space within which to give voice to her concerns and questions. This act is an act of becoming conscious of the patient's needs, fears, and frustrations.[473] Communication as a trait refers to the development of one's voice. It is not enough to rehearse patient interviews or the preferred manner in which to deliver bad news. Instead, according to Haidet, a physician must develop his or her own style of communicating that is rooted in the fundamentals of clinical medicine but fluid enough to be adapted to the unique case of each new patient.[474] Communication as an event refers to the cultivation of a communication style that is responsive and allows for mutual engagement. This act requires that the physician humbly set aside a model in which only her own voice and her own questions are important. As all of the voices in the conversation join together in a sort of harmony, all participants are given

[471] Paul Haidet, "Jazz and the 'Art' of Medicine: Improvisation in the Medical Encounter," *Annals of Family Medicine* 5, no. 2 (March/April 2007): 164-169.

[472] Ibid., 165.

[473] Ibid.

[474] Ibid., 166.

the opportunity to incorporate "each others' ideas into a common understanding."[475] Haidet is certain that as long as a physician remains dependent upon scripts, never straying from a list of standard questions, she will be unable to hear the full voice of her patient and the patient's perspective will be marginalized. As the patient grows silent, the physician begins, more and more, to speak for and to define the patient. On the contrary, Haidet challenges:

> Physicians must become skilled improvisers, able to efficiently explore the unique aspects of a patient's illness and communicate in a way that is in harmony with that patient's style, all while managing tension between new territory and established patterns.[476]

Haidet is convinced that improvisation is essential to effective communication between patient and physician and contributes to improved outcomes.

Others have considered the important role of improvisation in the clinical encounter. Donald Schön, a philosopher who explores the development of reflective practitioners (across a number of disciplines), reflects extensively on the patterns that distinguish novice technicians from reflective practitioners. Although Schön identifies the value of reflective practice in clinical care, he also acknowledges how the absence of reflection can lead to unjust distribution of medical services. Citing surveys conducted on client populations across the professions, Schön reports that there is a widespread belief that "professionals overcharge for their services, discriminate against the poor and

[475] Ibid., 167.

[476] Ibid., 168.

powerless in favor of the rich and powerful, and refuse to make themselves accountable to the public."[477]

Schön advocates for a move from *technical rationality* to *reflection-in-action*. Schön understands *technical rationality* as a "rule governed inquiry" that draws from the Positivist tradition of defining authentic knowledge as knowledge that is based on actual sense perception.[478] Schön holds that technical rationality "has powerfully shaped both our thinking about the professions and the institutional relations of research, education, and practice."[479] In the wake of the spread of technical rationality, for any assertion to be valid it needed to be placed under analytical or empirical scrutiny. Propositions that were not adequately tested—or failed under such evaluation—"were dismissed as emotive utterance, poetry, or mere nonsense."[480] As Postivism took hold, Schön reports, scholars began to develop rigorous models for theorizing, hypothesizing, and testing to confirm or disconfirm their ideas. Scholars grew confident in their belief that with proper experimentation they could arrive at scientific truths that accurately explained the natural world.

Schön then introduces his readers to "a puzzling anomaly" that developed with regard to practice—the application of these various scientific theories.[481] As Schön explains the dilemma, "Practical knowledge exists, but it does not fit neatly into Positive

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[477] Donald A. Schön, *The Reflective Practitioner: How Professionals Think in Action* (New York, NY: Basic Books, 1983), 12.

[478] Donald A. Schön, *Educating the Reflective Practitioner: Toward a New Design for Teaching and Learning in the Professions* (San Francisco, CA: Jossey-Bass, 1987), 34; and Schön, *The Reflective Practitioner*, 31.

[479] Schön, *The Reflective Practitioner*, 21.

[480] Ibid., 33.

[481] Ibid.

categories."[482] Scientific knowledge, in the positivist model, included descriptions of the natural world and mathematical theory. Practical knowledge did not belong to either of these domains, but neither could it be disregarded. In response to this puzzle, Schön explains that positivist theorists reinterpreted practical knowledge in terms that they found intellectually acceptable: "Practical knowledge was to be construed as knowledge of the relationship of means to ends."[483] Practical knowledge came to be understood in terms of choosing the correct course of action. This choice was to be governed by a strict adherence to an empirical understanding of desired ends. Causal relationships were to be studied and quantified. The appropriate means were to be decided based on observed experience regarding their suitability to achieving the stated goals. Ultimately, according Schön, in technical rationality, "The question, 'How ought I to act?' could become a scientific one, and the best means could be selected by the use of science-based technique."[484]

Technical rationality, as described above, is appealing to those who long for clearly demarcated pathways and testable, provable answers. But technical rationality is not without its limitations. The strengths of technical rationality, as Schön explains, rest upon the assumption that problems are easily identified and fall into predetermined categories. Solutions, then, can be prepared and articulated in advance and indexed for future reference. However, "with this emphasis on problem solving, we ignore problem *setting*, the process by which we define the decision to be made, the ends to be achieved, the

[482] Ibid.

[483] Ibid.

[484] Ibid., 34.

means which may be chosen."[485] Before a solution can be devised, the problem needs to be recognized. Contrary to assumptions embedded within technical rationality, problems do not appear as discrete, easily identifiable situations. As Schön states, "[Problems] must be constructed from the materials of problematic situations which are puzzling, troubling, and uncertain."[486] By attending exclusively to the scientifically sound method for determining an acceptable solution to a specific problem, little attention is given to the skills necessary for recognizing, identifying, and organizing the loose collection of puzzling materials that may or may not be relevant to a problem. In problem setting, the professional *names* the elements that are pertinent to the situation and *frames* a manageable context in which the problem can be solved. Even in skilled hands, all of the pertinent materials will not be noticed or included and the best possible contextual frames will still be susceptible to an incomplete understanding of the situation. It is unlikely, then, that all problems encountered by a professional could be accounted for in advanced with scientifically reasoned solutions at the ready.[487]

Schön considers how technical rationality also relies on the assumption that the appropriate ends are clearly defined and commonly held by all participants. However, there is often great disagreement regarding ends. And, as Schön states, "A conflict of ends cannot be resolved by the use of techniques derived from applied research."[488] Instead, the process of framing is needed to resolve the conflict over the appropriate ends. Only by understanding the specifics of the particular situation is the medical professional (or a team

[485] Ibid., 40.

[486] Ibid.

[487] Ibid.

[488] Ibid., 41.

of professionals) in a position to "organize and clarify both the ends to be achieved and the possible means of achieving them."[489] The likelihood of conflict is only increased when professionals from various disciplines join together in a collaborative effort. Physicians from different specialties (e.g., cardiology, neurology, emergency medicine, etc.) may identify different ends and means for the same medical case. This conflict may be heightened when nonmedical professionals become involved and bring their own values, perspectives, and traditions to the conversation (e.g., social workers, chaplains, administrators, etc.). Finally, the appropriate ends and means for a particular patient may be influenced by nonmedical factors (e.g., financial resources, living conditions, accessibility, etc.). To the extent possible, these various factors need to be named and organized within a manageable frame.

This process of naming and framing comes together in what Schön calls *reflection-in-action*. Reflection-in-action is "central to the 'art' by which practitioners sometimes deal well with situations of uncertainty, instability, uniqueness, and value conflict."[490] Reflection-in-action implies reflecting on or thinking about an action at the same time that one is engaged in that action. This allows for constant renegotiation. Naming and renaming, framing and reframing, are guided by the constant reflective attention being give to one's action. That reflection is shaped by and is responsive to the unexpected discoveries that one makes in the course of a particular action. As Schön explains,

> When intuitive performance leads to surprises, pleasing and promising or unwanted, we may respond by reflecting-in-action ... In such processes,

[489] Ibid.

[490] Ibid., 50.

> reflection tends to focus interactively on the outcomes of action, the action itself, and the intuitive knowing implicit in the action.[491]

The irony of reflection-in-action, as Schön explores in his work, is the fact that it is not unusual. It is a common activity engaged in by children, athletes, musicians, and professionals. Some professions depend on reflection-in-action and recognize the importance of accepting that uncertainty is an integral aspect of any human endeavor. Others, however,

> have become too skillful at techniques of selective inattention, junk categories, and situational control, techniques which they use to preserve the constancy of their knowledge-in-practice. For them, uncertainty is a threat; its admission is a sign of weakness.[492]

In the quest for scientific rigor, the unpredictable negotiations required in naming and framing are avoided by many. And, as a result, reflective practice is set aside. When this happens, one loses the insight that is possible only as a result of the constant reformulation of one's understanding in response to the surprises that one finds in reflective practice.

Like Haidet, Schön recognizes the importance of improvisation in medical practice. Patients' symptoms, reports Schön, do not always present themselves in easily recognizable patterns. Very often, "the case is not 'in the book.'"[493] In these cases, if a physician is to be successful in determining the cause of the patient's symptoms, "she must do so by a kind of improvisation, inventing and testing in the situation strategies of her own devising."[494] Reflective professionals build upon a knowledge base and develop the ability to consider

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[491] Ibid., 56.

[492] Ibid., 69.

[493] Schön, *Educating the Reflective Practitioner*, 5.

[494] Ibid.

problems from new perspectives. These new perspectives are possible only when the professional is confident and humble enough to engage in a process of questioning and listening so that an understanding can be reached that goes beyond the superficial presentation of any case or situation.

> Debates involve conflicting frames not easily resolvable—if resolvable at all—by appeal to data. Those who hold conflicting frames pay attention to different facts and make different sense of the facts they notice. It is not by technical problem solving that we convert problematic situations to well-formed problems rather it is by naming and framing, that technical problem solving becomes possible.[495]

By naming and framing the elements of a problem, one can have a better understanding of the many forces that may be at work in one patient's experience of illness. However, the need for reflective action in health care should be expanded beyond the physician-patient encounter in the examination room. Physicians could engage in the same reflective practice of naming and framing the social context in which they practice. In this act, they may acquire new insight into the number of forces (political, economic, social) that converge in the lives of persons who are barred access to medical services. Schön, however, recognizes the limitations physicians might face in attempting to reflect upon and engage the complicated and overwhelming landscape of health disparities:

> As physicians have turned their attention from traditional images of medical practice to the predicament of the larger health care system, they have come to see the larger system as a "tangled web" that traditional medical knowledge and skill cannot untangle.[496]

[495] Ibid.

[496] Schön, *The Reflective Practitioner*, 14.

If physicians are to succeed in their efforts to reflect upon, rename, and reframe social factors for the purposes of understanding health disparities between racial groups, the insights of educational theorists may provide much needed insight and direction.

Multicultural Education

James A. Banks, a social scientist specializing in multicultural education, has identified four approaches to multicultural education: the *contributions approach*, the *additive approach*, the *transformation approach*, and the *social action approach*.[497] Banks describes each of these approaches as stages in a continuum from less to more desirable (social action being the most desirable). Banks is clear, however, that the approaches with more desirable outcomes require the most investment and planning. Banks's work is focused on creating fruitful learning environments in *multicultural classrooms* where the students represent an increasingly wide range of cultural backgrounds. His theories, however, are directly applicable to the development of educational models for medical curricula that would better prepare students to care for a culturally and racially heterogeneous patient population.

The *contributions approach* will appear quite familiar to many who have been involved in multicultural projects. Commonly referred to as the *heroes and holidays* model, this approach requires the least amount of investment and demands the least amount of revision to a curriculum. In this model, "Heroes, cultural components, holidays, and other discrete elements related to ethnic groups are added to the curriculum on special days,

[497] James A. Banks, "Approaches to Multicultural Curriculum Reform," in *Multicultural Education: Issues and Perspectives*, ed. James A. Banks and Cherry A. McGee Banks (Hoboken, NJ: Wiley, 2006), 247-270.

occasions, and celebrations."[498] Examples of how such an approach is implemented include presentations on what are believed to be typical cultural practices of a particular group (e.g., funerary practices, birth rituals, alternative healing techniques, etc.), an introduction to the foods unique to different cultural groups, and an acknowledgement of key historical figures. These presentations, however, are limited and often presented as an interruption of the established curriculum (and, therefore, a legitimization of that curriculum's claim to being the standard). They may coincide with particular cultural holidays or be incorporated into a *special topics* segment of an established class. This method requires the least amount of preparation and results in the least amount of integration as the existing curricular structure remains intact. Banks and others agree that such an approach leads only to a superficial understanding of cultural differences and tends to reinforce stereotypes. This model, however, is the dominant model in many training programs for cultural competency.

The second model, the *additive approach*, requires only slightly more investment. The general structure of a curriculum is preserved with minimal modification. According to Banks, "This model consists of the addition of content, concepts, themes, and perspectives to the curriculum."[499] Examples of this approach include the addition of works by African-American authors to the syllabus for a literature class, the development of an elective course in Latin American health issues, or the inclusion of diseases that are believed to be racially specific in an epidemiology lecture. The inclusion of these elements, while modestly altering the curriculum, remains separate from the established curriculum. The new cultural material is explored only from the perspective of the dominant group's experience. This

[498] Ibid., 262.

[499] Ibid.

model can reinforce the mistaken belief that the there is a standard or mainstream cultural perspective and that these other practices are not part of that standard. Other cultural experiences and values can become tokenized. In a reflection on her efforts to promote multicultural education at Oberlin College, bell hooks, an education and social activist provided this example: "In women's studies, individuals will often focus on women of color at the very end of the semester or lump everything about race and difference together in one section."[500]

The *transformation approach* is the third stage in the continuum. Requiring much more investment, this model would require more structural changes in curricula and could lead to more significant development in students. In describing this model, Banks states, "The basic goals, structures, and nature of the curriculum are changed to enable students to view concepts, events, issues, problems, and themes from the perspectives of diverse cultural, ethnic, and racial groups."[501] In this model, issues and themes are explored from a number of social perspectives. A curriculum on international health would go beyond the documentation of differences and the presentation of data. Instead, students would be invited to consider the many ways in which all cultural and racial groups are interrelated and how health issues are not so easily defined by skin color or hair texture. Races and cultures begin to be understood as historically interactive and not as isolated and distinct realities. The American perspective is decentralized. This approach, however, requires a great deal of investment. Banks warns that many faculty members would require education and ongoing

[500] bell hooks, "Transformative Pedagogy and Multiculturalism," in *Freedom's Plow: Teaching in the Multicultural Classroom*, ed. Theresa Perry and James W. Fraser (New York, NY: Routledge, 1993), 93. The use of lowercase letters in the author's name is in deference to her own stated preference.

[501] Banks, "Approaches to Multicultural Curriculum Reform," 263.

support. Resources developed by other cultural groups would need to be gathered, investigated, and incorporated.

The final model explored by Banks is the *social action approach*. According to Banks, "In this approach, students identify important social problems and issues, gather pertinent data, clarify their values on the issues, make decisions, and take reflective actions to help resolve the issue of problem."[502] In this model, Banks envisions that students would engage in an exploration of prejudice and discrimination as they are experienced locally and in other settings. Instead of learning a few disconnected facts about persons living in a foreign country or a remote part of their own, they would be challenged to reflect upon the implications of foreign medical aid practices, the incursion of Western culture as a by-product of relief efforts, and the social factors that contribute to race-based health disparities. Students would then be guided in developing responses to particular instances of disparity and the need for the development of just policies.

Banks's social action approach gives shape to the reflection-in-action and improvisation for which Schön, Haidet, and others have advocated. This model, certainly, would require the greatest degree of modification to the existing curriculum. The time needed to identify, understand, and respond to a problem may not fit into current academic schedules. Courses may need to be developed that span across several semesters. Banks also warns that this model is the one most likely to draw students (and faculty) into controversial areas for which there may not be easily attainable solutions. The awareness that such problems exist, however, would prove be a vast improvement to the minimal reflection and engagement required for learning the funerary rites of a particular cultural

[502] Ibid.

group. When reflecting on the challenges of creating a more progressive curriculum, bell hooks comments, "The unwillingness to approach teaching from a standpoint that includes awareness of race, sex, class, etc., is often rooted in the fear that classrooms will be uncontrollable, the emotions and passions will not be contained."[503] Yet, hooks also states, "no education is politically neutral."[504] According to Shirley Grundy, a professor of education and curriculum development,

> Curriculum ... is not a concept; it is a cultural construction. That is, it is not an abstract concept which has some existence outside and prior to human experience. Rather, it is a way of organizing a set of human educational practices.[505]

A curriculum committee that chooses to omit overt reflections of racism out of concern about entering into political territory makes a political statement by giving tacit support for unjust practices. Further, by avoiding these issues in medical school curricula, medical educators are missing a valuable opportunity to contribute to the development of a more just system. Megan Boler, a philosopher and scholar of cultural and feminist studies, states, "Education is by no means merely 'instruction' and transmission of information. Education shapes our values, beliefs, and who and what we become."[506]

Many of the current models for training medical students to be culturally competent tend toward the first (and least valued) approach presented by Banks. This approach may serve only to maintain the otherness of certain social groups, an otherness that allows the

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[503] hooks, "Transformative Pedagogy and Multiculturalism," 93.

[504] bell hooks, *Teaching to Transgress: Education as the Practice of Freedom* (New York, NY: Routledge, 1994), 37.

[505] Shirley Grundy, *Curriculum: Product or Praxis* (London, UK: Taylor and Francis, 1987), 5.

[506] Megan Boler, *Feeling Power: Emotions and Education* (London, UK: Routledge, 1999), xvii.

dominant group to keep those others at a safe distance. Yet, even when efforts to instill cultural competency have been undertaken in good conscience, the methods have proven to be ineffective. Educational models that invite students into deeper reflection on the complex of issues that contribute to race-based health disparities are needed. Such models will need to be based on a sound understanding of adult learning methodologies and incorporate many of the issues explored in this dissertation.

Conscientização

Paulo Freire, a Brazilian educational theorist, is largely known for his contributions to postwar adult education. Temporarily exiled from his own country for his teaching, Freire was an outspoken advocate for literacy education in impoverished communities. Most recently, Freire's theories have been taken up by educators who desire to develop curricular models that are rooted in an awareness of social structures of power and the ways these structures can be perpetuated (consciously or unconsciously) by certain models of education. Freire regularly argued for adult education to be rooted in a participatory style. Only by participating might one develop the skills necessary to perceive economic, political, and social injustices at work in society (i.e., to develop the skills required to engage in Schön's naming and framing). Freire names this process *conscientização*.[507] For Freire, the

[507] In translations of Freire's work, *conscientização* is sometimes left in the original Portuguese with explanatory notes provided by the translator. Others have chosen to translate the term. Some of these translations include *conscientization*, *conscientiation*, *critical consciousness*, or *consciousness raising*. This last translation, consciousness raising, is somewhat problematic and has been criticized by some scholars. Arlene Goldbarb, a cultural development theorist, states that consciousness raising "may involve transmission of preselected knowledge," while *conscientização* "means breaking through prevailing mythologies to reach new levels of awareness—in particular, awareness of oppression, being an 'object' of others' will rather than self-determining 'subject.' The process of conscientization involves identifying contradictions in experience through dialogue and becoming part of the process of changing the world." In this dissertation, the term will appear in the original Portuguese. Arlene Goldbard, *New Creative Community: The Art of Cultural Development* (Oakland, CA: New Village Press, 2006), 242.

process of *conscientização* is the capacity to view one's social context from new perspectives: "A posição crítica é a em que, tomando distância epistemológica da concretude em que estou, com o que a conheço melhor, descubro que a única forma de dela sair está na concretização do sonho, que vira, então, nova concretude."[508] *Conscientização*, according to Freire, "só é possível porque a consciência, condicionada, é capaz de reconhecer-se como tal."[509] Freire's work is known for its emphasis on enlightening and empowering the marginalized and dispossessed members of society. However, Freire also addressed the work of those (e.g., development workers, relief workers, public health workers, etc.) whose work brought them into direct contact with these oppressed groups. Freire argued that, without adequate reflection, these well-intentioned individuals could perpetuate patterns of dominance and oppression.

One of Freire's concerns was the dehumanizing nature of political and economic oppression. For Freire, "A desumanização, que não se verifica nos que têm sua humanidade roubada, mas também, ainda que de forma diferente, nos que a roubam, é distorção da vocação do *ser mais*."[510] Freire affirms that dehumanization is an historical fact; however, he warns, it is the result of a distortion of proper relations between persons and not the

[508] Paulo Freire, *Pedagogia da Indignação: Cartas Pedagógicas e Outros Escritos* (São Paulo, Brazil: Unesp, 2000), 133. Translation: The critical position holds that by gaining an epistemological distance from my concrete situation I can then better understand my situation. Only then will I discover that the only way to leave that situation is to realize my dream and transform my reality.

[509] Paulo Freire, *Ação Cultural para a Liberdade* (Rio de Janeiro, Brazil: Paz e Terra, 1981), 54. [*Conscientização*] Translation: ... is only possible because human consciousness, which is conditioned, has the capacity to recognize itself as such.

[510] Paulo Freire, *Pedagogia do Oprimido*, 46 ed. (São Paulo, Brazil: Paz e Terra, 2000), 32. Translation: Dehumanization, which is not only realized in those who have their humanity stolen, but also (albeit in a different form) in those who have stolen it, is a distortion of the vocation to *be more* fully human.

product of some illusive natural law. Freire insists that dehumanization must be denounced and fought against.[511]

Critical of what he calls the *banking* approach to education, Freire argues against what he recognizes as a prevailing model when he states:

> Desta maneira, a educação se torna um ato de depositar, em que os educandos são os depositários e o educador o depositante. Em lugar de comunicar-se, o educador faz "comunicados" e depósitos que os educandos, meras incidências, receben pacientemente, memorizam e repetem. Eis aí a concepção "bancária" de educação, em que a única margem de ação que se oferece aos educandos é a de receberem os depósitos, guardá-los e arquivá-los. Margem para serem colecionadores ou fichadores das coisas que arquivam. No fundo, porém, os grandes arquivados são os homens, nesta (na melhor das hipóteses) equivocada concepção "bancária" de educação. Arquivados, porque, fora da busca, fora da praxis, os homens não podem ser. Educador e educandos se arquivam na medida em que, nesta distorcida visão de educação, não há criatividade, não há transformação, não há saber. Só existe saber na invenção, na reinvenção, na busca inquieta, impaciente, permanente, que os homens fazem no mundo, com o mundo e com os outros. Busca esperançosa também.[512]

Such models of education, according to Freire, maintain oppressive social orders by preventing the oppressed (and their potential collaborators) from gaining the perspective necessary to address the injustice that hides in plain sight. In medical education, arguments could be made for *depositing* and *archiving* scientific data regarding cell regeneration, the

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[511] Ibid.

[512] Ibid., 66-67. Thus, education becomes an act of depositing, in which students are the depositories and the teacher is the depositor. In place of communicating, the teacher issues "communiqués" and makes deposits which the students, merely incidentals, patiently receive, memorize, and repeat. This is the "banking" model of education, in which the only range of action available to the students is to receive deposits, save them, and file them. They can become collectors and archivists of the materials they store. Ultimately, however, what is archived are the very students themselves in this (at best) misguided "banking" approach to education. They are stored away and archived. When one is separated from inquiry, from practice, one cannot be human. Both teacher and students become filed away because, in this distorted view of education, there is not creativity, no transformation, and no knowledge. Knowledge is created only in the invention and reinvention, in the uneasy, impatient, ongoing, and hopeful quest in which human beings engage in this world. This quest is engaged in the world, with the world, and with each other.

mechanisms of oft-prescribed drugs, and modes of infection. However, medicine is not only science; it is a social enterprise. Recalling Virchow's insight, physicians should be challenged to accept the social aspects of their profession and advocate on behalf of those who would otherwise remain unheard. Yet, if students are introduced to professional and ethical conduct from the same *banking* model of education, "tanto menos desenvolverão em si a consciência crítica de que resultaria a sua inserção no mundo, como transformadores dele."[513]

Conscientização, a goal that Freire articulated for the oppressed, must be considered for the ways in which health-care professionals may be in need of the same expanded perspective on the ways in which certain values, values that foster exclusion and marginalization, may have become incorporated into clinical practice, medical training, and multicultural programming. *Conscientização* can be understood as the means by which someone, fully engaging in one's educational experience, breaks through the discursive mythologies and becomes more aware of ways in which social power is wielded. It is the development of critical thinking. It is being fully human.

To this pedagogical end, Freire argues that a *problem-posing* approach to education is more likely to foster an environment where moral insight and ethical reflection are possible. Freire describes his preferred method as follows:

> Ao contrário da "bancária", a educação problematizadora, respondendo á essência do ser da consciência, que é sua *intencionalidade*, nega os comunicados e existencía a comunicação. Identifica-se com o próprio da consciência que é sempre ser *consciência de*, não apenas quando se intenciona a objetos, mas também quando se volta sobre se mesma, no que

[513] Ibid., 69. Translation: ...the less they will develop the critical consciousness that would result from their insertion into the world, as transformers of the world.

> Jaspers chama de "cisão". Cisão em que e consciência é consciência de consciência.[514]

Freire's problem-solving approach to education is rooted in communication and provides the space necessary for individuals to develop into mature human beings. Participants are transformed as they come to recognize the complex (and sometimes unjust) relationships that surround them and in which they are engaged.

In the pursuit of fostering socially conscious medicine, Freire's *conscientização* would be an essential component of reforms to medical education. Sayantani DasGupta and her colleagues explore the advantages of a Freirian influence in medical education. In the course of their discussion they state:

> The current culture of medicine does not incorporate social issues as central to its practice; moreover, when such a perspective is incorporated into medical education or residency training, issues including health care disparities, culturally and linguistically acceptable care, homelessness, poverty and immigration are usually afforded a one-hour lecture block at the end of a long day of physiology and pathology or situated in the middle of rigorous hospital-based clinical responsibilities.[515]

When social justice issues are presented in this manner, the unstated message is that they are not as important as the scientific knowledge that is being acquired (or deposited). Further, social justice is not an academic subject in the same way that physiology or anatomy are. DasGupta and her colleagues state that it is absurd to attempt to teach social justice in the same manner one teaches the skeletal system. Instead, they suggest, "by

[514] Ibid., 77. Translation: In contrast to "banking" education, problem-posing education, responding to the essence of consciousness (which is *intentionality*) rejects communiqués and gives rise to communication. It identifies itself with consciousness which is always *consciousness of*, not only when attending to objects, but also when turned back on itself in a Jasperian "split," a split in which consciousness is consciousness of consciousness.

[515] Sayantani DasGupta et al., "Medical Education for Social Justice: Paulo Friere Revisited," *Journal of Medical Humanities* 27, no. 4 (Winter 2006): 247.

teaching all relevant subjects, including social justice, in a new way, social justice becomes an integral part of the process of education itself."[516] Quoting the work of Ira Shor, a longtime collaborator of Paulo Freire, DasGupta and her colleagues state, "A Freirian pedagogy would create classrooms and clinics in which 'educators pose critical problems to students, treat them as complicated substantial human beings, and encourage curiosity and activism about knowledge and the world.'"[517]

Freire articulates a clear preference for a pedagogical method rooted in participatory action. However, he recognizes the need for a plurality of methodological approaches. Other approaches, particularly the approach of empirical investigators, is necessary for making the case for the very need for reform. Explicit connections between policy and the social conditions of the oppressed will need to be made.[518] The presentation of empirical data on the social reality of oppression may be necessary to motivate others to action. Empirical data would also serve to measure any objective change in the social climate. Accroding to Freire, "Da mesma forma como é em uma situação concreta—a da opressão—que se instaura a contradição opressor-oprimidos, a superação deta contradição só se pode verificar *objetivamente* também."[519]

[516] Ibid., 248.

[517] Ibid., 249-250.

[518] Paulo Freire, *Cartas a Cristina: Reflexões sobre Minha Vida e Minha Práxis* (São Paulo, Brazil: Unesp, 2003), 202.

[519] Freire, *Pedagogia do Oprimido*, 40. Translation: Just as there is a concrete situation (that of oppression) that has been established in the oppressor-oppressed contradiction, the resolution to that contradiction must be objectively verifiable.

Transformative Learning

For adults, in this case medical students and physicians, learning is the process of making new meaning from one's experiences. The experiences themselves may or may not be new, but when they are perceived, interpreted, and judged in new ways, new meaning is created. Jack Mezirow, an education theorist, differentiated between two dimensions of meaning.[520] Mezirow defines the first dimension as *meaning schemes*. These schemes are the learned patterns by which one interprets her environment. Mezirow provides examples such as how individuals learn to expect that the sun will set in the west and that the consumption of food will satisfy hunger.[521]

The second dimension, *meaning perspectives*, brings the elements of interpretation and judgment into play with one's meaning schemes. Self-concept, perception, social values, and social consciousness are all shaped by meaning perspectives. Mezirow claims that most meaning perspectives are socially conditioned in early childhood. When this is not understood, meaning perspectives can be mistaken for fixed rules rooted in *truth*. Not all meaning perspectives, however, develop without the conscious awareness of the individual. Mezirow states:

> Most meaning perspectives are acquired through cultural assimilation, but others, like positivist, behaviorist, Freudian, or Marxist perspectives, may be intentionally learned. Others are stereotypes we have unintentionally

[520] Jack Mezirow, "How Critical Reflection Triggers Transformative Learning," in *Fostering Critical Reflection in Adulthood: A Guide to Transformative and Emancipatory Learning* (San Francisco, CA: Jossey-Bass, 1990), 1-20.

[521] Ibid., 2.

> learned regarding what it means to be a woman, a parent, a manager, a patriot, a member of a particular racial group, or an older person.[522]

Because meaning perspectives are the basis for judgments made about others, it becomes essential to identify and reflect upon one's perspectives and, when necessary, engage the work of altering (or correcting) them. The need to correct or modify meaning perspectives reinforces a central problem explored in this dissertation: if certain meaning perspectives go unchallenged, certain segments of the population are likely to bear the burden of the stereotypes held by health-care professionals. Health disparities (due to race, age, gender, or sexual orientation) can be traced to negative meaning perspectives held by health-care practitioners and administrators.

In order to revise certain meaning perspectives, Mezirow shows that one must engage in the process of reflecting upon one's beliefs, attitudes, and assumptions. With regard to adult education, Mezirow emphasizes the importance of "reflecting back on prior learning to determine whether what [one has] learned is justified under present circumstances."[523] Mezirow defers to the definition of reflection provided by John Dewey, philosopher and educational reformer, when he defines reflective thought as "active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends."[524] In reflection, one critically assesses and considers the perspectives that one has held for the purposes of justifying actions taken and choices made. Reflection, says Mezirow, is asking

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[522] Ibid., 3.

[523] Ibid., 5.

[524] Jack Mezirow, *Transformative Dimensions of Adult Learning* (San Francisco, CA: Jossey-Bass, 1991), 100; and John Dewey, *How We Think* (New York, NY: D.C. Heath, 1910), 6.

"why [one has] perceived, thought, felt, or acted" a certain way.[525] In reflection, the validity of statements and assertions is tested.

Reflection allows for what Mezirow calls *communicative learning*. Certain that "not all learning involves learning to do," Mezirow draws attention to the need for "understanding the meaning" of what others are attempting to communicate.[526] The understanding that is achieved in communicative learning is achieved through the assessment of the intent "behind the words."[527] All speech, including one's own, is shaped by unspoken assumptions. In communicative learning, one engages in a process of determining those assumptions in what one hears (or reads)—the dominant discourse—and critically analyzing their validity. Words, whether spoken or written, cannot be separated from the assumptions that reside beneath them.[528] Spivak addresses this idea by stating, "If the lines of making sense of something are laid down in a certain way, then you are able to do only those things with that something which are possible within and by arrangement of those lines."[529] Freire emphasizes the power of the hegemonic discourse or ideology as a

> false consciousness, as a distortion or inversion of the real reality or the real concreteness. It's something which puts a kind of veil over reality and over the world. It's something which says that A is B, and not A is A. There are interests, social interests, which make it possible for ideology to operate and work.[530]

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[525] Mezirow, "How Critical Reflection Triggers Transformative Learning," 6.

[526] Ibid., 8.

[527] Jack Mezirow, "Learning to Think like an Adult: Core Concepts of Transformation Theory," in *Learning as Transformation: Critical Perspectives on a Theory* (San Francisco, CA: Jossey-Bass, 2000), 9.

[528] Mezirow, *Transformative Dimensions of Adult Learning*, 9.

[529] Gayatri Chakravorty Spivak, *Outside in the Teaching Machine* (London, UK: Routledge, 1993), 34.

[530] Alice Frazer Evans, Robert A. Evans, and William Bean Kennedy, *Pedagogies for the Non-Poor* (Maryknoll, NY: Orbis Books, 1987), 223.

If injustice is to be addressed, this veil will need to be pierced. Academics, physicians, medical students, relief workers, citizens, must all engage in the work of seeing what resides beneath the commonly accepted *truth*.

Collaborators of Mezirow, Mary Field Belenky and Ann V. Stanton (both educational theorists) reflect on Mezirow's conception of communicative learning. In their assessment, "The goal of communicative learning ... is not winning an argument for argument's sake or proving that one is smart, worthy, or wise." Instead, they argue, "The goal is to achieve consensus about the best judgment the discourse community is capable of reaching with the information currently available."[531] For Mezirow, communicative learning is the core of transformative learning. Transformative learning, holding much in common with the work of Paulo Freire, is the "expansion of consciousness in any human system."[532] This applies both to individuals and to society in general. New ways of perceiving, interpreting, and judging human action extend from transformative learning. At the heart of this process is the transformation of one's understanding of oneself. In the process of transformative learning, there is a change in the "learner's relationship to his or her or the group's identity."[533] Transformation is achieved through a "fundamental reordering of assumptions."[534]

Advocates of transformative learning have recognized the potential for using literature to foster these same goals. Reading literature is recognized as an opportunity for

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[531] Mary Field Belenky and Ann V. Stanton, "Inequality, Development, and Connected Knowing," in *Learning as Transformation: Critical Perspectives on a Theory in Progress* (San Francisco, CA: Jossey-Bass, 2000).

[532] Elizabeth Kasl and Dean Elias, "Creating New Habits of Mind in Small Groups," in *Learning as Transformation: Critical Perspectives on a Theory in Progress* (San Francisco, CA: Jossey-Bass, 2000), 233.

[533] Ibid.

[534] Stephen D. Brookfield, "Transformative Learning as Ideology Critique," in *Learning as Transformation: Critical Perspectives on a Theory in Progress* (San Francisco, CA: Jossey-Bass, 2000), 139.

the *conscientização* of Paulo Freire. Maxine Greene, an educational theorist, states, "Encounters with fiction can and do acquaint people with alternative ways of seeing, feeling, and understanding."[535] Referring to the work of literary critic Louise Rosenblatt, Greene considers how it is possible to engage literature from a purely aesthetic level. Here literature is read and evaluated in terms of its poetic form and the quality of its prose. However, literature can also be engaged in such a way that a change is effected in the reader's lived experience.[536] Greene also suggests that certain works of literature may have the power to inspire a sense of indignation in the reader. The reader, in turn, by exploring the sources of that indignation, is open to the possibility of transformation. Greene believes that reading literature provides the opportunity for the reader "to see, to attend, to notice what was hidden until then."[537]

The concepts explored in this chapter (Haidet's improvisation, Schön's reflection-in-action, Freire's *conscientização*, Mezirow's transformative learning) may all be seen as aspects of the same human endeavor to understand (to the fullest extent possible) and respond to one's social context. These theorists have challenged teachers and learners to consider the need for becoming conscious of both one's own knowledge and perceptions and the social context in which that knowledge was gained. Carson is critical of methods of inquiry that claim to be free of political and cultural influence.[538] Instead, he argues that "the task of discernment is to limn those loyalties, bringing them into line with recalcitrant

[535] Maxine Greene, "Realizing Literature's Emancipatory Potential," in *Fostering Critical Reflection in Adulthood: A Guide to Transformative and Emancipatory Learning* (San Francisco, CA: Jossey-Bass, 1990), 263.

[536] Ibid., 254.

[537] Ibid., 261.

[538] Carson, "Interpretive Bioethics," 52.

circumstances where necessary, altering circumstances to fit convictions where that is called for."[539] Physicians must be aware of their own social and political context. They must understand how this context can shape their attitudes towards certain groups and how those attitudes may, sometimes, need to be modified. They must learn to recognize the social structures that operate to exclude those same (or other) groups and engage, when necessary, in the work of altering those structures. In opening oneself up to one's environment, one may be surprised or dismayed to find that unjust practices go uncorrected, unnoticed, or even protected. The same process by which one becomes conscious of that unjust system is the same process by which one becomes conscious of the forces that work to maintain that system. The personal reflection and transformation that the preceding scholars are calling for are essential to developing a response that would contribute to the transformation of society and the practice of medicine. But, first, one needs to develop the skills necessary for recognizing, identifying, analyzing, and organizing the relevant social factors. As Greene has suggested, these skills may be fostered by engaging literary works. Literary theorists have long argued for the development of narrative skills for the purposes of enhancing clinical skills. Narrative skills must also be recognized for how they can contribute to socially conscious medicine.

[539] Ibid., 53.

Chapter 8: Literature and Medicine

As I discussed in the last chapter, *cultural knowledge* (i.e., awareness of the fluidity of culture and acknowledgement of the wide range of cultural expressions) can be helpful in a multicultural clinical setting, but without the proper foundation such knowledge is easily misused. Joseph Betancourt, a physician and medical educator, acknowledges the importance of cultural knowledge but chooses to locate it in the context of two other essential components: *attitude* and *skill*.[540] For Betancourt, knowledge, skills, and attitude (the classic triad of educational theory), when held in balance, provide a stronger base from which to engage intercultural communication.

In his proposal, Betancourt has evidently drawn from the work initiated by Benjamin Bloom and his colleagues. Bloom and a large team of researchers collaborated on an extensive study of educational domains for learning objectives. Their goal was to articulate a taxonomy for learning objectives. According to the researchers, "It [was] expected to be of general help to all teachers, administrators, professional specialists, and research workers who deal with curricular and evaluation problems."[541] Bloom and his colleagues believed that problems in education were exacerbated by educators' inability to address educational objectives with any precision. When discussing educational goals, reports Bloom, educators would often use a number of different terms and phrases that may or may not have been interchangeable (e.g., "really understand," "internalize knowledge," "grasp the core or

[540] Betancourt, "Cross-Cultural Medical Education," 561.

[541] Benjamin S. Bloom et al., eds., *Taxonomy of Educational Objectives: The Classification of Educational Goals: Handbook I: Cognitive Domain* (New York, NY: David McKay, 1956), 1.

essence," or "comprehend").[542] The research group hoped to provide educators with a taxonomy that would allow for greater understanding and more clearly defined goals in the development of curricula.

The taxonomy was divided into three domains: cognitive, affective, and psychomotor.[543] The researchers acknowledge that they were not the first to have considered a tripartite approach to educational objectives. They did expect that their model would bring a degree of clarity and precision to contemporary discussions and debates regarding curricular development and assessment.

The cognitive domain "includes those objectives which deal with the recall or recognition or knowledge."[544] This domain attends to both the learning capacity of the student and the ability of the student to effectively recall what she has learned. The researchers discovered that the cognitive domain contained the largest proportion of educational objectives.

The affective domain includes "objectives which emphasize a feeling tone, an emotion, or a degree of acceptance or rejection."[545] Objects that fall into this domain deal with "changes in interests, attitude, and values."[546] The researchers described the objectives belonging to this domain as the most challenging to articulate or evaluate. These

[542] Ibid.

[543] Ibid., 7.

[544] Ibid.

[545] David R. Krathwohl, Benjamin S. Bloom, and Bertram B. Masia, *Taxonomy of Educational Objectives: The Classification of Educational Goals: Handbook II: Affective Domain* (New York, NY: David McKay Company, 1956), 7.

[546] Bloom et al., eds., *Taxonomy of Educational Objectives*, 7.

objectives, according to the researchers, include the development of attitudes and feelings that are not observable and, thus, difficult to measure.

The third domain, the psychomotor or motor-skill domain, includes "objectives which emphasize some muscular or motor skill, some manipulation of material and objects."[547] The researchers claim that the objectives included in this domain are more applicable to primary education. Adolescent and adult learners, claim the researchers, generally engage in psychomotor learning objectives only when they are learning skills for a particular trade.[548]

With regard to medical education, cognitive learning objectives would include the acquisition of knowledge regarding disease processes, anatomical structures, drug mechanisms, etc. Medical education would obviously include the objectives from the psychomotor domain. Medical students develop their communication skills and learn to perform physical exams, clinical procedures, invasive surgeries, and specimen analyses. These objectives, as suggested by Bloom and many others, are more easily defined, observed, and assessed. The learning objectives in the affective domain, however, present more of a challenge. Medical students are expected to develop empathy, compassion, and respect for their patients. Certain behaviors have been coded as signifiers of these affective dispositions. Yet the behaviors can be learned and adopted without the corresponding personal, interior growth and development.

As I have argued in this dissertation, in training clinicians to become culturally competent, there has been a great emphasis on the acquisition of knowledge and—

[547] Krathwohl, Bloom, and Masia, *Taxonomy of Educational Objectives*, 7.

[548] Bloom et al., eds., *Taxonomy of Educational Objectives*, 7.

unfortunately—it has been the wrong sort of knowledge. However, when cultural mastery is no longer the goal, the knowledge, skills, and attitude required for providing clinical care for cultural strangers and the development of a social consciousness in clinicians can be seen in a different light. Instead of learning group-specific cultural practices, students should be required to learn *about* culture as a social phenomenon: how it functions, how it evolves, why it is important, and how all persons exist at the intersection of any number of cultures. Students should be required to learn that there is a wide array of healing traditions, nutritional habits, and conceptions of the causation of illness and disease. Without focusing on specific groups, such information would provide students with the opportunities to decentralize their own perspective and to unlearn attitudes of superiority and negative biases. When faced with such diversity, students may better learn the importance of eliciting information directly from their patients and not assuming that they already know everything they need to know simply by having identified the patient by race or by culture. Typical models of medical education have not been effective at challenging students to develop the skills necessary to engage these aspects of clinical practice. Ayelet Kuper (a physician, medical educator, and literary scholar) argues: "[S]tudents need to be taught empathy, self-reflection, and comfort with uncertainty, and ... curricula need to remain open to other subjects that teach the competencies of physician as professional and physician as person."[549]

The skills that are essential to intercultural communication in the clinic are the same skills required in any patient encounter. The student must learn effective interviewing techniques. This requires that clinicians learn to approach each new patient as a new case.

[549] Kuper, "Literature and Medicine: A Problem of Assessment," S134.

Reflective of Benhabib's concept of the concrete other, clinicians must learn to recognize the *specificity* of the patients who seek their assistance. Instead of imposing a preconceived set of expectations on a patient and forcing the patient to conform, clinicians should learn to elicit the patient's understanding of her illness and how she understands her own sociopolitical context. Clinicians must also develop the ability to adapt their communication style to the particular needs of the patient. A student who has developed these skills is more likely to communicate effectively with her patients regardless of the cultural differences between her and the patient.[550]

Success in these two areas, cognitive and psychomotor, however, is largely dependent upon the affective development of the student. If a student is lacking in respect for those who differ from her in culture, race, or class, she may not effectively implement the knowledge or exercise the skills that she has developed in the course of her education. If a student does not believe that it is necessary to consider the broader sociopolitical structures that may negatively affect her patients, she will be less likely to educate herself on relevant social issues and she may not identify the need to advocate on behalf of her patients when the need arises. As a result of the student's (or physician's) attitude, she may not even recognize (or admit) that there is a problem that needs to be addressed. The affective development of the medical practitioner includes both a reflection on one's personal attitudes and biases and a reflection on the predominate attitudes in the society.

[550] Some students may also choose to develop the language skills necessary to speak with patients who do not speak English.

Bloom, Betancourt, and their colleagues acknowledge that this is the most difficult aspect of professional education.[551]

Betancourt explicitly calls for addressing these different educational domains simultaneously in medical education.[552] There is a danger in focusing exclusively on only one domain. Bloom and his colleagues were criticized for not addressing the importance of integrating educational experience across all three domains.[553] Their critics have pointed out that "nearly every cognitive objective has an affective component."[554] For example, medical educators will want for their students to *learn* about health disparities and become familiar with the data and statistics. However, the educators should also want the students to *care* about the injustice of the disparities as only an affective response will motivate students and physicians to work and advocate for systemic change. Betancourt and others are challenging medical educators to develop pedagogical models that are better equipped to attend to the multidimensional development in medical students and physicians. Such models would provide participants the opportunity to positively and constructively integrate newly developed skills and acquired knowledge with attitudes that may have been recently challenged and reshaped. Further, such a model would also provide the tools required for self-assessment and reflection.

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[551] Krathwohl, Bloom, and Masia, *Taxonomy of Educational Objectives*, 15; and Betancourt, "Cross-Cultural Medical Education," 564.

[552] Benhabib, *Situating the Self: Gender, Community, and Postmodernism in Contemporary Ethics*, 564.

[553] Lorin W. Anderson, David R. Krathwohl, and Benjamin Samuel Bloom, *A Taxonomy for Learning, Teaching, and Assessing: A Revision of Bloom's Taxonomy of Educational Objectives* (New York, NY: Longman, 2001), 258.

[554] Ibid.

Narrative and Learning

The work of literary theorists has been especially useful in providing an effective theoretical foundation for modeling educational programs in clinical practice. For, as W. J. T. Mitchell, a well-known literary critic and scholar of art history, states, "the study of narrative is no longer the province of literary specialists or folklorists borrowing their terms from psychology and linguistics but has now become a positive source of insight for all the branches of human and natural science."[555] Donald E. Polkinghorne, a psychologist, argues that human knowing is narrative in nature. Narrative is what allows persons to organize and benefit from the information they acquire throughout their lives.[556] Polkinghorne holds that "narrative is the kind of knowing that is used to understand personal action and autobiography."[557] He states:

> We live immersed in narrative, recounting and reassessing the meanings of our past actions, anticipating the outcomes of our future projects, situating ourselves at the intersection of several stories not yet completed. We explain our actions in terms of plots, and often no other form of explanation can produce sensible statements.[558]

According to Polkinghorne, human understanding arises from a narrative interpretation of lived experience: "[T]he narrative form constitutes human reality into wholes, manifests human values, and bestows meaning on life."[559] However, Polkinghorne stresses, the narrative dimension of understanding is often unrecognized: "The emplotment of events

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[555] W. J. T. Mitchell, ed. *On Narrative* (Chicago, IL: University of Chicago Press, 1981), ix.

[556] Donald E. Polkinghorne, *Narrative Knowing and the Human Sciences* (Albany, NY: State University of New York Press, 1988), 111.

[557] Ibid.

[558] Ibid., 160.

[559] Ibid., 159.

into narrative form is so much a part of our ordinary experience that we are usually not aware of its operation, but only of the experience or reality that it produces."[560]

Medical educators, for some time, have been working to bring a degree of consciousness and intentionality to the manner in which narrative shapes medical and clinical knowledge and guides professional practice. The relationship between literature and medicine is certainly not new. Literature and narrative theory have explicitly been a part of medical education for, at least, the last three decades. Rita Charon (a physician, medical educator, and literary scholar) briefly traces the history of the incorporation of literature and literary methods into medical school curricula.[561] Since the early 1990s, Charon reports, medical schools in the United States have included literature in their curricula, "and in 39% [of the schools reviewed] ... such study was part of a required course."[562]

From many different perspectives, literature can contribute to the development of expert clinicians. Literature and narrative skills are also important tools in recognizing, critiquing, and challenging social and political ills. Frank Lentricchia, a literature scholar and literary critic, advocates for using literature and literary theory

> to make a contribution to the formation of a community different from the one we live in: "society" as the function of many things, one of them being "education." Not all social power is literary power, but all literary power is social power ... The literary act is a social act."[563]

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[560] Ibid., 160.

[561] Rita Charon, "Literature and Medicine: Origins and Destinies," *Academic Medicine* 75, no. 1 (January 2000): 23.

[562] Ibid.

[563] Frank Lentricchia, *Criticism and Social Change* (Chicago, IL: University of Chicago Press, 1983), 19.

Italo Calvino, an Italian journalist and writer of short stories, identifies literature as "one of society's instruments of self awareness," and states, "Literature is necessary to politics [or medicine] above all when it gives a voice to whatever is without a voice, when it gives a name to what as yet has no name, especially to what the language of politics [or medicine] excludes or attempts to exclude."[564]

Several aspects of the use of literature in medicine will be considered here for how they can contribute to the development of socially conscious medicine. A literary approach to medical education can contribute to development in two, overlapping and related domains. One applies to engaging the patient at a personal level while the other takes a global view of justice in health care. First, through the development of narrative skills, physicians can learn to privilege the patient's perspective and frame the situation in the patient's terms. According to Howard Brody, a medical ethicist and physician, when an understanding of the patient's experience "is jointly constructed, power is shared between physician and patient, and the sharing of power constitutes an important ethical safeguard within the relationship."[565] Such an approach would be reflective of the posture of cultural humility for which Tervalon and Murray-García have advocated. Medicine is already recognized for its narrative structure, and it is held that physicians who work to develop competency in narrative skills are better able to elicit and honor the story of the patients who come before them. The development of narrative competency will be explored in greater detail below; however, it is important to note that, from this perspective, physicians who are trained to attend narratively to their patients will be better able to listen for,

[564] Italo Calvino, *The Uses of Literature*, trans. Patrick Creagh (New York, NY: Harcourt Brace, 1986), 98.

[565] Howard Brody, "'My Story Is Broken; Can You Help Me Fix It?' Medical Ethics and the Joint Construction of Narrative," *Literature and Medicine* 13, no. 1 (Spring 1994): 79.

recognize, and attend to cultural differences between themselves and their patients—without the need for training in cultural knowledge specific to certain populations (a practice, as has been shown, which has more negative repercussions than are often acknowledged).

Second, narrative and literature provide the opportunity to expand one's attention from the local level of the patient to the social or global level of policies and practices (often unjust) which shape the practice of health care. The use of literary works can create the space necessary for medical students and physicians to actively participate (an important aspect of Freire's theories), engage in moral inquiry, and learn to recognize, identify, and frame problematic structures in society (as advocated for by Schön). Ideally, the skills developed in this process would be transferred from the stories on the page to the individual's lived experience as she comes to identify how certain power relations can work to limit the availability or the quality of medical services for certain groups (e.g., racial discrimination, abuses of social power, or unethical relations with the *other*). The development of narrative skills can be approached, as will be shown below, through studying narrative theory, reading literary works, or by engaging in the act of writing and recording narratives for oneself—or by all three.

Narrative Skills in Clinical Practice

Kathryn Montgomery, a scholar of literature and medicine, addresses the inseparability of medicine and narrative. Describing the ways in which medical care is initiated, constituted, and guided by narrative, Montgomery states, "Medicine can be

characterized by its dependence upon narrative."[566] Narratives and stories provide the framework necessary for assessing the limits of one's knowledge that is relevant to the case at hand. And narratives provide the means by which physicians communicate with the patient—using stories to explain a patient's medical condition and the measures that will be taken to remedy the situation. The multiple ways in which narrative is applicable to clinical care is "an inalienable part of medicine."[567] According to Montgomery, "Narrative ... is the source and agent of both the knowledge of others and a sense of a moral or professional community, a community of practice."[568] Anne Hudson Jones, a literature-and-medicine scholar, recognizes that a narrative approach to medicine demands "a focus on the patient as narrator of his or her own story."[569] Trisha Greenhalgh and Brian Hurwitz, both physicians and medical educators, argue that "narrative provides meaning, context, and perspective for the patient's predicament. It defines how, why, and in what way he or she is ill."[570] And, Stephen Rachman, a literature-and-medicine scholar, states, "Medicine concerns itself with biological events, to be sure, but those events, once named, enter into language and, as such, are framed by culture and mediated by literature."[571]

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[566] Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton, NJ: Princeton University Press, 1991), 72. Kathryn Montgomery has published extensively under the name Kathryn Montgomery Hunter. Bibliographic citations will reflect the name under which the work was published. However, when discussing her work in my text, I will refer to her as either Montgomery or Kathryn Montgomery.

[567] Ibid.

[568] Kathryn Montgomery Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," *Journal of Medicine and Philosophy* 21, no. 3 (June 1996): 305.

[569] Anne Hudson Jones, "Narrative in Medical Ethics," in *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, ed. Trisha Greenhalgh and Brian Hurwitz (London, UK: BMJ Books, 2004), 222.

[570] Greenhalgh and Hurwitz, "Why Study Narrative?" 6.

[571] Stephen Rachman, "Literature in Medicine," in *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, ed. Trisha Greenhalgh and Brian Hurwitz (London, UK: BMJ Books, 2004), 123.

Martyn Evans, a medical humanities scholar, reflects on three *goods* of medical education as presented in *Tomorrow's Doctors*.[572] These three educational values are: education (as opposed to training), communication skills, and development of personal values. Each of these values, claims Evans, is well served by the incorporation of literature into medical education. While *training* implies the rote assimilation of information, *education* suggests an "imaginative, cultural, intellectual" experience in which the student is invited to consider new possibilities.[573] Evans connects this transition into "larger" realities with the development of literary skills. Literary interpretation, he claims, directly contributes to the "enlarged vision" that is necessary for conceiving of the world and society in new and critical ways.[574]

The second educational value, communication skills, has direct relevance to clinical practice. Evans draws from the work of Rita Charon on the role of literature in helping the medical student or physician learn how to elicit information from the patient in order to develop a better understanding of the patient's personal, political, and social context.

Evans suggests that personal values, the third *good* in medical education, often develop without much reflection: "It is not always easy to say exactly what we believe in or what our values are, even from the vantage point of middle age and mid-career."[575] Literary works, Evans suggests, can provide the space necessary for identifying, critiquing, and reshaping one's values. Connecting to the work of others in this field, Evans points to

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[572] Martyn Evans, "Roles for Literature in Medical Education," *Advances in Psychiatric Treatment* 9, no. 5 (September 2003): 383. *Tomorrow's Doctors* is a publication issued by the General Medical Council in the United Kingdom. General Medical Council, *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education* (London, UK: General Medical Council, 1993).

[573] General Medical Council, *Tomorrow's Doctors*, 383.

[574] Ibid.

[575] Ibid., 384.

the vulnerability that is afforded a reader who approaches a text without her defenses engaged. In this openness, Evans insists, one is allowed a more accurate view of one's most deeply rooted beliefs, values, and biases.

Kathryn Montgomery goes further than suggesting that literature simply *adds* to medicine. Instead, Montgomery insists, medicine is itself a narrative project.[576] She states, "Medicine is not a science. Instead, it is a rational, science-using interlevel, interpretive activity undertaken for the care of a sick person."[577] Ronald Carson argues, "The humanities have gravitated toward medicine because traditional means of interpreting experiences of illness no longer illuminate those experiences and need rethinking."[578] Montgomery elaborates on this point when she states, "Narrative is thus the principle [*sic*] medium of reasoning in medicine; it is not only the form taken by the expert's stock of clinical experience, it represents the process of clinical reasoning itself."[579]

In consideration of the insights reflected above, basing a study of socially conscious medicine on the interpretive strengths of literary studies would be an approach that draws strength from medicine as it is already practiced—physicians working to bridge the gap between the subjective and the objective.[580] Such an approach would also make it difficult to dismiss efforts to train practitioners in the skills needed for intercultural communication

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[576] Antony Kwame Appiah, a philosopher, suggests that human life itself is a narrative project: "We wouldn't recognize a community as human if it had no stories, if its people had no narrative imagination." Kwame Anthony Appiah, *Cosmopolitanism: Ethics in a World of Strangers* (New York, NY: W. W. Norton, 2006), 29.

[577] Hunter, *Doctors' Stories*, 25.

[578] Carson, "Interpretive Bioethics," 54.

[579] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 310.

[580] Hunter, *Doctors' Stories*, 70.

and social consciousness as peripheral or not part of *real medicine*.[581] While there is a strongly held belief that the practice of medicine is a rational, scientific, and transparent practice, experienced clinicians recognize the *messiness* to which both Jerome Bruner and Arthur Frank refer. [582] Yet it is from within this less-than-sterile context that health-care practitioners, on a daily basis, discern effective measures for treating their patients.

For Montgomery, clinical expertise is acquired when "each case is comprehended wholistically."[583] Further, she argues that the means by which physicians can approach (while never fully comprehending) the suffering of their patients is the narrative nature of the patients' experiences. According to Montgomery:

> What we are, the nature of human beings, is a question raised persistently in our encounters with illness, disability, and death. Medicine is ill equipped to answer this question directly. As a human enterprise, medicine speaks primarily through the narratives its practitioners construct as hypotheses about a patient's malady, the stories that convey the medical meaning they have discerned in the text that is the patient.[584]

It is through narrative that one can develop some sense of the meaning of both one's own life and the lives with which one is engaged.[585]

Perhaps unconsciously, physicians employ a narrative approach to *read* their patients and gain insights beyond the reported symptoms. It is to this phenomenon that Trisha Greenhalgh and Brian Hurwitz are speaking when they state: "Understanding the

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[581] Beagan, "Teaching Social and Cultural Awareness to Medical Students," 613.

[582] Bruner, "Narrative Construction of Reality," 4; Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago, IL: University of Chicago Press, 1995).

[583] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 309.

[584] Hunter, *Doctors' Stories*, 25-26.

[585] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 307.

narrative context of illness provides a framework for approaching a patient's problems holistically, as well as revealing diagnostic and therapeutic options."[586] Rita Charon is very critical of medicine that is practiced in the absence of narrative skills and perspective:

> Patients have suffered long enough the consequences of a medicine practiced by doctors without these skills—doctors who cannot follow a narrative thread; who cannot adopt an alien perspective; who become unreliable narrators of other peoples' stories; who are deaf to voice and image; and who do not always include in their regard human motives, yearnings, symbols, and the fellowship born of a common language. Literature thinks it can help medicine accurately interpret the stories of sickness and courageously recognize—and thereby soften—human suffering.[587]

For Charon, the two disciplines, literature and medicine, share similar "beliefs, methods, and goals."[588] In elaborating upon the role of narrative in the practice of medicine, Charon distinguishes between different forms of clinical knowledge when she states, "Logicoscientific knowledge attempts to illuminate the universally true by transcending the particular; narrative knowledge attempts to illuminate the universally true by revealing the particular."[589] Charon defines narrative knowledge as that which one "uses to understand the meaning and significance of stories through cognitive, symbolic, and affective means."[590]

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[586] Trisha Greenhalgh and Brian Hurwitz, "Narrative Based Medicine: Why Study Narrative?" *British Medical Journal (Clinical Research Edition)* 318, no. 7175 (January 2, 1999): 49.

[587] Rita Charon, "Literary Concepts for Medical Readers: Frame, Time, Plot, Desire," in *Teaching Literature and Medicine*, ed. Anne Hunsaker Hawkins and Marilyn Chandler McEntyre (New York, NY: Modern Language Association of America, 2000), 29-30.

[588] Charon, "Literature and Medicine," 23.

[589] Rita Charon, "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust," *JAMA* 286, no. 15 (October 2001): 1898.

[590] Ibid.

Finally, according to Charon, in medical decision making, there are insights and information that "only narrative knowledge can give."[591]

Like Montgomery, Charon acknowledges the importance of the *logicoscientific* foundations of medicine. However, she, like Montgomery, is passionate in her conviction that scientific ability simply is not sufficient in the clinical care of patients: "Along with scientific ability, physicians need the ability to listen to the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient's behalf."[592] Charon defines narrative competence in medicine as

> the set of skills required to recognize, absorb, interpret, and be moved by the stories one hears or reads. This competence requires a combination of textual skills (identifying a story's structure, adopting its multiple perspectives, recognizing metaphors and illusions), creative skills (imagining many interpretations, building curiosity, inventing multiple endings), and affective skills (tolerating uncertainty as a story unfolds, entering the story's mood). Together, these capacities endow a reader or listener with the wherewithal to get the news from stories and to begin to understand their meaning.[593]

The interpretive skills that one develops in learning to read are what contribute to clinical expertise and sound patient care. Charon insists that it is narrative that makes the practice of medicine possible, effective, and trustworthy.[594] By engaging in works of literature, medical students and physicians can develop "interpretive and narrative abilities,

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[591] Rita Charon, "Narrative Contributions to Medical Ethics: Recognition, Formulation, Interpretation, and Validation in the Practice of the Ethicist," in *A Matter of Principles? Ferment in U.S. Bioethics*, ed. Edwin R. DuBose, Ronald P. Hamel, and Laurence J. O'Connell (Valley Forge, PA: Trinity Press International, 1994), 261.

[592] Charon, "Narrative Medicine," 1897.

[593] Rita Charon, "Narrative and Medicine," *New England Journal of Medicine* 350, no. 9 (February 26, 2004): 862.

[594] Charon, "Narrative Medicine," 1897; and Charon, "Narrative Contributions to Medical Ethics," 261.

perspectival vision, and communicative powers."[595] A purely rational or scientific approach to medicine would reduce the patient to bodily systems and that body would be excised from the social system in which it lives. A character in Roddy Doyle's novel *The Woman Who Walked into Doors* addresses this failure in some physicians when she states, "[The doctor] studied parts of me but he never saw all of me."[596] The woman, a victim of domestic violence, longed for someone to take notice—missing hair, teeth, dislocated shoulders, burns—and invite her to tell the story of her life. But in attending exclusively to the physical symptoms, the practitioners were blinded to the broader narrative—a narrative of violence and anguish—of that patient's life. The skills promoted by Charon and others would make it possible for the clinician to obtain a fuller understanding of the patient that stands before her. Charon holds that literary methods in clinical practice "help doctors and patients to achieve contextual understandings of singular human experiences."[597] From the perspective of narrative skills, cultural differences are not problems to be solved (or mastered in advance), but, instead, are part of the context and the narrative of the clinical encounter. The narratively skilled physician will create the space necessary for the specific patient to articulate her values, goals, and perspectives (however culturally, philosophically, or religiously formed).

Narrative, like clinical medicine, is not orderly and does not follow well-illuminated and predictable paths. Instead, Charon states:

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[595] Gillie Bolton, "Medicine and Literature: Writing and Reading," *Journal of Evaluation in Clinical Practice* 11, no. 2 (April 2005): 173.

[596] Roddy Doyle, *The Woman Who Walked into Doors* (London, UK: Jonathan Cape, 1996), 164.

[597] Rita Charon et al., "Literature and Ethical Medicine: Five Cases from Common Practice," *Journal of Medicine and Philosophy* 21, no. 3 (June 1996): 243.

> Narrative makes its own paths, breaks its own constraints, undercuts its own patterns ... [it] can make new out of old, creating chaos out of linearity while, subversively, exposing underlying fresh connections among the seemingly unrelated. Not only through its ordering impulses but also through its *disordering* ones, narrative can help one see newly and for the first time something concealed, something overlaid, something buried in code.[598]

For Charon, narrative knowledge is one possible tool in resisting dominant discourses: "With narrative competence, multiple sources of local—and possibly contradicting—authority replace master authorities."[599] Seeing something new can be an experience of coming to a new consciousness—*conscientização*. Through the literary skills of reflection and interpretation, one can come to terms with the discursive models—often hidden—that shape one's attitudes towards patients, policies, and the practice of medicine.

Developing Narrative Competence

A great many scholars have focused their attention on exploring ways in which to instill narrative competence in medical students and physicians. Largely, these scholars agree on at least three components that contribute to the development of narrative competence. First, medical students and physicians will benefit from a basic introduction to the foundations of literary theory. To that end, Rita Charon advocates for introducing students to some of the components and structures that form a literary work. Many scholars agree that reading and interpreting well-chosen literary texts is another significant component of developing narrative competence. Finally, the actual creation of narratives—that is, writing—has been identified as an essential element in this process. Proponents of

[598] Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford, UK: Oxford University Press, 2006), 219.

[599] Charon, "Narrative Medicine," 1898.

narrative competence in medicine argue that those who invest in the development of these skills will find their "interpersonal relational and empathic capacities ... strengthened."[600]

Narrative Features of Medicine. In working with medical students, Charon emphasizes the importance of developing narrative skills. These skills include the ability "to listen to narratives of illness, to understand what they mean, to attain rich and accurate interpretations of these stories, and to grasp the plights of patients in all their complexity."[601] But, as Charon argues, narrative skills are effective in the practice of medicine because medicine itself already has certain narrative features: *temporality*, *singularity*, *causality/contingency*, *intersubjectivity*, and *ethicality*.[602]

Temporality refers to the time in which "lives and diseases unfold."[603] It also refers to the time that is required of the physician to be present to the patient: "time to listen, time to recognize, time to care."[604] Time is required to develop an understanding of the patient's context (culture, socioeconomic status, religious affiliation, relational/familial status, etc.) as much as it is necessary for allowing a disease to manifest itself in a recognizable manner. When Charon speaks of the *singularity* of medicine, she is referring to the manner in which narrative knowledge "captures the singular, irreplicable, or incommensurable."[605] Singularity, or specificity, is exemplified in the way that "no story ...

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[600] Anne Hudson Jones, "The Color of the Wallpaper: Training for Narrative Ethics," *HEC Forum* 11, no. 1 (March 1999): 58.

[601] Charon, *Narrative Medicine*, 3.

[602] Ibid., 39.

[603] Ibid., 41.

[604] Ibid., 44.

[605] Ibid., 45.

repeats any other story."[606] From that perspective, each patient's case brings its own unique combination of medical, personal, familial, and social features. Taking the time to recognize that *this patient* is not the same as *that patient* (despite any superficial similarities) frees the physician and the patient from the mistakes and the harms that can and do arise from simply superimposing a set of expectations onto a patient and then blaming the patient when she fails to fit within the generic and ill-fitting frame. An important aspect of narrative is the manner in which it helps the reader/listener to make meaning of what may otherwise appear as random and unrelated events. Without a sense of *causality*, it would be impossible to understand why something has happened (illness, recovery, or death). In the search for causality, one is compelled to identify connections between various elements that appear (or are hidden) in the narrative.[607] In clinical practice, the search for causality drives diagnostic interventions and patient interviews. The fourth narrative aspect that Charon addresses is *intersubjectivity*. Clinical practice is, by definition, intersubjective. In medicine, "two subjects ... meet."[608] Drawing from the work of Lévinas, Charon reflects on the manner in which medicine is an expression of the ethical response of the same to attend to the needs of the other. She states, "Like medicine, narrative situations always join one human being with another."[609] An understanding of and an appreciation for the intersubjective nature of medicine is critical if the clinician is to commit to listening closely to her patient so she can join with that patient to bring meaning

[606] Ibid.

[607] Ibid., 48.

[608] Ibid., 50.

[609] Ibid., 52.

to what might otherwise be a chaotic and painful situation.[610] Finally, medicine's narrative *ethicality* arises from the manner in which attending to stories (stories of patients) provides insight that would not be available if one attended only to physical symptoms and laboratory reports.[611] Further, "the receiver of another's narrative owes something to the teller by virtue, now, of knowing it."[612] By learning the story of another, one accepts a certainly responsibility to that other—a need to respond. How one responds—in a very Lévinasian sense—is ethics. Like the reader responding to a text, the clinician is summoned to act by the patient's story.[613] Each of these five features, Charon affirms, "arise in congress, intertwining, emboldening one another."[614]

Reading. Anne Hudson Jones suggests that one approach to developing narrative competence and the ability to read "in the fullest sense" is through structured exposure to "complex written narratives."[615] Jones and Faith McLellan, addressing the contributions of literature to medical education, assert that the interpretation of literary texts reminds physicians "of the totality of the lives of patients they may meet only in limited, fragmented ways."[616] Montgomery suggests that "[t]o read is literally to subject oneself to a different

[610] Ibid., 54.

[611] Ibid., 55.

[612] Ibid.

[613] Ibid., 56.

[614] Ibid., 59.

[615] Anne Hudson Jones, "Narrative Based Medicine: Narrative in Medical Ethics," *British Medical Journal* 318 (1999): 255; and Jones, "Color of the Wallpaper," 58.

[616] M. Faith McLellan and Anne Hudson Jones, "Why Literature and Medicine?" *Lancet* 348, no. 9020 (July 13, 1996): 110.

point of view."[617] Learning to read *in the fullest sense* becomes an opportunity to develop the skills necessary to read one's environment and the society in which one lives.[618]

Many of these scholars insist that narrative is not something new that is being placed over an outmoded system of medicine. Instead, it is new way of understanding what has always been done in the work of comforting and healing the sick. According to Jones, because of "the inherently narrative structure of medical knowledge and practice, doctors' intellectual skills and habits better prepare them for a kind of narrative ethics than for the analytic, principle-based ethics that has dominated medical ethics for the past 25 years."[619] However, this is not to suggest that all physicians are necessarily and automatically narratively competent or that physicians are always cognizant of the narrative manner in which they gain understanding, interpret information, and articulate meaning. Montgomery states:

> Clinical medicine shares its epistemological predicament and its methods of knowing with history, law, economics, anthropology, and other human sciences less certain and more concerned with meaning that the physical sciences. But unlike those disciplines, it does not explicitly recognize its interpretive character or the rules it uses to negotiate meaning.[620]

Instead of recognizing how much of what they know has come to them through interpretation, many physicians will insist that the knowledge they have of their patient is completely objective. Montgomery's assessment is reminiscent of Gayatri Spivak's criticism

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[617] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 312.

[618] Ibid.

[619] Anne Hudson Jones, "Literature and Medicine: Narrative Ethics," *Lancet* 349 (April 26, 1997): 1243.

[620] Kathryn Montgomery Hunter, "'Don't Think Zebras': Uncertainty, Interpretation, and the Place of Paradox in Clinical Education," *Theoretical Medicine* 17, no. 3 (September 1996): 229.

of political representatives who fail to recognize that the representation they provide is, in a sense, an artistic interpretation.

Each of these scholars has been addressing the role that narrative skills and the reading of literature has to play in enabling the physician to comprehend the patient's realm of meaning. As I argued at the beginning of this dissertation, culture can and will affect how patients understand their illnesses and their bodies. Culture will influence how patients communicate their symptoms. Culture will shape how patients respond to the suggestions of the physician. But the only way to know how culture will do these things can come only from the patient and never from preformulated lists. Through the use of narrative skills, the clinician must listen to the patient's story and allow her to articulate how she is shaped by cultural influences.

Additionally, reading and the interpretation of literature challenge the idea that there is one authoritative view of reality.[621] This realization can occur through the observation of the plurality of interpretations of a single text. It may also occur through exposure to points of view foreign to one's own:

> Through literature we can experience and reflect upon things that are totally different from anything we'll ever experience in our own lives: situations, incidents, and issues; cultural and social norms and expectations; different or alien ways of thinking and being; emotions and their effects on people.[622]

By the use of one's imagination, one can gain some small insight into the experience of being misunderstood, unknown, or invisible. Reading oneself into the life of another is an

[621] Victoria Bonebakker, "Literature and Medicine: Humanities at the Heart of Health Care: A Hospital-Based Reading and Discussion Program Developed by the Maine Humanities Council," *Academic Medicine* 78, no. 10 (October 2003): 966.

[622] Bolton, "Medicine and Literature," 172.

opportunity to begin to understand (always in limited ways) how someone else—perhaps someone very unlike oneself—interprets and perceives the world. Further, students and practitioners, reading in a safe environment, can begin to unlearn old patterns of looking at the world around them.[623]

Writing for Skill Development. Charon works to instill a respect for the narrative features in her students by having them create what she calls a Parallel Chart.[624] This teaching tool is an opportunity for students to record their own reactions to what they are experiencing in their clinical encounters. In the instructions that are provided to the students, Charon states:

> If your patient dying of prostate cancer reminds you of your grandfather, who died of that disease last summer, and each time you go into the patient's room, you weep for your grandfather, you cannot write that in the hospital chart. We will not let you. And yet it has to be written somewhere. You write it in the Parallel Chart.[625]

The students are required to share what they have written with Charon (who serves as their preceptor) and the other members of their cohort. Charon is careful to distinguish this activity from "support groups, venting sessions, or group therapy."[626] Instead, the Parallel Chart is intended to bring the students to a deeper awareness of both the patient's experience and their own development as professional healers. The students develop the narrative skills that Charon upholds by the very act of committing their own experiences and

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[623] Jane Adamson, "Against Tidiness: Literature and/versus Moral Philosophy," in *Renegotiating Ethics in Literature, Philosophy, and Theory*, ed. Jane Adamson, Richard Freadman, and David Parker (Cambridge, UK: Cambridge University Press, 1998), 91.

[624] Charon, *Narrative Medicine*, 155.

[625] Ibid., 156.

[626] Ibid.

the experiences of their patients to a narrative form. Studies have been conducted to assess the effectiveness of using the Parallel Chart as a teaching tool. Charon states that the reports indicate that students who participate in this activity are "more effective in conducting medical interviews, performing medical procedures, and developing therapeutic alliances with their patients" and that they "improve their ability to adopt the perspectives of others."[627] Finally, Charon argues, "The more closely the relations between literature and medicine are scrutinized, the better the deep structures of both are understood."[628]

Sayantani DasGupta explored the influence of reflective writing on the development of empathy and perception.[629] DasGupta worked closely with medical students at Columbia University as they explored illness by writing about the experience from a number of perspectives, in a variety of styles, and with different voices. In their work, students were asked to write from the perspective of the ill person or to rewrite an account in the form of a poem or to address the patients' social and cultural contexts. According to DasGupta, "The writing of the 'personal illness narrative' allowed participants to benefit from reflective writing in a new way. Rather than maintaining a clinician's point of view or adopting the point of view of an 'other,' this exercise allowed medical students to explore subjective experiences of illness."[630] One of the fruits of such a process is that participants may have to directly confront biases and prejudices they hold—values that heretofore may have remained unarticulated.

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[627] Ibid., 174.

[628] Charon, "Literary Concepts for Medical Readers," 29.

[629] Sayantani DasGupta and Rita Charon, "Personal Illness Narratives: Using Reflective Writing to Teach Empathy," *Academic Medicine* 79, no. 4 (April 2004): 353.

[630] Ibid., 353-354.

Writing as Assessment. Writing, the construction of narrative, may also be an ideal method for assessing the development of narrative skills. Ayelet Kuper is critical of positivist attempts to assess the development of narrative skills with methods designed to objectively measure a student's success with clinical skills that are more easily observed and delimited. The assessment of narrative skills, according to Kuper, "is resistant to simplified analysis and is not compatible with straightforward positivism."[631] The problem is, as Kuper explains, the very strength of literature and medicine: "[T]here can be no one right answer when discussing a text and, indeed, this very ambiguity is one of the lessons that may be learned from literature and carried forward into the context of patient care."[632] Kuper challenges medical educators to develop new, more appropriate models of assessment for narrative skills. Objective tools (e.g., multiple choice questionnaires), she argues, are inadequate.

Kuper recommends incorporating qualitative evaluative methodologies from the humanities:

> Rather than attempting to apply the rules of quantitative rigor to the qualitative, individualized world of patient experience, physican experience, and ambiguity, we can look to the increasing published recognition that some forms of assessment can be better studied, and some questions better answered, using qualitative methodology.[633]

Reflective writing of students, gathered into portfolios, can serve as a record of the students' accomplishments and development. Kuper argues that there are insights into the students' development that are not accessible through standardized evaluative methods

[631] Kuper, "Literature and Medicine: A Problem of Assessment," S129.

[632] Ibid.

[633] Ibid., S133.

(regardless of efforts made to enhance those methods).[634] She holds that written assignments are an appropriate method of evaluation for narrative-skill development as written work can show the students' ability (or inability) to extract meaning from and interpret stories.[635] Kuper recognizes, as have others, that such an approach to assessment also provides an opportunity for medical students to "explore possible emotional repercussions of a patient's illness."[636] Kuper holds that educators must be properly prepared to implement a narrative method of assessment and that they must adequately prepare the students who may engage in processes with which they are quite unfamiliar. Kuper acknowledges that her proposed methodology will not satisfy the psychometric criteria that are typically used in the evaluation of medical students. However, she argues, "[T]here are rigorous, usable criteria taken from another discourse" that will be equally (if not more) effective in evaluating certain aspects of medical students' professional development.[637]

Practicing Narrative Medicine

At the center of her work in narrative medicine, Charon identifies a conceptual triad: attention, representation, and affiliation.[638] For Charon, these three components related directly to success in "the gathering of information, the keeping of records, the

[634] Ibid.

[635] Ibid.

[636] Ibid., S134.

[637] Ibid.

[638] Charon, *Narrative Medicine*, 186.

making of therapeutic decisions, and the building of relationships over time."[639] *Attention* refers to engaging in the act of attending to one's patient. Charon warns, "The state of attention is complex, demanding, and difficult to achieve."[640] In attending closely to the patient, the physician supports the patient in her task of finding meaning in what may be a difficult situation. Fully attending to the patient is most challenging, perhaps, in the demand it places upon the physician to empty herself by placing herself (and her knowledge, skills, etc.) at the disposal of the patient. What Charon has identified as *attending to the patient* is, perhaps, an embodiment of Lévinas's insistence that the *same* (in this case the physician) has but one proper posture to take before the *other* (the patient): indebtedness and obligation. Attending fully to the patient makes it possible for the physician "to hear patients more accurately and comprehend their situations more fully."[641] Attending more fully to the patient also safeguards the *humanization* (one of Freire's priorities) of the patient.

Attention contributes to the physician's work of representing the patient in written form whether it is in official medical records or in the creative process of writing about patients for one's own reflection and growth.[642] Drawing from the work of philosophers, literary scholars, and phenomenologists, Charon argues that writing (as opposed to talking) "endows the reflections with lasting form and, therefore, gives them existence."[643] Echoing Spivak's cautions, Charon is careful to emphasize that the representation that a physician

[639] Ibid.

[640] Ibid., 132.

[641] Ibid., 135.

[642] Ibid., 236.

[643] Ibid., 139.

crates in her writing is "[b]y no means a Xerox reproduction or neutrally given 'reality.'"[644] Writing, argues Charon, brings experiences to mind in ways that may not occur otherwise. In the process of writing, one is drawn into a process of reflection-in-action in which one is actively engaged in naming and framing (and renaming and reframing) the events and issues surrounding the patient's experience. Through writing, one's understanding of the patient's rich context is deepened and, ideally, one's relationship with those patients are strengthened. As greater attention contributes to deeper representation, sincere representation may inspire one to attend even more deeply. This reciprocal relationship can contribute to the "transformative *contact* of one with another, banishing aloneness, refusing to abandon, demonstrating love."[645]

This transformative contact leads directly to the third feature of Charon's triad: affiliation. According to Charon, "These narrative practices [attention and representation] ... authorize a new kind of affiliation between clinician and patient and among clinicians themselves."[646] Genuine attention and representation lead the physician to action that is more closely oriented towards the patient and her particular situation: "[One] can do things for [one's] patients as a consequence of these narrative actions, achieved dutifully and skillfully."[647] The deeper contact that is possible through a sustained commitment to attention and representation fosters a richer relationship between patient and physician.

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[644] Ibid., 140. Although the inclusion of this warning is important and valuable, more attention could have been given to the dangers of forgetting that one's *representation* is very much the artistic creation of one who has made choices regarding perspective, tone, and content. Charon's work on this issue would be strengthened by a reflection on how the practice of narrative representation may, with guidance and reflection, reinforce this understanding over time.

[645] Ibid.

[646] Ibid., 149.

[647] Ibid., 150.

This richer relationship can contribute to experiences of greater healing or stronger support for those who suffer.

In her exploration of these components of narrative medicine, Charon does not refer to racial of cultural differences that might exist between the patient and the physician. This cannot be an oversight on her part. Within her description of narrative medicine, and the deep affiliation that is fostered between patients and physicians, is a clear understanding that one must always and in every way approach the patient as a distinct other to whom one is obligated to serve and support. One attends to a patient in her unique situation—in her concrete otherness. One struggles to shed, as much as it is possible, one's own biases and motives in trying to respectfully and appropriately represent that patient. In the process, one develops an affiliation with the patient *through* the interpersonal differences and not *despite* them. It could be argued that Charon would accept that medicine practiced well (i.e., narrative medicine) is medicine that has no need of reference cards, flip charts, and manuals full of cultural descriptions. Narrative medicine provides an excellent practical and conceptual foundation for the work of cultural humility proposed by Tervalon and Murray-García.

Narrative Competence and Social Consciousness

Narrative medicine, as has been shown, has much to offer to the practice of medicine. However, the same skills that have been explored here can do more than improve medical communication and care in local, clinical settings. Race-based health disparities are deeply rooted in social structures of dominance, oppression, and distorted views of *others*. Yet the majority of the work on narrative competence focuses on the ways

in which it benefits communication and relationship between individual physicians and individual patients. Charon explores narrative medicine for the way in which in which it facilitates the formulation of "effective dyads."[648] Yet, regardless of how effective communication may be in a clinical dyad, it will not be enough to address destructive and oppressive social structures and patterns. Any solution will need to extend beyond the consultation room (and beyond the clinic).

Charon does begin to address this issue in a short section titled "Narrative Roads to Social Justice."[649] She states, "Rather than submitting to the narrow and the given, narratively informed health care can *re-vision* the goals of medicine to embrace a zeal for health as well as for unity and for justice."[650] She is quick to articulate, however, that narrative cannot and will not be a "cure-all" for the injustice that exists within society and within the health-care system.[651] But narrative skills can contribute to the development of social and political affiliations that may lead to the reduction of disparities in health care based on social and economic status. These affiliations are established, Charon states, "with the oppressed who suffer, with fellow health care workers, and with public health activists in global communities of agency."[652] Perhaps narrative cannot solve every problem, but it can be pressed into greater service than has been done by many of the proponents of narrative or literature and medicine.

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[648] Ibid. Beyond the partnership that is fostered between patient and physician, Charon considers the ways in which narrative medicine can lead to the development of "cohesive professional collectives with colleagues." However, this may still not be enough to address deeply engrained social structures of injustice.

[649] Ibid., 229-234.

[650] Ibid., 229.

[651] Ibid.

[652] Ibid., 231.

Chapter 9: Literature and Moral Reflection

Charon's reflections on the implications of narrative for social justice are insightful, but brief. Here, the work of Megan Boler may help to transform narrative competence in medicine into a project with even greater societal implications.[653] Boler, a philosopher and cultural studies scholar, argues for a pedagogical method that serves, by means of the experience of discomfort, to invite participants to "willingly ... inhabit a more ambiguous and flexible sense of self."[654] The process of inquiry for which she advocates "is a collective, not an individual, process."[655]

Charon, throughout her exploration of narrative medicine, acknowledges the ways in which medical students and physicians can come to greater understanding of themselves in the process of attending, reflecting, and affiliating more closely with their patients.[656] Boler, however, is wary of pedagogical models that place too much emphasis on the reflection and subsequent growth of the individual. Boler is dissatisfied with "Western conceptions of liberal individualism."[657] She argues that personal growth must be both

> (1) collective: "who we feel ourselves to be," how we see ourselves and want to see ourselves, is inextricably intertwined with others. To evidence [one must] examine how our identities, frail and precarious, are bound up with "popular history," with self-images, investments, and beliefs reiterated through the mass media, school textbooks, and dominant cultural values.

[653] Boler, *Feeling Power*.

[654] Ibid., 176.

[655] Ibid., 177.

[656] Charon, *Narrative Medicine*, 135.

[657] Boler, *Feeling Power*, 177.

> (2) flexible: leading to a willingness to reconsider and undergo possible transformation of our self-identity in relation to others and to history.[658]

Individual reflection is too susceptible to rationalized dismissals of new perspectives that are too troubling, too convicting. Further, in isolation from others, moral reflection on injustice may only amount to what Boler refers to as *passive empathy*.

Passive empathy, as described by Boler, amounts to reading or hearing about the misfortune of another and coming to the conclusion that one now understands that experience. Rather than bringing one closer to the other in her experience, this approach serves only to protect and distance one from the experience of suffering and pain. Instead, Boler argues that, upon learning of injustice or misfortune, one must consider in what ways one has been complicit in that situation. To read a story of another's encounter with injustice should enrage one and force one to question what one has believed to be true. This approach, albeit difficult, will lead to personal and social transformation and (perhaps) better position one to enter into the transformative affiliations for which Charon advocates. Boler argues, "A pedagogy of discomfort, then, aims to invite students and educators to examine how our modes of seeing have been shaped specifically by the dominant culture of the historical moment."[659]

Charon calls, repeatedly, for the physician to take action on behalf of the patient by serving the patient to the best of her ability. Boler, too, calls for action. Like Charon, Boler is calling for an increase in *attention*. By attending to the social and political structures that contribute to injustice, one can begin to articulate (represent) the deeper structures that are

[658] Ibid., 178-179.

[659] Ibid., 179.

at work. This reflection will, subsequently, lead one to pay closer attention and the cycle continues. Just as Charon has argued, this reciprocal process should call one to action. But, for Boler, this process must take place in dialogue with others and with history. One's action, while enacted locally, must be oriented globally. In Boler's assessment, the lack of communal orientation in ethical inquiry has, thus far, failed to "provide sufficient response to a system of differential privileges built upon arbitrary social hierarchies."[660]

Judith Andre asked an important question: how does one learn to *see*? Boler, it seems, has taken up this same question and provided some much needed insight. Affirming the need to pay attention, Boler is critical of "inscribed habits of (in)attention."[661] Individuals, with the freedom afforded them by refraining from communal forms of ethical inquiry, can develop habits of blindness and inattention. These patterns are protective and limit the degree to which one feels accountable to act. Boler, deferring to Aristotle, insists that "[t]he ability to see one's own foibles requires ... dialogue and audience."[662] It is for this reason that Boler, like Freire, insists that critical inquiry must be a collective process.

Boler does not specifically address the use of stories or literature in her exploration of a pedagogy of discomfort. Yet her reflections provide a conceptual frame by which to expand the work of Charon and other proponents of narrative competence in medicine. Guided by her insights, medical educators could challenge (and guide and support) students to turn to works of literature for the purposes of leaving "the familiar shores of learned beliefs and habits, and swim further out into the 'foreign' and risky depths of the sea of

[660] Ibid., 180.

[661] Ibid.

[662] Ibid.

ethical and moral differences."[663] This process would require a certain vulnerability and a commitment to ongoing dialogue between the students and the faculty. But once one has recognized and reflected upon the "selectivity of one's vision and emotional attention," one may then be better situated to begin to question the authority claimed by those who have taken it upon themselves to name the *good* and the *normal* in society.

Why Literature?

Jerome Bruner, a psychologist who has studied cognitive learning theory and educational psychology, has tremendous confidence in the power of literature to affect readers in meaningful ways. Bruner acknowledges that the majority of literary analysis is focused on scrutinizing a text for "its structure, its historical context, its linguistic form, its genre, its multiple levels of meaning and the rest."[664] He laments that only occasionally is a text analyzed at a deeper level: "To discover how and in what ways the text affects the reader."[665] This deeper analysis, Bruner suggests, is a way of understanding what makes good stories. Such an understanding, for Bruner, is critical as he holds that life itself is a narrative project: "[W]e organize our experience and our memory of human happenings mainly in the form of narrative—stories, excuses, myths, reasons for doing and not doing, and so on."[666] It could be argued that Bruner is arguing that literature has the power to shape or reshape one's attitudes.

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[663] Ibid., 181.

[664] Jerome Bruner, *Actual Minds, Possible Worlds* (Cambridge, MA: Harvard University Press, 1986), 4.

[665] Ibid.

[666] Bruner, "Narrative Construction of Reality," 4.

When exploring how good literature influences the reader, Bruner describes four interconnected functions of such literature. First, he says, literature "deals with the vicissitudes of human intentions."[667] Bruner, drawing from his knowledge of psychology, emphasizes both the importance and the appeal of intention: "Intention is immediately and intuitively recognizable: it seems to require for its recognition no complex or sophisticated interpretive act on the part of the beholder."[668] Citing the work of other psychologists, Bruner claims that recognizing intention and causation is a primitive human capacity. According to Bruner, It is this deeply embedded human capacity to perceive intention that responds to well-written stories.

The second dimension shared by good stories is the manner in which alternative possibilities are explored. Good stories "initiate and guide a search for meanings among a spectrum of possible meanings."[669] In this way, the reader participates in the creation of the narrative itself. Quoting Wolfgang Iser, a reader-response theorist, Bruner emphasizes the "inherently 'indeterminate'" nature of narrative that allows the reader "to participate both in the production and comprehension of [the literary] work's intention."[670]

A third dimension of the ways well-written literature influences the reader is by engaging the reader with the characters in the text. Bruner describes this experience as "inherently dramatic."[671] His point is that one engages characters in literature based upon

[667] Bruner, *Actual Minds, Possible Worlds*, 16.

[668] Ibid., 17.

[669] Ibid., 25.

[670] Ibid., 24.

[671] Ibid., 39.

one's "beliefs about how people fit in society"—one's attitude.[672] However, the undetermined nature of literature leaves the reader who encounters a character in a story with a dilemma. Conflicts arise as the reader begins to understand that there are a number of possible ways in which she can characterize and interpret the same character in a story. The conflict is heightened when the reader discovers—as Lévinas held—that persons she meets in life are just as indeterminable (if not more so) as the characters in the pages of a book.

Finally, as a result of the other three dimensions, well-written stories provide the opportunity for readers to consider and inhabit alternative realities and other possible worlds. The reader constructs her own text in the process of reading a story. Helena María Viramontes, a writer of fiction and professor of English, states, "That's the power of imagination, peeking beyond the fence of your personal reality and seeing the possibilities thereafter."[673] This alternative text is the site of another possibility, another interpretation, another reality, another social discourse.[674] In the space of these other possible worlds, the reader is given the freedom to test the limits and the validity of the truth claims by which she has lived her life. Arthur W. Frank, a sociologist, describes this process as "thinking with stories."[675] To think with stories, states Frank, "is to experience it affecting one's own life and to find in that effect a certain truth of one's life."[676] By thinking *with* stories and not

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[672] Ibid.

[673] Helena María Viramontes, "'Nopalitos': The Making of Fiction," in *Making Face, Making Soul = Haciendo Caras: Creative and Critical Perspectives by Feminists of Color*, ed. Gloria E. Anzaldúa (San Francisco, CA: Aunt Lute Books, 1990), 292.

[674] Bruner, *Actual Minds, Possible Worlds*, 37.

[675] Frank, *Wounded Storyteller*, 23.

[676] Ibid.

simply *about* stories, one is called to greater responsibility to the truths and insights that one encounters in that space. A valuable aspect of thinking with stories, according to Frank, "is not to move on once the story has been heard, but to continue to live in the story, *becoming* in it, reflecting on who one is becoming."[677]

Stories invite reflection not only on the story, but on life itself. Literature can enable the reader to resist the dominant discourse. In the engagement of good stories, the reader is invited to contemplate the foundational questions of the moral life. This goes far beyond learning a moral at the end of the fable. Instead, readers are challenged to come to a new consciousness about themselves and their society. Thinking with stories is an opportunity for and an invitation to personal transformation. But this transformation must then extend outward as injustice is recognized, named, and redressed.

Literature and Ethical Inquiry

Kathryn Montgomery states, "Literature concerns what might be; it engages the moral imagination."[678] The philosopher Martha C. Nussbaum makes a strong case for philosophers (and others interested in moral inquiry) to turn to literature in their philosophical reflections on morality and ethics. Philosophical inquiry, according to Cora Diamond's interpretation of Nussbaum, would be incomplete without the presence of morally rich works of literature.[679] Literature, according to Nussbaum, has the capacity both

[677] Ibid., 159.

[678] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason."

[679] Cora Diamond, "Martha Nussbaum and the Need for Novels," in *Renegotiating Ethics in Literature, Philosophy, and Theory*, ed. Jane Adamson, Richard Freadman, and David Parker (Cambridge, UK: Cambridge University Press, 1998), 47.

to draw the reader into philosophical analysis and to provide models for that very philosophical exercise:

> [T]his conception of moral attention implies that the moral/aesthetic analogy is also more than analogy. For (as [Henry] James frequently reminds us by his use of the author/reader "we") our own attention to his characters will itself, if we read well, be a high case of moral attention.[680]

For Nussbaum, however, it is not enough to simply *read* through a text. Rather, Nussbaum insists that one must commit oneself to *read well*. Although, as Nussbaum holds, literature may be quite capable of providing the framework for deliberation upon moral questions, it is necessary for readers to accept the responsibility of fully engaging with the characters as they are found in their full literary context.

Howard Brody considers the ideas of those scholars who are skeptical of the legitimacy of the claim that literature contributes to (or even completes) philosophy. Brody deals specifically with bioethicist John Arras who contends that principles are normative in moral inquiry and that stories serve only to facilitate one's comprehension of those principles.[681] Brody, however, refutes this claim and, by drawing upon the work of other scholars, argues that ethical principles are not simply illuminated by stories but are in fact dependent upon them.[682] Brody argues that abstract principles are "toothless" until reflected upon in the form of narratives.[683] Further, discussions of virtue and character are possible only in the context of stories. For one to engage in the work of developing a sense

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[680] Martha C. Nussbaum, *Love's Knowledge: Essays on Philosophy and Literature* (New York, NY: Oxford University Press, 1990), 162.

[681] Howard Brody, *Stories of Sickness*, 2nd ed. (New York, NY: Oxford University Press, 2002), 179.

[682] Ibid., 178.

[683] Ibid., 179.

of virtue, one must be able to reflect upon the narrative structure of one's life. Further still, the possibilities that are opened by stories provides one with the opportunity to explore various principles in the context of imagined human experiences.[684] Brody later elaborates on this practice and reflects upon the act of trying on a new, different, or imagined life experience or perspective.[685] Brody refers to the work of Martha Montello who, states: "[R]eaders [of literary works] are able to try on more lives in a month of reading than they ever could in a lifetime of living."[686] Nussbaum adds, "Our experience is, without fiction, too confined and too parochial."[687] Without the lives that one may try on in the act of reading, one will never have "lived enough" to have the perspective necessary to fully engage some of the more vexing moral and ethical dilemmas that haunt society.[688]

Montgomery argues, "Literature is unmatched for the access it gives to the experience of others, especially the inner lives of patients and the meaning of circumstances physicians cannot (or do not yet) share."[689] It is just such access and insight that leads Nussbaum to argue that literature provides a rich context for moral deliberation. This richness cannot be duplicated by philosophical constructs and examples:

> Schematic philosophers' examples almost always lack the particularity, the emotive appeal, the absorbing plotedness, the variety and indeterminacy, of good fiction; they lack, too, good fiction's way of making the reader a participant and friend; and we have argued that it is precisely in virtue of

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[684] Ibid., 181.

[685] Ibid., 202.

[686] Martha Montello, "Narrative Competence," in *Stories and Their Limits: Narrative Approaches to Bioethics*, ed. Hilde Lindemann Nelson (London, UK: Routledge, 1997), 189.

[687] Nussbaum, *Love's Knowledge*, 47.

[688] Ibid.

[689] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 312.

> these structural characteristics that fiction can play the role it does in our reflective lives.[690]

Nussbaum elaborates on this perspective:

> Interpreting a tragedy is a messier, less determinate, more mysterious matter than assessing a philosophical example; and even when the work has once been interpreted, it remains unexhausted, subject to reassessment, in a way that the example does not.[691]

Literature does more than provide examples of moral quandaries for one who is contemplating the moral life. The reader's very engagement of literature is integral to the moral work itself, for as Nussbaum states in an earlier work, "[Literature] plays a part in our search for truth and for a good life."[692] Further, literature is "an 'optical instrument' through which the reader becomes a reader of his or her own heart."[693] Literature, from this perspective, is essential to philosophy, moral reflection, and professional ethical development.

However, philosophical and moral deliberation does not simply occur as the result of reading a work of literature. In a sense, it is in the space between the work of literature and the philosophical or ethical theory that moral insight occurs. When one *reads well*, one is in dialogue with a text—and it is not a one-way communication. On this point, the philosopher Charles Taylor, states, "We have to maintain a kind of openness to the text, allow ourselves to be interpellated by it, take seriously the way its formulations differ from

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[690] Nussbaum, *Love's Knowledge*, 46.

[691] Martha C. Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy* (Cambridge, UK: Cambridge University Press, 2001), 14.

[692] Nussbaum, *Love's Knowledge*, 228.

[693] Ibid., 47.

ours—all things which a live interlocutor in a situation of equal power would force us to do."[694] Clearly, the printed text does not respond to the reader's questions in the same way as a living, breathing interlocutor. Yet, in engaging the text, the reader has something to say to the text; the reader provides a commentary on what is being experienced. In effect, the reader must be responsible for giving voice to several sides of the conversation—the voice of the text, the voice of the theories she holds to be true, and the voice of her own questioning. It is in this unusual conversation that moral insight can be achieved. This insight, for Nussbaum, should always be new insight into the Aristotelian question: how should I live?

However, theory must not be cast aside for the immediacy of an engaging plot. Nussbaum calls for a balance to be maintained. In the absence of theory, it can become difficult to articulate the moral deliberation and formulate a proper argument that may come from engaging a text. Simply stated, "novel-reading all by itself will not supply those arguments."[695] Further, in the absence of a moral and ethical framework, each new story will remain detached from the next and—more importantly—from life itself. According to Nussbaum:

> Ethical assessment of the novels themselves, in conversation both with other readers and with arguments of moral and political theory, is therefore necessary if the contribution of novels is to be politically fruitful. We are seeking, overall, the best fit between our considered moral and political judgments and the insights offered by our reading. Reading can lead us to alter some of our standing judgments, but it is also the case that these

[694] Charles Taylor, "Understanding the Other: A Gadamerian View on Conceptual Schemes," in *Gadamer's Century: Essays in Honour of Hans-Georg Gadamer*, ed. Jeff Malpas, Ulrich Arnswald, and Jeus Kertsher (Cambridge, MA: MIT Press, 2002), 288.

[695] Martha C. Nussbaum, *Poetic Justice* (Boston, MA: Beacon Press, 1995), 12.

> judgments can cause us to reject some experiences of reading as deforming or pernicious.[696]

While Nussbaum is challenging scholars to move beyond the sterility of philosophical formulae and theories, she is certainly not advocating for a total moral surrender to whatever one encounters in the pages of a novel. Nussbaum is quick to warn that literature must not replace philosophy, but enlarge it. In the absence of theory or dialogue with trusted peers, Nussbaum insists that the reader's emotional response to the novel is insufficient for moral deliberation and, further, "might even prove misleading."[697] Literature needs philosophy, for as Nussbaum states:

> [S]ometimes ... the human heart needs reflection as an ally. Sometimes we need explicit philosophy to return us to the truths of the heart and to permit us to trust that multiplicity, that bewildering indefiniteness. To direct us *to* the "appearances," rather than to somewhere "out there" or *beneath* or *behind* them.[698]

Learning from literature is not intended to be a substitution for learning from life itself. Yet Nussbaum insists that literature provides a reflective context that is simply not available from lived experiences.

Like other scholars considered above, Nussbaum agrees that there can be a certain safety in learning vicariously through the experiences of characters in a novel. There is also safety in, when necessary, criticizing the attitudes and behaviors of those same characters—characters who will not take offense or retaliate. Nussbaum acknowledges this safety when she states that, with regard to fictional characters, "we have no sense of transgression or

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[696] Ibid., 10.

[697] Ibid., 12.

[698] Nussbaum, *Love's Knowledge*, 283.

violation."[699] A reader would be in a position to provide an unrestrained criticism of the discriminatory attitudes and actions of a particular character, an insight she may not have come to were it not for the literary structures of the piece she was reading. In reading, the reader is permitted an attentiveness that may be unavailable or impractical in life (although, with practice, this pattern of attentiveness slowly extends to one's lived experience). In the process of engaging a work of literature with all of its complexities and particularities, Nussbaum holds that "we actively care for the particularity, and we strain to be people on whom none of their subtleties are lost, in intellect and feeling."[700]

Similar to the work of Seyla Benhabib, Nussbaum's reflections on the role of literature in moral deliberation and philosophy are shaped her conviction that such acts must be made from a place of love. Any critical assessment of another must be an act of love. Nussbaum emphasizes this position when she states that the novel "in its very form, emphasizes this idea of the person as a deep and manifold inner world that it would be transgressive for any gesture but that of love to invade."[701] Nussbaum's purpose for calling scholars' attention to love is that moral philosophy must not be an abstract exercise in which one's contemplation is separate from shared human existence. Rather, moral deliberations arise precisely because of one's relationships with others and one's thoughts about and actions towards those others must be motivated by love. Philosophy alone, however, has not adequately addressed love as a human experience. Nussbaum acknowledges the limits of theorizing about love when she states:

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[699] Martha C. Nussbaum, "Reply to Papers," *Philosophical Investigations* 16, no. 1 (January 1993): 73.

[700] Nussbaum, *Love's Knowledge*, 162.

[701] Nussbaum, "Reply to Papers," 73.

> [T]heories about love, especially philosophical theories, fall short of what we discover in the story because they are too simple. They want to find just one thing that love is in the soul, just one thing that its knowledge is, instead of looking to see what is there.[702]

Nussbaum elaborates on this point and emphasizes the very personal nature of the work of genuine moral philosophy when later she writes:

> How clear it is to me that there is no neutral posture of reflection from which one can survey and catalogue the intuitions of one's heart on the subject of love, holding up the rival views to see how well they fit the intuitions—no activity of philosophizing that does not stand in some determinate relation to the love.[703]

For Nussbaum, to act from love is essential to living the moral life. Rather than flee from the uncertainty of human existence that is reflected in well-written literature, Nussbaum argues that "philosophy must be more literary, more closely allied to stories, and more respectful of mystery and open-endedness."[704] In the absence of meaningful reflection on moral questions and social ills, justice is unattainable. And, as Nussbaum continues, "any adequate conception of social justice must rest on some general conception of the human being and human need."[705] When morality and literature are engaged together, scholars are, according to Nussbaum, better situated to reflect on human need and to imagine a just resolution. Literature provides the space to do the work advocated by Schön and Freire.

If, according to Nussbaum, literature and philosophy must be brought together for meaningful moral reflection, how is this to be accomplished? Building on an understanding

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[702] Nussbaum, *Love's Knowledge*, 283.

[703] Ibid., 329.

[704] Ibid., 284.

[705] Nussbaum, "Reply to Papers," 54.

of *reflective equilibrium*, Nussbaum proposes a method she calls *perceptive equilibrium*.[706] In *reflective equilibrium*, developed extensively by the philosopher John Rawls, one engages a moral question by working back and forth between one's intuitions (or *considered judgments*) regarding a specific situation, the principles that are believed to govern such situations, and any theoretical considerations that may weigh on accepting these intuitions and principles. Revisions are made to both throughout the process until equilibrium can be reached. This equilibrium is often described as coherence between one's beliefs about a situation and the principles that pertain to that situation. One's beliefs must be consistent with each other and, further, it is essential that they support each other. The process is complete when no further revision is necessary in order to satisfy the need for coherence.

Nussbaum, however, both extends and transforms this practice. For Nussbaum, *perceptive equilibrium* is "an equilibrium in which concrete perceptions 'hang beautifully together,' both with one another and with the agent's general principles; an equilibrium that is always ready to reconstitute itself in response to the new."[707] For Nussbaum, perceptive equilibrium is the core of moral judgment and understanding. Without it, moral philosophy devolves into an exercise of robotically applying rules to questions that arise (i.e., the technical rationality criticized by Schön). Instead, moral discernment should be a constant "dialogue between perception and rule."[708] Nussbaum describes what one ought to expect from such a process:

> [I]f there is for us any prospect held out for a life that combines perception with the silence and the hidden vision of love, it would only be in a condition

[706] Nussbaum, *Love's Knowledge*, 168-194.

[707] Ibid., 183.

[708] Ibid., 157.

> that is not itself "equilibrium" at all, but an unsteady oscillation between blindness and openness, exclusivity and general concern, fine reading of life and the immersion of love.[709]

Rather than a linear process with clear steps, the goal of moral thinking and discernment "might not be equilibrium at all, but a dynamic tension between two possible irreconcilable visions."[710] It is through discernment that one can come to a deeper understanding of what is needed for virtuous action, what is needed for justice.

Justice and virtue, for Nussbaum, may not be reduced to the interactions between two individuals. Personal ethics are important, but global justice is essential. To this end, Nussbaum advocates for "the life of the cosmopolitan, who puts right before country and universal reason before the symbols of national belonging."[711] Here Nussbaum is calling attention to the ways in which a moral life ought to attend to the real needs of those who suffer, both near and far. A first step in such a life may be the need to develop the skills necessary for recognizing those needs—the particulars of life. Norma Alarcón reflects on the failure to do when she argues, "As tribal 'ethnicities' are broken down by conquest and colonization, bodies are often multiply racialized and dislocated as if they had no other contents."[712] In support of a recognition of the complexities of life, Nussbaum turns to ways in which literature can provide the space for that moral growth. Nussbaum states, "the novel constructs in its imagined reader, an ideal moral judge who bears a close resemblance

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[709] Ibid., 190.

[710] Ibid.

[711] Martha C. Nussbaum, "Patriotism and Cosmopolitanism," in *For Love of Country: Debating the Limits of Patriotism*, ed. Martha C. Nussbaum (Boston, MA: Beacon Press, 1996), 17.

[712] Alarcón, "Chicana Feminism," 250.

to the parties in John Rawls's Original Position."[713] Such an engagement, she affirms, "inspires a passion for justice."[714]

As a "civic use of the imagination," literature can motivate the reader to long for "more truly compassionate" ways of being in the world.[715] For true social justice to be actualized, it cannot be imposed by authorities in the form of sterile laws and policies and it will certainly never come into being if fear of moral ambiguity leads to the abandonment of moral questioning and discernment. Social justice is served by literature, as Nussbaum states:

> Great art plays a central role in our political lives because, showing us the tangled nature of our loves and commitments ... it moderates the optimistic hatred of the actual that makes for a great deal of political violence, moderates the ferocious hopefulness that simply marches over the complicated delicacies of the human heart.[716]

By engaging art (in this case literature), one is able to see one's own life more clearly. According to Cora Diamond,

> What is primarily important for Martha Nussbaum, in her treatment of particular novels ... is the activity of the novelist: his moral vision, his moral achievement. In discussing her claims, people tend to get distracted by the fact that she does direct attention to (among other things) the deliberations of characters in her novels. Her primary focus, though, is always on *how to live*, and how a novel can convey the novelist's view of *that*.[717]

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[713] Nussbaum, *Poetic Justice*, 36.

[714] Ibid.

[715] Nussbaum, *Love's Knowledge*, 217.

[716] Ibid., 213.

[717] Diamond, "Martha Nussbaum and the Need for Novels," 42.

In many cases, one will be in a position to see one's life more clearly than life ordinarily allows itself to be seen. Gillie Bolton, a creative writing theorist, endorses this function of literature when she states, "As I read about the going on *there*—in the fiction—I am empowered to think afresh about issues *here* in my everyday life."[718] The skills developed by learning to read well lead to Schön's goal of reflection in action. By learning to reflect on what one encounters in literature, one can learn to reflect actively upon one's lived experience. The reflective skills developed by engaging literature can translate into the capacity to *reflect in action* in one's relationships and in one's profession. Further, this level of reflection can lead one to the *conscientização* required to recognize, frame, and address social injustice in one's social context.

There is a distance provided by literature that allows for a safe appraisal of a new social landscape. Like Saïd's guidebooks, well-written stories can serve as guides for forays into experiences of injustice, discrimination, exclusion, and powerlessness. Readers are given the opportunity to "suspend immediate habitual value judgments."[719] Bolton is calling for Nussbaum's perceptive equilibrium (while not in name) when she states that when individuals reflectively engage literature, they "are enabled to experiment with very different values," and "having become involved in this way, they ponder afterwards according to their own principles."[720] In this process, the reader may discover that the principles by which she has lived are unacceptable and in need of modification. Moral

[718] Bolton, "Medicine and Literature," 173.

[719] Ibid.

[720] Ibid.

development becomes possible when "habitually held views [are] questioned and perspectives broadened."[721]

Rita Charon holds that in addition to providing the space to deliberate over philosophical questions and ethical problems, a narrative framework can also provide the means by which that problem is first recognized and articulated. Charon focuses her reflection on the literary aspects of identifying and deliberating cases in medical ethics. However, her methods could easily be extended and applied to social and political conflicts. With regard to social injustices that impede certain groups from accessing health-care services, literary or narrative skills enable

> the recognition of the ethical problem, the written or oral formulation of the problem, the interpretation of the ethical case, and the validation of the chosen interpretation as the most reasonable and helpful among the many alternative interpretations available.[722]

A literary framework, then, provides a method for engaging in Schön's *naming* and *framing* of social, ethical, and professional problems.

In order to *recognize* a problem, one must first be attentive. Recognition, states Charon, often comes through an experience of surprise. Deferring to Jerome Bruner's comments on surprise, Charon suggests that one is surprised by events that are contrary to what one has grown to expect.[723] These surprises may be an indication that further attention and investigation are necessary. But, in order to be surprised, one must be attentive to the broader social contexts of patients' lives and medical practice. And, once

[721] Ibid.

[722] Charon, "Narrative Contributions to Medical Ethics," 261.

[723] Ibid., 264.

having been surprised, in order to *name* the relevant components of the problem, one must have developed the *narrative sensitivity* necessary to take note of information that may not always be easily accessible.[724]

The *formulation* of the problem requires an examination of the "beliefs, motives, and relationships" that converge within the problem.[725] Here the "relevant content" of the problem is framed with an eye towards causality and intention.[726] The framer of the problem bears the responsibility of setting the perspective by which the situation will be assessed and must evaluate how her own biases contribute to her assessment of what information is relevant and what information may be discarded. There will never be one correct formulation—only the best possible formulation at the time.

Once the problem has been framed, the next step is to interpret the material. Here the content of the case is brought into dialogue with the "preexisting theories of the interpreters."[727] "Multiple, simultaneous interpretations" are considered as the one engaged in the process considers the ways in which she may need to either modify her own theories or clarify the content of the case (or both).[728]

Charon affirms the importance of *validation* while simultaneously acknowledging the difficulty of doing so in ethical deliberation. The multitude of professional perspectives and the plurality of cultural and religious traditions make it impossible to articulate the *right*

[724] Ibid., 265.

[725] Ibid., 267.

[726] Ibid., 266.

[727] Ibid., 272.

[728] Ibid.

answer.[729] Validation of a decision may only come through the long-term observation of the effects of that decision—that is to say, by following the story on into the future.[730]

The moral and ethical deliberation required in reflecting upon race-based discrimination, the harmful effects of unjust distributions of power, and the violence that occurs when one group defines another group to their own advantage can occur within the pages of well-written literature. The stories that are discovered can provide the opportunity to see what has remained hidden in one's lived experience and bring one to *conscientização*. The narrative skills that one develops in the process of moral inquiry in a text could be translated to the inquiry necessary for naming, framing, and responding to ethical and moral dilemmas that exist in society.

Unlearning through Literature

Boler reflects directly on the need to recognize learned habits of inattention. She insists that it must be an invitation (and not an obligation), but she argues that avoiding this important work will leave one incapable of truly seeing and understanding one's social and political context. In effect, Boler articulates an invitation to *un*learn old ways of seeing (or not seeing). *Unlearning* is an essential component of learning to practice socially conscious medicine. One must unlearn fixed and narrow ways of perceiving certain patients and their situations. Anzaldúa refers to this as *selective reality* and defines it as "the narrow spectrum

[729] Ibid., 275.

[730] Ibid.

of reality that human beings select or choose to perceive and/or what their culture 'selects' for them to 'see.'"[731]

In an essay on geography and postcolonial societies, Cheryl McEwan, a lecturer in human geography, reflects on the work of Spivak:

> Spivak's "unlearning" of privilege involves working hard to gain knowledge of others who occupy spaces most closed to our privileged view and attempting to speak to those others in a way that they might take seriously and be able to answer back.[732]

Students and physicians (and all persons) carry with them unexamined perceptions of certain social groups. According to Paul Lauter, a professor of English, "Literary texts are very helpful ... in penetrating the ideological screens that disable student perceptions."[733] Clark, Zuk, and Baramee reiterate this sentiment:

> Literature helps us to reconsider the otherness of our clients and unmask our own stereotypes and myths about culturally different clients. "Educators can help students move through this process beyond the childhood egocentric worldview that most people are 'just like me' where 'like me' is a positive and 'unlike me' is a negative."[734]

The contributions that literature can make to communication (clinical or otherwise) are undeniable. The greater understanding that can come through broadening one's view of

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[731] Anzaldúa, *Making Face, Making Soul = Haciendo Caras*, xxi.

[732] Cheryl McEwan, "Material Geographies and Postcolonialism," *Singapore Journal of Tropical Geography* 24, no. 3 (November 2003): 348.

[733] Paul Lauter, "Teaching History through Immigration Stories," *Magazine of History* 13, no. 2 (Winter 1999): 10.

[734] Clark, Zuk, and Baramee, "A Literary Approach to Teaching Cultural Competence," 202.

the human condition can do much to improve one's communication skills as one unlearns certain habits and patterns and learns to listen to what is beyond the familiar.[735]

When reflecting on the role of education and the cultivation of a mature approach to human relationships, Anthony Cunningham, a philosopher, states, "The goal is not to eliminate anger but to educate it."[736] Cunningham's point is that emotional reactions are not authoritative in and of themselves. At times, one's emotional reaction is shaped by an inappropriate expectation or a limited understanding of a local or global situation. One may become angry because one does not get what one wants—despite the fact that what one wants may be morally or ethically questionable. Cunningham stresses the importance of unlearning immature attitudes and expectations.

Moral Reflection with Short Stories

There is a fair amount of debate regarding which genre is most appropriate for the work of ethical enquiry as articulated by Martha Nussbaum and others. Wayne C. Booth (a scholar of English literature), for example, argues: "When I read only a few pages, I simply do not dwell with a character's spirit for long enough to become thoroughly enamored, thoroughly reconstituted by his or her patterns of hopes and fears."[737] Booth apparently rejects the idea that short stories can provide enough material for adequate moral reflection. Others, however, are open to the use of short stories and other genres.

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[735] Bolton, "Medicine and Literature," 172.

[736] Anthony Cunningham, *The Heart of What Matters: The Role for Literature in Moral Philosophy* (Berkeley, CA: University of California, 2001), 120.

[737] Wayne C. Booth, *The Company We Keep: An Ethics of Fiction* (Berkeley, CA: University of California Press, 1988), 430-431.

Nussbaum has a stated preference for novels, yet she confesses that "neither all nor only novels" may be used for the work she proposes.[738] She favors novels because of the power they have to "focus in some manner on our common humanity, through their structures of friendship and identification, and thus make some contribution to the pursuit of those projects."[739] Yet she recognizes that "[n]ot only novels prove appropriate."[740] While allowing for other literary forms (e.g., short stories), Nussbaum insists that they must be "written in a style that gives sufficient attention to particularity and emotion, and so long as they involve their readers in relevant activities of searching and feeling, especially concerning their own possibilities as well as those of the characters."[741] Other advocates of using literature in moral reflection also advocate for the acceptability of short stories (without, however, articulating, as Nussbaum has done, a standard for choosing appropriate works). Martha Montello, a literature scholar, recognizes both novels and short stories as "principal vehicles of moral vision and change."[742] Charon, who appears to favor the use of novels, acknowledges the unique qualities that various literary genres (including short stories) offer to this process.[743] Montgomery identifies the value of not only short stories but also plays and movies.[744]

The use of literature in moral discernment, therefore, is not limited to lengthy novels. Nussbaum's conditions are suggestive of the oft-quoted adage that values quality

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[738] Nussbaum, *Love's Knowledge*, 45.

[739] Ibid.

[740] Ibid., 46.

[741] Ibid.

[742] Montello, "Narrative Competence," 189.

[743] Charon, *Narrative Medicine*, 117.

[744] Hunter, *Doctors' Stories*, 53.

over quantity. If one is to use short stories for the purposes of ethical reflection and discernment, one bears the responsibility of choosing works that are rich and deep enough to *search* and *feel* one's way along the path of discernment.

Reading Is Not Enough

Novels, short stories, poems, and literary nonfiction about persons from a particular culture must not be understood as transparent and generalizable descriptions of all members who may identify (or be identified) with that specific cultural group. As has been explored in this dissertation, cultures are far too complex and fluid to be represented in their entirety in tersely written encyclopedic descriptions or even in well-written works of literature. Using *The Color Purple*, for example, to teach medical students that all African-American families are "resourceful and resilient" or that they all use storytelling "as a medium through which healing occurs" reduces all African Americans to a single, acceptable, and controllable definition.[745] Contrary to the suggestion of Ardis C. Martin, a physician, Ellison's *The Invisible Man* does not describe "*the* African-American man."[746]

Even when cultural essentializing is not the intention of the educator, efforts must still be made to challenge students to avoid generalizing the personal characteristics they discover in the characters of a story. Without proper guidance, many students will mistakenly "go beyond the particular and think that [they have] learned something about a

[745] Genevieve M. Bartol and Lenora Richardson, "Using Literature to Create Cultural Competence," *Image* 30, no. 1 (1998): 77.

[746] Ardis C. Martin, "The Use of Film, Literature, and Music in Becoming Culturally Competent in Understanding African Americans," *Child and Adolescent Psychiatric Clinics of North America* 14, no. 3 (July 2005): 596. (My emphasis).

people."[747] Using such texts must be done only with the explicit understanding that the characters who appear on the pages are not exemplars of the cultures to which they belong. Here attention must be drawn to Charon's claim that narrative knowledge illuminates universal truths by drawing attention to particulars.[748] These universal truths must be understood as referring to questions of justice and society, not universal truth about all people who fit a particular descriptive template. Texts can be used as opportunities to reflect upon the social issues that arise when different cultures come into contact with each other. The pages of a novel or a short story can provide the space necessary for moral reflection on the injustices of stereotyping, essentializing, and presuming to know all that there is to know about others. Works of literature can provide the opportunity to explore, from a new position, the dangers of economic oppression. Literature and narrative skills can help one understand the damage that is done when cultural groups are defined—even for the presumably benevolent purposes of training physicians to be culturally competent.

One text in particular has become quite popular in multicultural education in health care: Anne Fadiman's *The Spirit Catches You and You Fall Down*.[749] This journalistic work introduces readers to the experiences of a Hmong family (and their community) when a young child, Lia Lee, begins to experience epileptic seizures. The American doctors promptly identify the disorder and prescribe various medications to control the child's seizure activity. The child's parents and community, however, attribute the child's symptoms to "soul loss" and choose to treat the child with various herbal remedies and the spiritual interventions of

[747] John Condon, "Exploring Intercultural Communication through Literature and Film," *World Englishes* 5, no. 2-3 (July 1986): 157.

[748] Charon, *Narrative Medicine*.

[749] Anne Fadiman, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (New York, NY: Farrar, Straus, and Giroux, 1997).

a Hmong healer. Over the course of several years, conflicts arise between the Hmong family and the American doctors. From the perspective of the American doctors, Lia's parents were inconsistent in complying with their prescribed treatment, and legal proceedings were initiated to remove the child from her family's home. The child was eventually returned to her parents' custody. However, in time, the child suffered from a catastrophic epileptic episode that, combined with septic shock, left the child severely brain damaged and comatose.

Fadiman's work has been identified as an ideal text through which to explore a particular culture and the potential conflicts that can arise when cultures with different cosmologies and understandings of illness come into contact. Many medical schools that address cross-cultural issues in their curricula have included this work in their coursework. There is, however, one significant shortcoming in this text. Culture, as a human phenomenon, is portrayed as a static and closed system. Hmong cultural identity is reduced to a rigid and deterministic set of rules and beliefs. In the case where a Hmong person has incorporated other traditions or perspectives, the characters within the text dismiss that person from the legitimate cultural group.[750] From this text, a reader could develop the idea that culture (or at least Hmong culture) has never changed and will never change. This perspective is contradictory to the anthropological theories presented above and denies the historical development that is part of all human society.

Although Fadiman portrays several characters who are unwilling—or unable—to compromise on their values and principles, this portrayal appears to be somewhat unbalanced. In Fadiman's work, both the Lees and Neil Ernst (one of the treating physicians)

[750] Ibid., 13, 165.

are depicted as individuals who are unable to entertain other perspectives. According to the narrative, the Lees' unwillingness to compromise is the direct result of the strict mandates of Hmong culture. Yet Janelle S. Taylor, an anthropologist, notes that in the case of Ernst, "the same [uncompromising] quality seems to be less an inborn trait shared in common with all other Americans, or all other doctors, than an idiosyncratic quality of his individual personality."[751] According to Taylor's assessment, Fadiman allows Ernst's inflexibility to arise from his own agency whereas the Lees are driven by external forces.

Taylor modifies this criticism later in her article when she draws the reader's attention to one of the strengths of Fadiman's work. It is quite possible that Ernst was simply unaware of the many ways in which he had been conditioned by his own cultures to think and to perceive in certain ways. Taylor argues, "The kind of misunderstandings that arose between Ernst and the Lees were neither completely idiosyncratic, nor 'totally irrational', they 'made sense' in terms of the culture and social organization of U.S. medicine."[752] From that perspective, Taylor's reading identifies a challenge for the medical profession in Fadiman's work which provides a valuable example of the dangers of mistaking one's personal or social expectations for universal truths (a conceptual flaw that I have criticized in this dissertation).

This text is widely used in medical education and students are encouraged to consider the dangers of an elitist perspective that does not allow for other cultural practices or conceptions of illness. I maintain my concern that Fadiman's work can be misused. Fadiman's challenge—as articulated by Taylor—is not always explicit and, as a result, it can

[751] Janelle S. Taylor, "The Story Catches You and You Fall Down: Tragedy, Ethnography, and 'Cultural Competence'," *Medical Anthropology Quarterly* 17, no. 2 (June 2003): 168.

[752] Ibid., 171.

be overlooked. In the absence of a clear challenge, the text can be read as an authoritative and definitive text on Hmong culture. Despite Fadiman's intentions, the unexpected lesson that might be learned (that people are trapped by their cultures) may serve to reinforce the need to rescue people from themselves—particularly when practitioners judge those persons to be primitive and naïve. Such a reading can be avoided (or corrected) if this text is engaged by a group who share their reflections and reactions to the text. A skilled facilitator could draw attention away from the rigid representation of Hmong culture and challenge readers to consider the shortcomings of the physicians and the dangers that arise in the absence of adequate self-reflection. A reader of Fadiman's work might also be well served by reading commentaries such as the one provided by Taylor.

Selected Texts

There are countless literary works that could be used for the purposes I have articulated. Certain pieces can contribute to the development of an attitude of humility when working with patients whose cultural practices differ from one's own. Some pieces will effectively draw readers into deeper reflection on the ethics of representation. Other pieces can foster the vision necessary for recognizing social injustice and the moral imagination needed to respond. Still others will challenge what readers think they know to be true. I will evaluate two pieces at length in the next two chapters. However, what follows below are shorter reviews of other recommended works (some of which are already in use in medical education). Medical educators could help students come to a new understanding of their professional and ethical responsibilities to practice socially conscious

medicine by bringing the stories into dialogue with some of the moral and ethical theories presented in this dissertation.

***Bone* by Fae Myenne Ng.** This is a fictional account of a multigenerational Chinese family living in San Francisco's Chinatown.[753] As an educational intervention, this novel provides a counterclaim to the conception of culture as monolithic and an opportunity for students to witness the plurality of values and perspectives that regularly coexist within a single family despite their shared cultural identity. This novel can serve to illustrate the limitations of cultural encyclopedias. In conjunction with reading this novel, students could be directed to review the information on Chinese-American culture as it is presented in the resource book developed by Wintz and Cooper (or any of a number of others resources).[754] Students could be asked to keep a record of how the two texts compare. Is the information in the cultural description reflective of *all* the members of the family (particularly across generations)? Can the students identify how the information in the cultural resource manual may contribute to misunderstandings between practitioner and patient?

"A Face of Stone" by Williams Carlos Williams. In the first two paragraphs of this short story, the reader must wrestle with a physician's hostile reaction toward a married couple who have come to his office. The physician, initially annoyed by the couple's tardiness, eventually allows himself to be open to their life stories and, in time, amends his attitude towards them. By the end, when he has developed a sympathy for the couple, readers have been given the opportunity to reflect on their own prejudices and biases.[755]

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[753] Fae Myenne Ng, *Bone* (New York, NY: HarperCollins, 1994).

[754] Wintz and Cooper, *Quick Guide to Cultures and Spiritual Traditions*.

[755] William Carlos Williams, "A Face of Stone," in *The Doctor Stories*, comp. Robert Coles (New York, NY: New Directions Books, 1984), 78-87.

"Milk" by Eileen Pollack. It would be difficult to explore socially conscious medicine and not attend to some of the more egregious barriers to health-care services faced by racial and cultural minorities. Pollack draws readers into the story of Bea (a white woman) and her roommate (a black woman) and their experiences as new mothers on a labor and delivery unit. This short story draws one's attention to the everyday racism that continues to impede the delivery of health-care services.[756]

***Interpreter of Maladies* by Jhumpa Lahiri.** Lahiri provides the readers with a collection of nine short stories. The collection, as a whole, functions to illustrate the cultural and linguistic diversity within Indian society. Readers' temptations to view other societies as monolithic and uniform in their cultural expression will be challenged as they are introduced to the difficulties that arise when cultural expectations and languages clash. Two of the pieces within this collection are reflections of the challenges faced by adult children of Indian families who were raised in the United States. These individuals struggle with being outsiders in their homeland. The stories of the cab driver/medical interpreter who has the difficult task of facilitating communication across the many languages that are spoken in India serve to highlight the dangers of miscommunication.[757]

"Theng" and "Shambalileh" by Susan Onthank Mates. In "Theng," readers are exposed to an often overlooked challenge faced by those who immigrate for political reasons. Many immigrants who are employed in the lowest rungs of the service industry left behind prestigious careers, considerable wealth, and prominent social status. The writing in "Shambalileh" draws the reader unwittingly into the confusion of an American

[756] Eileen Pollack, "Milk," *Ploughshares* 20, no. 1 (1994): 76-94.

[757] Jhumpa Lahiri, *Interpreter of Maladies* (New York, NY: Houghton Mifflin, 1999).

husband. Only after several readings of the tense conversations—fraught with missed communications—between the husband and the Persian immigrant wife, might the reader grasp the difficulty that arises when one remains too firmly rooted in one's own point of view.[758]

***Death of the Good Doctor* by Kate Scannell.** While not directly about culture, this is collection a well-written autobiographical stories from the life of a physician who must, through reflection-in-action, discover new methods of communication and open herself to the unique ways in which her patients need healing.[759]

[758] Susan Onthank Mates, *The Good Doctor* (Iowa City, IA: University of Iowa Press, 1994), 1-8, 91-99.

[759] Kate Scannell, *Death of the Good Doctor: Lessons from the Heart of the AIDS Epidemic* (San Francisco, CA: Cleis Press, 1999).

Chapter 10: "The Stranger"

Julia Alvarez, although born in New York City, was raised in the Dominican Republic until the age of ten. Her parents, both native Dominicans, moved to New York shortly before Alvarez was born and returned to the Dominican Republic soon after her birth. According the biography provided on the author's official website, her parents found the social climate of 1950s New York unwelcoming of Dominican immigrants and preferred to return to live under the dictatorial regime of President Trujillo.[760] When Alvarez was ten years old, the political situation in the Dominican Republic had become too volatile and too dangerous for her family and they returned, once again, to New York. Alvarez describes her transition to life in New York, with all of its racial hostilities, as the watershed moment that impelled her to become a writer.

Alvarez's novel *¡Yo!* is the story of the family of Yolanda García, a Dominican woman who has lived most of her life in New York City (an alter ego, of sorts, for Alvarez herself). The title has two meanings: it is a diminutive form of Yolanda, but it is also the Spanish word for "I." In a previous novel, Alvarez introduced readers to Yolanda and her family. Yolanda, a talented author, turned her family members into characters in her own novel-within-the-novel. *¡Yo!* gives voice to the disgruntled family members who grew somewhat resentful of having been exposed to the public at Yolanda's hand. In this novel, the members of Yolanda's extended family take their turn at telling their version of their own stories. Each chapter within the book functions like a short story. Taken together, they contribute to a larger whole, yet each can each stand alone and be read apart from the

[760] Julia Alvarez, *About Me*, http://www.juliaalvarez.com/about/ (accessed on April 22, 2008).

context of the complete novel. The chapter titled “The Stranger” is a story of Yolanda’s travels in the Dominican Republic.[761] Readers are presented with the conflicts that arise when Yolanda (a Dominican-American woman) comes into contact, in broken Spanish, with a culture that is not quite her own.

One reason “The Stranger” and “The Cariboo Cafe” (the short story that is discussed in the next chapter) were chosen for presentation here is that neither story deals directly with health care or medical practice. This was a deliberate choice. There are countless texts (several were noted in the previous chapter) that do provide accounts of intercultural conflict in the clinical setting. Much can be learned by using texts such as these in the setting of medical education. However, in an attempt to draw attention to some of the social structures which contribute to health disparities, I chose these texts for the distance they provide from immediate criticism of either cultural competency or medical practice. Further, experience has shown that medical students—when invited to engage social justice issues in the context of literature, movies, or other visual media—may prefer to focus their attention on the clinical issues (symptoms, diagnoses, prognoses, etc.). Those students may be simply following a pattern that they have developed in the course of their studies. Or these students may be choosing a safe topic to discuss so as to avoid other troubling issues that might be present.[762] However, if read well, “The Stranger” and “The Cariboo Cafe" can provide the moral reflection necessary for students to engage in their own criticism of cross-cultural education in medical schools, medical practice, and the current health-care system.

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[761] Julia Alvarez, "The Stranger," in *¡Yo!* (New York, NY: Plume, 1997), 97-109.

[762] These insights are drawn from my own personal experience of working with medical students (as a teaching assistant and as an instructor) in courses that explored issues of medical ethics and professionalism.

The self-application of the themes to the practice of medicine may provide for more meaningful reflection on some of the issues raised in this dissertation.

The Story

Although she is not named in the context of this story, Yolanda García is the stranger who meets and interacts with an elderly Dominican woman named Consuelo. By not naming Yolanda in this piece, Alvarez succeeds in emphasizing Yolanda's social distance from Consuelo.

As the story opens, Consuelo is recalling her dream from the night before. The central element of the dream is a conversation between Consuelo and her daughter Ruth. Consuelo explains that except for the conversation with her daughter, the events in the dream reflected her lived experience. In the dream, as in Consuelo's waking life, Ruth had become pregnant while living in a neighboring city and had returned home to leave her newborn daughter, Wendy, in Consuelo's care. Ruth had forged a dangerous plan to leave the Dominican Republic and begin a life in *Nueva York*. Ruth would regularly send money to her mother. However, communication was a challenge. Consuelo could neither read nor write and depended upon the assistance of someone from the community to help her read Ruth's letters. And without a telephone of her own, Consuelo was forced to take telephone calls at the public phone booth that stood at a distance from her home.

Ruth, both in the dream and in life, had married for the purposes of securing residency in the United States. This arrangement troubled Consuelo who regularly prayed that the relationship would be transformed into something more meaningful. Ruth, who

entered the marriage for practical reasons, soon wanted to be free of it. Her husband, however, refused to agree to a divorce.

The Ruth from the waking world, desperate and trapped, writes to her mother seeking her counsel. Consuelo, upon learning the contents of the letter, longs to advise and comfort her daughter. Consuelo rehearsed what she would tell Ruth on the occasion of their next telephone conversation. But before she had a chance to speak with Ruth, Consuelo dreamed of a conversation between herself and her daughter. This is where the dream differs from Consuelo's waking life. The conversation, full of what Consuelo remembered to be wise and wonderful words, never occurred. And to Consuelo's dismay, when she awoke she could not recall what she was certain had been excellent advice.

Frustrated by her inability to recall the advice she had given in the dream, Consuelo confides in her neighbor, María. María recommends a ritual that will restore Consuelo's memory so that she can call Ruth and share the wisdom from the dream. Consuelo confesses that she does not have a telephone number for Ruth—as it is always Ruth who calls her. María then suggests that Consuelo's only option is to write a letter herself and mail it to the return address printed on the letters that Ruth sends. As neither woman can write, María recommends that Consuelo take advantage of the presence of an American woman (Yolanda) who has travelled from New York City to visit relatives in the area. Consuelo reluctantly agrees.

Consuelo is pleasantly surprised by the woman's kind and respectful manner. The woman had already been informed of some of the details and was eager to help Consuelo in her mission to advise and comfort Ruth. Consuelo informs the woman of Ruth's present condition: her inability to obtain a divorce, her political vulnerability, and the physical abuse

that her husband has begun to inflict upon her. Slowly, Consuelo begins to dictate a letter to her eager scribe.

Consuelo begins with a lengthy and almost prayerful salutation. The woman, edging her way from scribe to editor, suggests a shorter greeting (while affirming that this was Consuelo's letter to have written as she wished). Despite her reservation, the woman eventually agrees to the lengthy greeting. But, as Consuelo continues to dictate, the woman announces that she cannot write the words that Consuelo has spoken. Consuelo's advice to her daughter is that she must learn to honor her husband so that he will not have reason to abuse her. The woman voices her objection to such advice and questions Consuelo's motivations, but concludes by affirming, once again, that this was Consuelo's letter to have written as she wished. Consuelo agrees that perhaps the woman could add her own thoughts to the letter—a postscript to Consuelo's own words. The woman, however, misunderstands and discards the letter she had begun. She then proceeds to write the letter without any input from Consuelo. The letter that the woman writes has a markedly different tone as she advises Ruth, in Consuelo's name, not to accept such treatment and to seek the help from any of the many agencies in New York City. Consuelo comes to believe that the woman's words *may* have been more reflective of the words from her dream—the words that she could not remember.

Speaking for the Other

This short story, like any other work of literature, could be approached from a variety of perspectives and engaged at a number of levels. For the work of moral inquiry, however, Martha Nussbaum claims:

> Moral knowledge ... is not simply intellectual grasp of propositions; it is not even simply intellectual grasp of particular facts; it is perception. It is seeing a complex, concrete reality in a highly lucid and richly responsive way; it is taking in what is there, with imagination and feeling.[763]

A reader could leave this story having affirmed that domestic violence is a terrible thing or even that undocumented immigration leaves one vulnerable. One could focus on the bare facts of the story: Ruth immigrated into the United States without documentation, Ruth is being abused by a man she married for the purposes of securing citizenship, Consuelo (Ruth's mother) lives in poverty in the Dominican Republic, Consuelo is raising Ruth's daughter Wendy. But this is not perception. This is not recognition of the complex, concrete reality in which these women meet. This does not require a response from the reader and it certainly does not stimulate the imagination. To understand Consuelo is to see and feel both the anguish she feels over her daughter's situation and her own lack of awareness of her own voicelessness. To respond is see and feel the conflict in Yolanda's offer to help.

Representation, according to the work of Gayatri Spivak, can take one of two forms: political representation or artistic representation. The differences, Spivak states, are between that of proxy and portrait.[764] One represents another by standing in their stead and speaking on their behalf. Or one represents another (or an object) by means of artistic interpretation. Spivak cautions that these two activities are more alike than many are able to acknowledge or willing to accept. All acts of representation are interpretive. Neither an artist nor a political advocate can apprehend the totality of their subject and bring that

[763] Nussbaum, *Love's Knowledge*, 152.

[764] Spivak, "Can the Subaltern Speak?" 276.

subject into being where it is not. The representative can re-present and re-create only simulacra of their intended subject.

Julia Alvarez's short story creates an opportunity for readers to enter into this issue. Like the British colonialists intent upon saving the lives of women by preventing them from throwing themselves upon their husbands' flaming funeral pyres, Yolanda García is adamant in her mission to save another "brown woman": Consuelo's daughter, Ruth, a Dominican immigrant living in New York City, a victim of domestic violence. And Consuelo, like the advocates for the preservation of Indian cultural traditions who rationalized that death upon the burning bodies of their husbands was what the widows wanted, seeks to justify the abusive husband's actions. Consuelo's instinct is to advise her daughter to pacify her husband in order to prevent further violence. Yet, as in both sides of the *sati* debate, neither Yolanda nor Consuelo recognizes the need to hear from Ruth. In their attempts to rescue Ruth, she becomes a stylized and silent object in their discussion. Yolanda's silencing mission, however, is compounded in this story because she is also intent upon rescuing Consuelo from a mindset that she finds unacceptable. However, she does not so much rescue Consuelo as silences her.

In the *sati* debate, there were surely those whose only concern was that widows were no longer immolating themselves alongside their dead husbands. That the voice of the widows was never heard was of no consequence. Readers who come to the end of this piece by Julia Alvarez may identify Yolanda as a hero and be grateful that she tossed Consuelo's words aside (literally) in favor of her own advice (dispatched in Consuelo's name). That both Ruth and Consuelo are silenced might be an acceptable price to pay.

But is it of no consequence? Does Yolanda commit psychological violence against Ruth and Consuelo in the name of seeking to rescue Ruth from physical harm? And is this ethically and morally acceptable? Is one's judgment influenced by the fact that Yolanda is also a woman and, by birth, Dominican? Would the same act be more or less acceptable if committed by a white man? Once the envelope has been sealed, whose letter is it?

Consuelo is narratively constructed as someone who, quite literally, cannot speak. Not having learned to write (in English or in Spanish), Consuelo is unable to send a letter to Ruth without assistance. As she does not have any contact information for her daughter, Consuelo is unable to use the communal telephone to call her daughter as she pleases. Her economic and social circumstances have silenced her with regard to her relationship to her own daughter. But there are also suggestions that Consuelo may have been influenced by her religious tradition to accept physical abuse in her own life—never believing that it was her place to speak a word of resistance. Now faced with her daughter's situation, she must depend upon the assistance of a stranger—a stranger who must be brought into the most intimate details of Consuelo's family's life. In addition to the invasion of privacy, Consuelo's social location leaves her extremely vulnerable in the hands of the woman who offers to serve as a scribe. Consuelo knows, perhaps without knowing, that she must not upset the stranger. Otherwise, she will remain unable to speak to her daughter. The irony, of course, is that it precisely through the action of the stranger that Consuelo's silence is maintained.

The struggle for control over the content of the letter begins shortly after pen is set to paper. Yolanda, resting on her authority as a writer, is critical of Consuelo's lengthy and

disjointed introduction: "It's not a sentence."[765] Yolanda, disagreeing with Consuelo's advice and perspective, continues to exert her authority over what should be included in the letter. She takes complete control when she discards the first draft which bore some tacit resemblance to Consuelo's own words and begins to write what she believes Ruth needs to hear. Consuelo is not given the opportunity to voice an objection although she most certainly does object: "She had meant the lady's words to be added to the one that had already been written. But the lady crumbled the sheet in her hand and commenced a new letter."[766] Despite the fact that Yolanda genuinely believed that she had only assisted in transcribing what was truly "Consuelo's letter," it was a letter in which, once again, Consuelo's voice would remain unheard, a letter which symbolizes for Consuelo that she does not deserve to speak. [767]

As the reader, how does one respond to what occurs in the pages of this short story? Given some of the principles articulated in this dissertation, what are some of the questions that one might ask as one engages the characters present and absent in this text? What are the discursive values that are expressed in this story? How is social power exercised? How is otherness approached? As an advocate, how does Yolanda understand Ruth? As a representative, what does Yolanda do for/to Consuelo?

Readers who agree that domestic violence is something that must be stopped or prevented will be likely to endorse Yolanda's advice. By implication, those same readers will have determined that Consuelo was wrong in having wanted to encourage Ruth to placate

[765] Alvarez, "The Stranger," 106.

[766] Ibid., 108.

[767] Ibid., 109.

her husband. Some readers may be inclined to find justification for Yolanda's actions by pointing to Consuelo's alleged assent: "It *seemed* to [Consuelo] that these were the very words she had spoken that Ruth had been so moved to hear."[768] But despite what Yolanda's letter may have accomplished for Ruth (for it was Yolanda's letter), the reader cannot avoid the violence that has been done to Consuelo in the process. Readers are then drawn into an ethical dilemma and forced to decide between (at least) two undesirable positions: reject Yolanda's actions and endorse the violence that Ruth endures or support Yolanda's choice and, by extension, support the violation of Consuelo's agency if not her very person. There is, of course, (at least) another choice.

A lecture on the ethical parameters of representation may accomplish only so much. To have been drawn into a story for oneself is another experience entirely. It is very different when one must reflect upon one's own emotional responses and reflect upon one's contradictory judgments regarding the acts of a particular character. If one must deal with the implications of having identified oneself with a particularly problematic character, the insights that one comes to may have a more lasting effect. By becoming a part of Consuelo's story, a reader has the opportunity to come to a new understanding of her own values. A story like the one that Alvarez has created is not just a rehearsal. One must actually do the work of negotiating contradictory values and attempt to articulate a new, acceptable response.

[768] Ibid. (My emphasis.)

Making the Other's Voice Heard

Alvarez's "The Stranger," like many of her other pieces, highlights the manner in which representation of an other is always, at some level, an act of violence. However, as Alcoff has stated, this is not an acceptable reason to abdicate one's moral responsibility to give voice to the one who has been exiled from places of social power. This violence may be minimized (but never avoided), only when the advocate makes the effort to recognize the situation for what it is. At the heart of the conflict in "The Stranger" are the unrecognized (or unacknowledged) differences between Yolanda and Consuelo (and Ruth). Yolanda is raised in the United States, college-educated, financially secure, and socially confident. Yolanda can speak and be heard. Consuelo, in many ways, is the exact opposite. Although she possesses the faculty of speech, she cannot be heard. The oppression that Consuelo experiences throughout her life is dependent upon this issue. Consuelo cannot and does not ask for relief because no one will listen to her pleas. Yolanda, motivated by a sense of justice, ironically joins forces with Consuelo's oppressors when she refuses to listen to her.

This is not to suggest that Yolanda (or someone in a similar position) should have jettisoned her own values and principles. Nor would it have been morally acceptable for Yolanda to have withdrawn her offer to assist. Instead, Yolanda should have worked to find other ways to support Ruth. While it would have been more labor intensive, Yolanda might have discovered a way to assist that both reflected her own values and preserved (if not restored) Consuelo's dignity.

To represent another, Spivak insists, is to contribute to the completion of the speech act initiated by the oppressed person.[769] Her point (referring to criticism of her assessment that the subaltern cannot speak) is that while the subaltern, the oppressed, the marginalized maintains the agency to speak, because of her social location, she cannot be heard (she is not listened to). In response, the very skilled and the genuinely reflective may find ways of representing the marginalized and successfully engage in speaking on behalf of another with minimal violence being done. Within the context of this story, however, another approach may also have been effective. This other approach demands that one invest the time and the resources needed to support the oppressed person in speaking for herself. Yolanda could have engaged Consuelo in a conversation and opened the space necessary for Consuelo to tell her own story—an opportunity for Consuelo to actually have her story heard by someone. Yolanda might have discovered that, ultimately, she and Consuelo really did want the same thing for Ruth: physical and emotional safety. In listening to Consuelo's story, Yolanda might have come to understand why Consuelo would believe that "do not provoke him" was the only advice a mother could give to a daughter.[770] In becoming Consuelo's ally (instead of her oppressor), Yolanda could have invited Consuelo to recognize the limitations of her own experience and challenge her—from a place of love—to imagine other ways to support Ruth. In effect, Yolanda may have been of greater service if she could have broadened Consuelo's perspective by first having learned to *be with* Consuelo. By becoming conscious of Consuelo's lived experience, she could have

[769] Spivak, "Subaltern Talk," 292.

[770] Alvarez, "The Stranger," 106.

brought Consuelo to a new consciousness for herself—she could have helped Consuelo expand and amplify her own voice.

It is possible that discomfort (or excessive identification) has led many commentators to read some of these responses into the text. William Luis, a Spanish literature scholar, comments, "Yo [i.e., Yolanda] helps Consuelo write a letter to her daughter Ruth" and "Yo counsels the mother not to interpret her daughter's situation from her own Dominican cultural referent."[771] Yolanda did not *help* Consuelo write a letter—Yolanda wrote her own letter. And there is no evidence that Yolanda *counseled* Consuelo. Instead, Yolanda substituted her own advice and her own perspective for Consuelo's. In Luis's judgment, Yolanda's actions amounted to "a cultural imposition."[772] If one holds in mind the ethical and moral principles articulated in this dissertation, it is unlikely that one would come to the same generous conclusion. Carine M. Mardorossian, an English literature scholar, claims that Yolanda "leads the old woman to condemn rather than rationalize domestic violence and to write an empowering rather than an accusatory letter to her daughter."[773] Once again, as there is no indication that Yolanda *led* Consuelo through any sort of discernment process, it is difficult to understand such an assessment of Yolanda's actions.

Eisegetical readings of morally troubling texts are not unusual. Several readings of the same text may prove an important step. By taking note of what she might have read

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[771] William Luis, "(Dis)Locating the 'I' of the 'Yo' in Julia Alvarez's *Yo* and Mario Vargas Llosa's *La Fiesta del Chivo*," *Vanderbilt e-Journal of Luso-Hispanic Studies* 1(2004), http://ejournals.library.vanderbilt.edu /lusohispanic/viewarticle.php?id=19.

[772] Ibid.

[773] Carine M. Mardorossian, "From Literature of Exile to Migrant Literature," *Modern Language Studies* 32, no. 2 (Autumn 2002): 24.

into the text, the reader may benefit by reflecting upon the ways that she might have unconsciously altered the text to suit her own comfort level.

Relevance for Socially Conscious Medicine

The purposes for including this short story and subsequent reflection in the context of this dissertation may already be clear. The practice of socially conscious medicine will require a keen understanding of the implications of representation. This understanding will be important for the social and political work necessary to recognize and address social structures that unjustly exclude certain groups from accessing necessary medical services. However, a deep understanding of the manner in which unreflective advocates can manifest models of dominance and perpetuate the silencing of oppressed persons is absolutely critical for those who seek to illuminate the most profound (and tragic) failure of many training programs designed to improve clinical care for cultural strangers.

Like Yolanda García, countless health-care professionals have willingly and generously dedicated themselves to speaking on behalf of those whose voices have gone unheard in medicine. The politically and socially vulnerable who have been barred access to health-care institutions or who have been permitted passage only to receive substandard care may be in need of authoritative voices to speak on their behalf. However, many (although not all) of those who have risen to the challenge of advocacy have been influenced by discursive forces that simultaneously silence the already voiceless at multiple levels.

First, the oppressed members of society who have historically not received adequate health-care services have frequently been kept from communicating their own

needs. Only when legitimate medical authorities noticed was it declared a problem. Second, the medically neglected (the unheard *them*) were kept in silence as benevolent health-care workers and medical ethics scholars articulated what needed to done on behalf of *them* in order to resolve the problems that *they* were facing. A solution was devised: *we* need to learn what *they* were like. Medical professionals need only to learn the cultural traditions, practices, and health beliefs of these cultural and racial others. Medical educators develop cultural profiles about these others. The profiles, however, are developed without significant contributions from the silenced. Further, equipped with these authorized cultural descriptions, physicians may believe that they have even less of a need to consult with the cultural strangers as the physicians already know all of the important information. Ultimately, when physicians and medical educators focus on cultural differences, the politically and socially marginalized are kept, once again, from giving voice to the complex network of social factors that they experience as barriers to adequate health care. Further, even when these person do find opportunities to speak, they may have been conditioned to overlook the extent of the oppression they endure. The structures that work to exclude them are most successful when the oppressed are blinded to the ways in which they are marginalized.

Native Informant vs. Advocate

There is something else to be learned from the history of the author herself. Julia Alvarez, born in the Dominican Republic and raised in the United States, has been criticized for having attempted to represent the experience of Dominican women who have lived their entire lives in that country. Roberto González Echevarría, a Spanish literature scholar, wrote

a review of Alvarez's novel *In the Time of the Butterflies* which was published several years before *¡Yo!*[774] In his review, he observes that "the *gringa dominicana* would never really be able to understand the other [Dominican] woman, must less translate her."[775] Essentially, González Echevarría is criticizing Alvarez for having, according to him, tried to play the role of the native informant. It is questionable, however, whether or not Alvarez was actually attempting to perform this function.

Native informants, generally called upon by members of the majority, are expected to expertly represent their (or a related) group. Spivak is critical of this practice: "[T]he Native Informant, who was found in these other places, his stuff was unquestioningly treated as objective evidence ... This is very frightening."[776] According to Amits S. Rai, a commentator on Spivak's work, "[F]or Spivak the native informant's perspective is (im)possible."[777] The insider, the native informant, can be no more capable of possessing objective evidence or of knowing all there is to know about others within her group than the outsider. Therefore, many will argue, the Guatemalan-American medical student cannot and should not speak for the Guatemalan-American patient experience as there is no single Guatemalan experience (just as there is no single Guatemalan body). And, subsequently, the single student is incapable of taking the perspective of every person who may have a claim of belonging to that group.

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[774] Roberto González Echevarría, "Sisters in Death," *New York Times Book Review* December 18, 1994, 28.

[775] Ibid.

[776] Gayatri Chakravorty Spivak, *The Post-Colonial Critic: Interviews, Strategies and Dialogues*, ed. Sarah Harasym (London, UK: Routledge, 1990), 66.

[777] Amits S. Rai, "*A Critique of Postcolonial Reason: Toward a History of the Vanishing Present* by Gayatri Chakravorty Spivak (A Book Review)," *Criticism* 42, no. 1 (Winter 2000): 120.

Placing confidence in native informants is particularly a problem when the expectation is that the one with a similar experience or heritage (e.g., the Guatemalan-American medical student) can speak to every facet of a particular cultural experience. When a Guatemalan student is singled out in a classroom discussion on Guatemalan or (as if more often the case) all Hispanic patients, this is disrespectful to the student and to all persons who might be identified as Guatemalan or Hispanic in that discussion. It would be irresponsible for the student to attempt to play the role of native informant and answer any and all questions posed to her: "Why do Guatemalans ... ?" The instructor, of course, is guilty of having violated the integrity of the student and the dignity of all persons she has joined into the designated group.

But what of advocacy? These criticisms of the practice of using a native informant are not to suggest that this particular Guatamalan student must never advocate on behalf of Guatemalan or Hispanic immigrants who are receiving substandard health care or being barred from access to services all together. Critics such as González Echevarría insist that distinctions must be made and that the medical student is not part of the same group of Guatemalan persons who were raised in Guatemala and only recently immigrated (or who have remained in Guatemala). But to what extreme must these distinctions be taken? Linda Martín Alcoff speculates that critics like González Echevarría may be satisfied only when all social groups are defined as "'communities' composed of single individuals."[778] If one can only speak for one's own group, and one's own group is composed only of oneself, there can be (as I have noted before) no advocacy on behalf of those who have been

[778] Linda Martín Alcoff, "The Problem of Speaking for Others," in *Who Can Speak? Authority and Critical Identity*, ed. Judith Roof and Robyn Wiegman (Urbana, IL: University of Illinois Press, 1995), 99.

systematically silenced. The philosopher Anthony Kwame Appiah argues, "[N]o loyalty can ever justify forgetting that each human being has responsibilities to every other."[779] Advocacy must continue, but it must be actualized in ways that complete the speech-act initiated by the person who has been oppressed and silenced.

[779] Appiah, *Cosmopolitanism*, xvi.

Chapter 11: "The Cariboo Cafe"

Helena María Viramontes is a Mexican-American writer of fiction and professor of English. She has made a significant contribution to the body of writing by Hispanic women and her stories often explore Latin American women's struggles against repression. Her stories are regularly set within a context of social oppression, economic vulnerability, and political disadvantage. The short story "The Cariboo Cafe" appears in a larger collection titled *The Moths and Other Stories.*[780] This particular piece is exemplary of Viramontes's use of multiple narrators and shifting points of view. Linearity is sacrificed for the purpose of interweaving the stories of various characters in a manner which emphasizes the social turmoil of their lives.

The Story

"The Cariboo Cafe" is set in an unnamed American city. The limited temporal clues indicate that the events could take place either in or close to the present. Structurally, the story is divided into three sections, each section focusing on the perspectives of different characters within the story.

The first section of the story is told from the perspective of two young siblings, Sonya and Macky. The children and their parents are undocumented immigrants, possibly of Mexican origin. Sonya is of school age and each afternoon retrieves her younger brother from the home of Mrs. Avila—Macky's babysitter. However, on this particular afternoon,

[780] Helena María Viramontes, "The Cariboo Cafe," in *The Moths and Other Stories* (Houston, TX: Arte Público Press, 1995). All quotations from this story are from this edition and will be quoted parenthetically in this chapter. I summarize the short story here, but it appears in its entirety in Appendix B.

the key to the apartment, usually worn by Sonya on a string around her neck, has been lost. Standing outside the locked door of the apartment, Sonya decides that they should return to Mrs. Avila's house. Although this is a route with which she is quite familiar, events along the way cause her to become disoriented and the children lose their way.

During the walk, Sonya takes special notice of the depravity in which her neighbors live. Sonya observes the police interrogate and arrest an African-American man, a man whom Sonya had mistakenly believed to be the father of a schoolmate. Having been taught to fear the police, Sonya and Macky run for the safety of darker, but unfamiliar streets. The dangers of this unknown territory are preferable to being apprehended by the police who—according to Sonya's father—collaborate with immigration officials. The children quickly find that they are lost and, as night falls, they seek refuge in a diner: the Cariboo Cafe.

The unnamed owner of the diner narrates the second section of the story. Given the distance that the diner's owner recognizes between himself and the other characters, it is possible to assume that he is white. His narration is interlaced with reflections on his life and attempts to justify recent actions. As he scrubs a stain from the floor, the reader learns that these recent actions have motivated many of the man's regular customers to keep their distance. The man's work at the diner fills the void created by the absence of his wife who left him and his son who died in the Vietnam war. Generally, the man is welcoming of the random assortment of people who frequent his diner. He is especially patient with Paulie, a drug addict, because he is reminded of his dead son, JoJo.

As he reflects on recent events, the man recalls an Hispanic woman who arrived with two children. The woman had a rough and unkempt appearance, but attended very closely to the two children. The young boy reminded the diner owner of JoJo when he was a

child, but the young girl maintained a look of suspicion and wariness. Shortly after they left his diner, the man recognizes the young boy in a news broadcast about two missing children.

The man also remembers that the next morning immigration officials searched a factory in the vicinity and several of the workers—undocumented immigrants—sought refuge in the diner. Many of the workers were regular customers whom the man recognized. However, he did not hesitate to assist the immigration officials in their search, and the workers were quickly arrested and led away in restraints. Disturbed by the events, the man is even more troubled when the woman and the two children return later that day.

The third and final section of the story is told from the perspective of the unnamed woman who was seen with the two children. As a result of textual clues, the reader is left to assume that the woman is an undocumented immigrant from a Central-American country, possibly Nicaragua. The woman lives in a constant state of grief for her five-year-old son, Geraldo, who was apprehended by soldiers in her home country. She joined the many other grieving mothers who searched for their missing children at the detention centers where the military held those accused of aiding the *Contras* (a rebel force). Despite her many efforts to rescue him, she eventually learns that her son is dead. Unable to accept the death of her son, she continues to believe that he has disappeared. Wracked by grief and traumatized by the violence she witnessed in trying to find him, she decided that her life there was over. With the assistance of her nephew, Tavo, she crossed the border into the United States and began a new life as a housekeeper.

One day, while working, the woman sees two young children, a boy and a girl. She is certain that the young boy is her son, Geraldo, and she takes both children to eat at a

nearby diner. After dinner, she takes the children to her home where she dotes on the young boy. She bathes him, sings to him, and tucks him into bed. After the children are asleep, she fantasizes about returning to her home country with the boy so that she can begin her life anew. The next day, the woman returns to the diner with the children.

It is here that all three stories intersect. Recognizing the children, the owner contacts the local police. When the police arrive, the woman refuses to allow them to take the boy—the boy she believes to be her son. The armed and uniformed police remind her of the soldiers who abducted Geraldo. Moved by a deep desire to protect the boy, she is not deterred by the gun pointed at her. Instead, she is only more resolved to protect the boy from the uniformed men. Although the author ends her narrative in the midst of this conflict, the reader is left to assume that the woman is ultimately shot and killed and that it is her blood that is being cleaned by the diner's owner when he is first introduced.

Oppression and Marginalization

"The Cariboo Cafe" is a story of "displaced people" (65). Each of the principal characters experiences the distress of displacement in his or her own way—a dislocation that is incompatible with human flourishing. For the children, Sonya and Macky, their displacement is characterized in the opening lines of the story as readers are introduced to the stark and impermanent living conditions of the two young children and others like them. Their new home in the unnamed American city is a "maze of alleys and dead ends" (67). Their lives in this labyrinth of dangers and threats are permeated with a sense of impermanence, but they believe it when their parents speak of a "finer future where the toilet [is] one's own and the children needn't be frightened" (65). Theirs is a life of fear and

hiding. For fear of deportation, they must hide from everyone—especially police officers who they have been taught to avoid because they are "La Migra in disguise" (65).[781] The stress of instability is exacerbated when the children are unable to enter the safety of their apartment—"the only protection against the streets until [their father] returned home" (65). Stripped of the usual avenues of aid and rescue, the children are left to fend for themselves in the dark shadows of unfamiliar streets. Instead of what otherwise might have been a story with a simple resolution (i.e., children waiting contentedly at a neighbor's home or dialing 911 from a pay phone), the plight of these children is the very story of political terrorism. Civil authorities of any stripe are viewed as dangerous and a threat to one's wellbeing. As undocumented immigrants, the children are left alone and vulnerable by a legacy of violence and mistrust.

Terrorized by his own grief, the owner of the diner becomes consumed by economic survival and interprets his world through a capitalistic lens. He finds the undocumented immigrants who populate the neighborhood abhorrent: "While I'm stirring the chili con carne, I see all these illegals running out of the factory to hide, like roaches when the lightswitch goes on" (71). Yet his disgust is easily set aside for the sake of income: "Like I gotta pay my bills, too. I gotta eat. So like I serve anybody who's got the greens" (69). His attitude mirrors that of the local factory owners. They all benefit economically from allowing undocumented immigrants to enter the community. The undocumented immigrants, denied the opportunity to become citizens, make a valuable contribution to society by providing affordable labor and spending their earnings in the local businesses.

[781] *La Migra* is a diminutive form of *la inmigración*, the Spanish term commonly used to refer to immigration agents.

That society, however, is not held accountable to these individuals—persons believed to be expendable in their anonymity. The business owners need only tolerate the inconvenience of occasional immigration raids and the temporary absence of their workforce/customer base that will quickly be replaced. For the diner's owner, the exploitation of this vulnerable population is not incompatible with his being a "fair guy" who runs "an honest business" (69). However, he could be read as a character stripped of any substantive agency by the fear of losing his meager livelihood. When he assists the police in locating the undocumented immigrants hiding in the bathroom, it is not an appeal to morality or national justice that motivates him. Instead, his own words suggest that he fears the loss of his diner if he does not cooperate with the local authorities. In his own economic vulnerability, he is not free to make an ethical decision, only a pragmatic one.

In telling the story of the woman, Viramontes expands the readers' view of social injustice from the local events of an American city to the international stage. In her country of origin the corruption that shaped the military left ordinary citizens at the mercy of the soldiers' whims. The woman's son, Geraldo, is detained because of the possibility that he might have provided assistance to the *Contras*. Further, the very young boy was defenseless and vulnerable precisely because of the poverty in which he and his mother were forced to live. "I am a washer woman," she confesses, "When my son wanted to hold my hand, I held soap instead" (74). The grieving mother's requests for more information are met with scorn. Her inability to secure information or assistance is indicative of the plight of a people who live amid uncertain allegiances, clandestine alliances, and overt abuses of power. In her desperate state, the woman identifies herself and the other grieving women with *La*

Llorona.[782] Their proper role as mothers who nourish and provide for their children is reversed and they are left only to grieve and to weep amongst the dead and dying. Their agony is echoed by the very land itself: "Weeds have replaced all good crops. The irrigation ditches are clodded with bodies" (75). As the woman searches fruitlessly for Geraldo, she reflects, "I hear the wailing of the women and know it to be my own" (72-73). This self-identification with *La Llorona* is interesting. Instead of a condemnation of failed womanhood, the mother's assumption of the role *La Llorona* could be interpreted as an act of rebellion. It is not that she is incapable of fulfilling her proper role and deferring to the will of the men in authority. Rather, she is unwilling to obey the soldiers' commands and loath to mourn the loss of her son in a silence that defers to the authority of her oppressors. Thus, she wails. She loudly proclaims the injustice that has been committed against her and her child. Yet her desire to rebel is short lived. Powerless even in her wailing, she flees the site of the violence and seeks refuge in an American city—a place, she discovers, that is less a refuge and more a reiteration of the violence she sought to escape. Unfortunately, the fruitless rebellion displayed as she wailed outside the detention center is reproduced at the end of the story when she attempts to resist the police officer's efforts to rescue the boy. Before she is killed, she shouts, "I will fight you all, because you can no longer frighten me. I

[782] *La Llorona*, The Weeping Woman, is a prominent character in Hispanic folklore. She appears in the folkloric heritage of many Latin American countries and, as such, has a diverse range of meanings and identities. Despite this diversity, *La Llorona* is generally portrayed as one of two basic characters. First, she is often depicted as a spurned lover who becomes consumed by grief and, in her despair, murders her own children. In the wake of such unspeakable violence, her agony exceeds her own mortality and she is left to roam the earth, wailing into eternity, searching for new children to replace her own. The second characterization is that of a nonhuman monster who serves only as an omen of imminent danger. *La Llorona* has often been linked with other female folkloric characters and with various indigenous female deities. Regardless of the origins of the character of *La Llorona*, she is often presented as a corruption of conceptions of femininity that are considered (by the story teller) to be proper or appropriate. For this reason, many feminist scholars regard representations of *La Llorona* as deeply misogynistic. Bacil F. Kirtley, "'La Llorona' and Related Themes," *Western Folklore* 19, no. 3 (July 1960): 155-168.

will fight you for my son until I have no hands left to hold a knife" (78-79). Her powerlessness transforms her rebellion into madness. Her madness, possibly, becomes the justification for the police officer's choice to remove (i.e., murder) a dangerous threat.

The children, not knowing its proper name, refer to the diner as the "zero-zero place" (68). The reader learns from the owner's narration that "if you take a look at the sign, the paint's peeled off 'cept for the two O's" (68). As a result of years of neglect and disrepair, the Cariboo Cafe has become "the double zero cafe" (68). Originally, the name was possibly intended to evoke the romance of a faraway land. Yet what remains serves only to identity the location as a place of double negation. Those who gather in this place are the victims of social structures that effectively strip them of any meaning, value, or hope.

Ramón Sampedro, a Spanish quadriplegic noted for having made the first official plea for a legal right to euthanasia in Spain (his request was not granted), documented his experience of twenty-nine years of immobility. Writing with a pen in his mouth, he recorded poems, letters, and musings. Shortly before his death, these were collected and published in a book titled *Cartas desde el Infierno* (*Letters from Hell*). In the final letter that Sampedro wrote, he states:

> La vida tiene que tener sentido. Y tiene sentido mientras esperamos algo. Casi nunca—o nunca—sabemos el qué, pero mientras disponemos de un cuerpo sensible y vivo que nos posibilita disfrutar del sentido de la libertad que nos da su movimiento, siempre tendremos esa sensación de poder ir de un horizonte a otro, en busca de ese algo indefinido y maravilloso que nos

> librará de la rutina y del monótono cansancio de luchar para vivir de una manera normal.[783]

Although Sampedro was speaking directly to the despair and the sense of otherness that emanated from his having lived in an immobile body for nearly thirty years, his insight into the need for hope is applicable to those who are socially exiled and whose bodies are looked upon by the majority as scrambling insects who only occasionally serve a purpose.

In this experience of double negation, the first layer of negation sets in as the residents of this community are transformed into the other that is too other. In this short story politics, capitalism, and war converge to leave individuals and families in a constant state of hopelessness and meaninglessness. Undocumented immigrants learn to accept paltry wages and scorn in exchange for a life that is always in danger of being interrupted or destroyed by deportation. Many of these same immigrants tolerate these horrible circumstances because of the atrocities that they have managed to escape in their countries of origin. In their despair, they are reduced to the need to survive but without an opportunity to flourish.

The second level of negation results from the constant suggestion throughout the story that the suffering of these persons is unknown (or insignificant) to those who live outside the shadowy maze of warehouses and crowded streets. The business owners and their clients, ignorant of or indifferent to the daily violence in this community, benefit from

[783] Ramón Sampedro, *Cartas desde el Infierno* (Barcelona, Spain: Editorial Planeta, 2005), 297. Translation: Life must have meaning. And it has meaning as long as we have hope in something. Hardly ever—or perhaps never—do we know what that something is. But while we possess a body that is alive with feeling, our body grants us the possibility of enjoying the sense of freedom that comes from its very movement. And we will always have the sense of being able to travel from one horizon to the other in search of that indefinite and marvelous *something* that frees us from our daily routines and from the monotonous exhaustion of struggling to live a normal life.

the labor of those who suffer without having to be present to their anguish. For the characters who appear in the story, the world is a hostile and deadly place. For those who are absent, the world progresses as it should.

These multiple layers of negation are further illustrated by the (possibly) deliberate lack of racial or cultural identifiers. As I indicated above, there are only hints of the national origins of the various characters in the story. Although the children fear being deported to Tijuana, Mexico, this may indicate that Mexico is their country of origin or it may be an acknowledgement of the indiscriminate practices of some immigration agents who do not concern themselves with relocating undocumented immigrants to their countries of origin—only with ensuring that they are no longer on *this side* of the border. Regardless of his own identity, the diner's owner identifies all of the other characters as members of a homologous group of Hispanic others. Their particular identities, cultures, and traditions are inconsequential. What matters is that, even in his destitute state, *they* are beneath *him*.

However, the zero-zero place, as a site of double negation, has a second double meaning. This second set of meanings directly addresses the experiences of exile. Macky, Sonya, their parents, and Geraldo's mother were all forced to abandon their original homes because of the dehumanizing effects of economic hardship and political corruption. They were forced to leave what they had known, what was familiar, what was home. As stated by Geraldo's mother, what they had left behind could no longer be home for them. They are the displaced people seeking a new home and upon arriving in the United States they find themselves subject, once again, to the same dehumanizing process. Their physical appearance and their manner of speech are markers of their alterity—their otherness. They are not welcomed, but exiled, once again. They are relegated to the invisible margins of

society. The diner's owner gives voice to this second exile when he says of Geraldo's mother: "I hear the lady saying something in Spanish. Right off I know she's illegal, which explains why she looks like a weirdo" (70). The literary theorist Sonia Saldívar-Hull comments on this short story: "Here Viramontes unmasks how the dominant marginalize on the basis of color and language."[784]

La Facultad

Gloria Anzaldúa calls for the development of *la facultad*, which she describes as "the capacity to see in surface phenomena the meaning of deeper realities, to see the deep structures below the surface."[785] *La facultad*, then, allows a reader to reflect upon the experiences of others (in this case the victims of oppression) and come to a new understanding regarding the nature of violence and injustice. Such an approach resonates with Boler's challenge to make contact with others in ways that go beyond a passive empathy that enables one to maintain a safe distance. One of the deeper realities that may be encountered in this story is the reader's own complicity in perpetuating systems of cruelty and brutality. *La facultad,* according to Anzaldúa, is a skill that is often developed, unconsciously, by those who live at the social margins. It is a skill that permits them to find meaning in experiences that might otherwise deny meaning. Further, this capacity helps to protect the marginalized from the reductionistic representations that are made of them by the privileged. Yet, Anzaldúa states, this capacity "is latent in all of us."[786] In the reader,

[784] Sonia Saldívar-Hull, *Feminism on the Border: Chicana Gender Politics and Literature* (Berkeley, CA: University of California Press, 2000), 148.

[785] Anzaldúa, *Borderlands*, 38.

[786] Ibid., 39.

development of *la facultad* marks a transition from apathy and naïveté to awareness, to attention, to *conscientização*. Anzaldúa concedes that for many this transition is a frightening experience. In place of a superficial view of the world, readers become aware of the stories of others—of unknown others. The social distance between the self and the other is reduced and the self is compelled to act by knowing the stories of others.

In "The Cariboo Cafe," the capable reader is invited to see past lost keys, grieving parents, and conflicted business owners. Instead, the reader is asked to see the multiple layers of oppression and racism that coalesce to dominate and annihilate certain groups. The reader is asked to see beyond the warehouse district of a single American city and recognize the convergence of international, national, and state practices which wreak havoc on the lives of the already vulnerable.

Both Geraldo's mother and the diner's owner exemplify what happens when one is incapable of coming to a new awareness regarding the lived experience of others. When a Lévinasian understanding of obligation towards the other (any other) is replaced by a belief that those of lower status are expendable, violence is the only result. For the owner, the stories of the lives of his customers mattered only to the extent that they reflected his own story. He was patient with Paulie only because he reminded the man of his son JoJo. The owner developed a certain amount of affection for Macky only because he reminded the man of a younger JoJo. Even after having to wipe the blood of a murdered woman from the floor of his diner, the man is conscious only of how that tragic event continues to affect his business.

The woman is moved to protect Macky because she confuses him with her own dead son. In effect, she becomes the worst personification of *La Llorona* who roamed the

earth looking for children to replace the ones she murdered. Because she is unable to gaze more deeply into Macky's (and Sonya's) situation, the woman's attempt to protect the children results in her placing them in even greater danger. For the woman and the man, finding deeper realities in the lives of others is irrelevant. Only their own stories matter. As a result, marginalization is perpetuated, even heightened.

Relevance for Socially Conscious Medicine

There is yet another reason that training programs in cultural competency will be ineffective in contributing to a reform of racial disparities in health care. Preparing medical students and physicians to attend to the cultural particularities of their patients rests on the assumption that the patients who are cultural strangers have unfettered access to medical services. But just as the characters in this short story have been negated and ignored by the broader society, those who are victims of health disparities often remain nameless, faceless, and voiceless. Rejection of their otherness prevents them from accessing the services they need, but it also prevents their suffering from being recognized or appreciated by the general public—double negation. Saldívar-Hull challenges readers to consider the social structures that work to exclude certain groups from the goods of society because they are *other*. Saldívar-Hull recognizes the voice of the diner owner's as a caricature of the voice of the dominant group in society. She holds that the diner owner's critical observations of Geraldo's mother reflect the

> rationale when people of color are barred from integration into U.S. society. Because immigrants of different skin color belie the melting pot myth, it is

> harder for them to be accepted in the same way that European immigrants have been accepted in the history of U.S. colonization.[787]

Nussbaum insists that reading literature is not enough. Ethical principles, lived experience, personal reflection, and the text must all be brought into dialogue. The reader's moral knowledge is expanded as she moves back and forth between each of these different elements.

Reading this story against a Lévinasian understanding of otherness could lead one to reconsider how a society (in this case the United States) and its citizens ought to respond to racial and cultural minorities. The argument has been made that the race-based disparities in access to health-care services are still present even when other confounding factors (education, employment, geography, language, etc.) can be accounted for. There is a subtle, but incredibly important, concept that is at the heart of this argument. It is akin to saying, Even when racial and cultural minorities are mostly like us there are still disparities in health care. Presumably, there should be some horror in bringing medical students and physicians to the realization that persons who are very nearly like the identified us are still not receiving adequate medical attention. Are those who make this argument trying to say, "They are so much like us that we should treat them like us." In their resemblance to the us, they are freed from the brand of other, because, as is suggested by this line of thinking, being too other may still be a justifiable reason for being excluded.

By returning to Lévinas, the reader may be challenged to remember that there is no other that is too other. All that one (the same) encounters is other. And one has the same ethical responsibility to any other. One is indebted to the other and is obligated to help, but

[787] Saldívar-Hull, *Feminism on the Border*, 148.

to help her as she needs to be helped. The grieving mother helped the children, but only because she was attempting to recreate her own life according to her own needs. The diner's owner opened his doors to undocumented immigrants and cultural strangers, but only because of the economic benefit of doing so. He also helped the immigration authorities but, again, only to help himself.

This story is also about the lack of openness to these others. They have been exiled to live in a most dangerous environment. But exiled by whom? Will the reader recognize her own complicity in allowing people to live in these conditions? Will the medical student, who volunteers a few hours a month at a community-based clinic in an impoverished neighborhood, recognize her blindness to the complex network of oppression that relegates her patients to seeking medical treatment in makeshift clinics?

Conclusion

There is a great deal of literature and scholarship on the issue of race-based disparities in health care. Effective solutions, however, have yet to be developed.[788] There are, unfortunately, a number of proposed solutions that may succeed only in worsening the situation.

Beyond Cultural Competence

When intercultural differences become the focus of efforts to reduce health disparities that correlate with racial identity, the issues are clouded and the problems are camouflaged. This is not to say that intercultural differences are not significant. Any miscommunication (including miscommunication between persons from different cultural traditions) is a real problem in clinical practice. And miscommunication may be exacerbated when one or more parties in the conversation have made assumptions about the other (e.g., the other's perspective, motivation, mental capacity, sophistication, education, intellect, etc.). Culture, as a human phenomenon, influences all parties in all of the capacities indicated here and the attitudes they may hold towards difference itself.

For all the reasons explored in this dissertation, memorizing cultural lists about particular groups is a dangerous and unethical practice. Instead, one must learn how to be present to the other *in her otherness*. Learning how to listen and to see (not despite but through these many interpersonal differences, the differences between the patient and the physician) is critical to expert clinical care. Narrative and literary theory and practices have

[788] Christopher Gearon, "Eliminating Disparities Using a Quality-Improvement Focus," *Advances*, no. 1 (2005): 1.

much to offer clinicians in this capacity. Such an approach will serve both clinicians and patients as it extends far beyond the differences that exist between cultures. In their practice, clinicians are exposed to the broad spectrum of humanity: gender, sexual orientation, ability, age, religion, philosophy, and political affiliation (to name but a few aspects of human identity). When miscommunication occurs (miscommunication that may contribute to health disparities), it is not because the other is different, but because those differences between the two have not been recognized and approached responsibly, those differences have been grossly exaggerated, or the other is disregarded because of the differences she represents. Training programs that focus on the differences of the other (either by minimizing those differences or by attempting to sensitize clinicians to specific differences by use of encyclopedic descriptions or native informants) fail to address the most critical aspect of that encounter: one's attitude towards difference.

There is yet another shortcoming in focusing on culture. Such an approach places the burden on the cultural stranger either to justify her otherness or to wait to be justified by one who has been identified as a legitimate speaker within the dominant medicoprofessional discourse. The requests made by cultural strangers must either be legitimized by accepted authorities on the clinical aspects of culture or they may be dismissed.

Finally, expecting multicultural training to resolve race-based health disparities rests on the assumption that those disparities are the result of simple misunderstandings between physicians and patients who do not share the same cultural values and perspectives. Focusing on intercultural differences ignores the legacy of interracial conflict and the long history of marginalizing those who do not fit into the hegemonic definition of

us. The unjust exercise of social power, the control over the very bodies of others, and the exclusion of certain groups from the goods of society are not explored. Further, the ways in which many training programs serve only to replicate the patterns of cultural and racial dominance—defining and speaking for others who are deemed unworthy of speaking for themselves—go unnamed.

For these reasons (and many others), cultural competency ought to be abandoned as a goal of medical education. In clinical care, narrative skills guided by an attitude of humility may be the only appropriate approach to a patient (regardless of her culture). And, in order to address racial disparities in health care, educational models are needed that facilitate the transformation of the participant and, subsequently, the transformation of society. Such models will require the active engagement by participants and will foster the development of the moral vision necessary to recognize, frame, and respond to unjust practices.

Using Literature

For some time, proponents of narrative competence in medicine have argued that medicine practiced well is medicine practiced from a narrative understanding of the patient, of illness, and of life in general. Narrative competence provides the physician with the skills necessary to read her patient more fully (although never completely) and to help bring cohesion and meaning to the story of the patient. Further, narrative competence contributes to the privileging of the patient's account of her own story. Curiously, these scholars have failed to identify narrative competence in medicine as a superior model for preparing physicians to effectively engage patients who may be cultural strangers.

Narrative competence in medicine would eliminate the need for training physicians about specific cultures. Instead, by privileging the patient's position, the physician is free to learn from the patient; the patient is acknowledged as the authority regarding her own identity and how she desires to live her life. Yet even narrative competence in medicine may not be enough to resolve structural and societal problems that contribute to race-based disparities in access to and quality of health-care services.

To that end, literature also provides an opportunity for engaging in moral and ethical reflection on issues of social injustice. The patterns and skills one develops in the reading of a work of literature can translate to one's lived experience. One can begin to read one's environment and recognize destructive patterns and practices that might otherwise have gone unnoticed. An important step in this process is also served by reading literary works: unlearning patterns of seeing (and not seeing). Well-written works of literature and the development of narrative skills can prepare clinicians to reflect upon the injustice that is present in the practice of medicine. By developing a new understanding, clinicians will be better positioned to address practices and policies that exclude certain members of the community from expert medical care.

Socially Conscious Medicine

Donald Bateman, the former Head of Faculty at Brunel College, states, "The history of medicine is officially recorded by its practitioners, or researchers, and not its victims. The sick, like the poor, leave few archives behind."[789] Those who have been excluded and

[789] Donald Bateman, "The Good Bleed Guide," in *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, ed. Trisha Greenhalgh and Brian Hurwitz (London, UK: BMJ Books, 2004), 39.

silenced may not be able to, on their own, make their voices heard. What is needed is for the medical profession to accept the responsibility of standing in solidarity with those who have been silenced. Care must be taken to ensure (to the extent possible) that advocacy be an act of completing the speech-acts of those who most need to speak. Ethical and responsible representation of another may only be accomplished by learning to stand in genuine solidarity with the other. Richard Rorty, a philosopher, states:

> Solidarity is not discovered by reflection but created. It is created by increasing our sensitivity to the particular details of the pain and humiliation of other, unfamiliar stories of people. Such increased sensitivity makes it more difficult to marginalize people different from ourselves.[790]

According to Rorty, learning to stand in solidarity "is a task not for theory but for genres such as ethnography, the journalist's report, the comic book, the docudrama, and, especially, the novel.[791] He continues, "Fiction ... gives us details about what sorts of cruelty we ourselves are capable of, and thereby lets us redescribe ourselves."[792] Although it does not appear in this short list, the short story clearly fits into Rorty's vision of what literature can do for medical education, clinical practice, and social consciousness.

This is no simple task. One will not be immediately transformed into an expert and socially conscious physician because one has skimmed the pages of a short story. Society will not be healed because a handful of students read a good book. On the contrary, it is a long and arduous process. And one must not forget that students and physicians may (consciously or unconsciously) resist the work for which I have advocated here. Not having

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[790] Richard Rorty, *Contingency, Irony, and Solidarity* (Cambridge, UK: Cambridge University Press, 1989), xvi.

[791] Ibid.

[792] Ibid.

written with the practice of medicine in mind, Gayatri Spivak does not define or propose a clearly articulated plan for an ethical practice of medicine (or for any profession). Yet her arguments, taken together, provide a rich resource for moral and ethical reflection (with literature and with lived experience) that fosters the practice of socially conscious medicine.

Learning to Learn. Spivak contends that for genuine reflection on issues of injustice, one must first learn (or, *re*learn) to learn. In this case, Spivak argues that one needs to learn *to* learn from below.[793] Her point is that there are some insights, some knowledge, some truth that will only come from the lived experienced of the most marginalized. No amount of talking *about* a *them* will bring one any closer to understanding. Instead, one must be willing to place oneself, humbly, into contact with the least privileged. This, Spivak argues, requires unlearning patterns of power, expectations of privilege, and perceptions of authority. In this area, it is the marginalized and the exiled who are the authorities on their own experience. Spivak defines her work thusly, "I always try to imagine what things look like from the point of view of the least privileged group of women."[794] And she finds answers to her questions in the activist work she does with disenfranchised persons. Paraphrasing Spivak's challenge to herself, one who seeks to practice socially conscious medicine might ask: "What do medicine and health care look like to the least privileged persons living in the United States?" One would then need to commit oneself to seeking the answers in the lived experience of those whom one has first contemplated. Here, narrative skills will prove useful as one attempts to read the experience of another and to identify coherence in her story.

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[793] Gayatri Chakravorty Spivak, "Cultural Dominance at Its Most Benevolent: An Interview with Gayatri Chakravorty Spivak," *Arena* 6 (1996): 36.

[794] Ibid., 35.

Inhabiting Dominance. Spivak reflects on speaking an "impossible 'no' to a structure which one critiques, yet inhabits intimately."[795] It is not possible, she argues, to critique a system or a social structure from a distance. Instead, "The only things one really deconstructs are things in which one is intimately mired."[796] To be effective, one must engage in critical inquiry from within—it is only from within that the dominant discourse can be challenged or changed.[797] By being within, however, one must acknowledge the ways in which one has been formed and manipulated by the dominant discourse. Spivak states, "[L]et us become vigilant about our own practice and use it is as much as we can rather than make the totally counter-productive gesture of repudiating it."[798] Disavowing a corrupt system may appear heroic or prophetic. Yet such an action can result only in distancing oneself from the site where one may do the most good. An attentive and reflective practitioner can establish meaningful and transformative affiliations with both her patients and the system that she seeks to renew.

A Collective Effort. Spivak acknowledges that, despite one's best efforts, in communication there is always that which remains unspoken.[799] It is not that one has chosen not to disclose certain information, but that one has been unable to communicate something that has remained unexpressed, secret. But, argues Spivak, that final piece may only ever be communicated through an intimacy that may never be attained. A physician, a

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[795] Spivak, *Outside in the Teaching Machine*, 281.

[796] Spivak, *The Post-Colonial Critic: Interviews, Strategies and Dialogues*, 135.

[797] Joanne Sulman et al., "Does Difference Matter? Diversity and Human Rights in a Hospital Workplace," *Social Work in Health Care* 44, no. 3 (2007): 49.

[798] Spivak, *The Post-Colonial Critic: Interviews, Strategies and Dialogues*, 11.

[799] Gayatri Chakravorty Spivak, translator's preface to *Imaginary Maps: Three Stories by Devi Mahasweta* (New York, NY: Routledge, 1995), xxv.

community leader, or a social activist will never be able to fully engage every possible patient, community member, or collaborator. For this reason, Spivak refers to ethics as "the experience of the impossible."[800] Her point is that movements succeed and transformation is possible only as a result of "collective political struggle."[801] Despite the impossibility of deep and meaningful engagement between all persons, working in a collective can compensate for some of those deficiencies. Yet in the absence of full ethical engagement, "there is no victory, but only victories that are also warnings."[802] In a sense, Spivak is warning against the loss of hope when faced with the reality that perfect and total transformation may not be possible. She provides an honest assessment of the difficulties (and impossibilities?) of social transformation, as she provides encouragement that in the absence of the ideal there can still be movement in a positive direction.

Complicity. This issue has already been addressed several times throughout this dissertation. Yet Spivak repeatedly calls the attention of readers (and potential revolutionaries) to the way in which one may be unknowingly complicit with structures of dominance. Further, Spivak warns that unreflective actions intended to *liberate* the oppressed are frequently (if unknowingly) supportive of the hegemonic discourse that maintains the oppression. That is it say, intended liberators, when they do not take the time to reflect on what they are doing, can often contribute to continued domination and oppression of their intended beneficiaries.[803] Spivak's challenge to recognize one's

[800] Ibid.

[801] Ibid.

[802] Ibid.

[803] Spivak, *In Other Worlds*, 109, 122, 347.

complicity is not intended as an accusation but as an invitation to respond and reflect in more intellectually robust ways.

No Guarantees. Spivak warns that all of one's most fervent efforts may not lead to the outcomes for which one hopes:

> What I am trying to come to grips with now is a much more serious problem, shared by old-style Marxist organization as well as these 'anti-systemic' imperatives, that real mind-changing formations of collectivity, that will withstand and survive victory, is incredibly slow and time-consuming work, with no guarantees.[804]

She is critical of superficial social action (i.e, corporate philanthropy) and argues that the trivialization of the humanities has left the general public ill-equipped to engage in the critical inquiry necessary to resist (or even recognize) destructive social structures. A return to the humanities (in this case, literature) would, therefore, provide individuals and collectives with the skills necessary to engage in the "slow and time-consuming work" of social transformation.

Intercultural differences will always exist, and the only appropriate posture is one of humility and indebtedness before the other who can never be fully known. Health disparities, which continue to persist, may be resolved only through social transformation that requires new ways of seeing the world and determining the good. Narrative skills, literary theory, and works of literature each have much to offer both of these challenges. Medical educators have already recognized the value of incorporating literary and narrative

[804] Gayatri Chakravorty Spivak, "A Note on the New International," *Parallax* 7, no. 3 (July 2001): 15.

skills into medical education. As I have argued, however, these practices can and must be pressed into greater service if there is to be meaningful change in the practice of medicine.

Health care must not be about treating patients like Mexicans, Nigerians, or Vietnamese. Health policy cannot be written by and for an *us* about a *them*. In an ethical system of health care, each will be treated like the person that he or she is: a person steeped in his or her own rich matrix of culture, politics, education, family, and history, each with a voice that must never be silenced.

Appendix A: Cultural Competency and Health Disparities

The following agencies, organizations, and individuals have all asserted that training in cultural competency will lead to a reduction in racial disparities in health care. Although most of these documents refer to disparities in health outcomes, many also refer to disparities in access to care. Both of these understandings of health disparities are considered in this dissertation.

Diana L. Denboba commenting on the work of the Health Services and Services Administration (HRSA) (1998):

> In order to achieve more culturally competent systems which reduce health disparities, all components of the HRSA's service systems are being re-examined.[805]

The Assembly on Federal Issues' Health Committee (2000):

> [Federal grants were awarded for] projects to develop curricula to reduce disparity in health care outcomes, including cultural competency in graduate and undergraduate health professions education.[806]

Cindy Brach and Irene Fraser (2000):

> Our review of the literature on disparities and cultural competency provides strong reason to believe that careful and appropriate implementation of

[805] Diana L. Denboba et al., "Reducing Health Disparities through Cultural Competence," *Journal of Health Education* 29, no. 5 (September-October 1998): S49.

[806] *Health Acts 2000: Summary: Minority Health and Health Disparities Research and Education Act of 2000*, National Conference of State Legislatures, http://www.ncsl.org/statefed/health/MinHlt.htm (accessed on March 12, 2008).

sound cultural competency techniques in delivering health services could go a long way toward reducing disparities.[807]

The Office of Minority Health (2001):

[B]y increasing [physicians'] cultural diversity and competence and making their patients feel comfortable about receiving health care, providers would be able to focus better on health disparities in minority populations and thus decrease a major health economic issue in the United States.[808]

The Agency for Healthcare Research and Quality (2001):

Cultural competence in the provision of care can minimize the perception of disadvantage in accessing quality health care.[809]

Joseph Betancourt, Alexander Green, and J. Emilio Carrillo writing for the Commonwealth Fund (2002):

Experts interviewed, on the other hand, drew clear links among cultural competence, quality improvement, and the elimination of racial or ethnic disparities in care.[810]

The HIV/AIDS Bureau (2002):

Improved cultural competency on the part of providers and health care organizations—which has been given considerable attention in the CARE Act community—is an important and, perhaps, decisive component of any

[807] Brach and Fraser, "Can Cultural Competency Reduce Racial and Ethnic Health Disparities?" 202-203.

[808] Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, 50.

[809] Agency for Healthcare Research and Quality, *Strategies to Reduce Health Disparities: Cultural Competence*, U.S. Department of Health and Human Services, http://www.ahrq.gov/news/ulp/dispar /dispar7.htm (accessed on March 12, 2008).

[810] Betancourt, Green, and Carrillo, *Cultural Competence in Health Care*, 6.

approach to mitigating disparities in health access and outcomes among minorities and other underserved populations.[811]

The Bureau of Health Professionals' Advisory Committee on Training in Primary Care Medicine and Dentistry (2003):

The provision of culturally effective care is critical to the delivery of quality health care for all Americans. Being culturally competent to deliver that care is seen as a way to respond to diverse patient populations, reduce health care disparities, and improve the quality of care for all patients. Experts draw clear links between cultural competence, quality improvement, and the elimination of racial or ethnic disparities in care.[812]

Wendy E. Mouradian, Joel H. Berg, and Martha J. Somerman (2003):

[H]ealth disparities may act through health systems as well as provider behaviors, systems must be examined for their cultural and linguistic competency.[813]

The Sullivan Commission (2004):

Public and private funding entities, including U.S. Public Health Service agencies, foundations, and corporations, should increase funding for research about racial disparities in health care and health status, including, but not limited to: research on culturally competent care, how to measure

[811] HIV/AIDS Bureau, *Mitigating Health Disparities through Cultural Competence*, Health Resources and Service Administration, http://hab.hrsa.gov/publications/august2002.htm (accessed on March 4, 2008).

[812] Advisory Committee on Training in Primary Care Medicine and Dentistry, *Training Culturally Competent Primary Care Professionals to Provide High Quality Healthcare for All Americans: The Essential Role of Title VII, Section 747, in the Elimination of Healthcare Disparities: Third Annual Report to the Secretary of the U.S. Department of Health and Human Services and to Congress*, Health Resources and Services Administration, http://bhpr.hrsa.gov/medicine-dentistry/actpcmd/reports/actpcmdreport.htm#hdccq (accessed on April 12, 2008).

[813] Wendy E. Mouradian, Joel H. Berg, and Martha J. Somerman, "Addressing Disparities through Dental-Medical Collaborations, Part 1: The Role of Cultural Competency in Health Disparities: Training of Primary Care Medical Practitioners in Children's Oral Health," *Journal of Dental Education* 67, no. 8 (August 2003): 863.

and eliminate racial bias and stereotyping, and strategies for increasing positive health behaviors among racial and ethnic groups.[814]

The American College of Physicians (2004):

Physicians and other health care providers must be sensitive to cultural diversity among patients and recognize that inherent biases can lead to disparities in health care among racial and ethnic minorities. Cultural competency training should be incorporated in the training and professional development of all health care providers, at all levels.[815]

Joseph Betancourt, Alexander Green, J. Emilio Carrillo, and Elyse Park (2005):

Cultural competence has gained attention from health care policymakers, providers, insurers, and educators as a strategy to improve quality and eliminate racial/ethnic disparities in health care. The goal of cultural competence is to create a health care system and workforce that are capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency.[816]

Wanda Jones, Guadalupe Pacheco, and Elena V. Rios (2005):

[C]ultural competency [is] a critical component in addressing racial and ethnic health disparities in women's health.[817]

Fadia T. Shaya and Confidence M. Gbarayor (2006):

Changing the behaviors, attitudes, and policies within the health professions to address cultural competence is warranted to meet the health care needs of diverse patient populations. This change is most effective at the initial stage of health professional education with the implementation of a

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[814] Sullivan Commission, *Missing Persons: Minorities in Health Professions* (Durham, NC: Duke University, 2004), 5.

[815] American College of Physicians, "Racial and Ethnic Disparities in Health Care," 228.

[816] Joseph Betancourt et al., "Cultural Competence and Health Care Disparities: Key Perspectives and Trends," *Health Affairs* 24, no. 2 (March/April 2005): 499.

[817] Wanda Jones, Guadalupe Pacheco, and Elena V. Rios, *Cultural Competency: A Critical Component to Address Racial and Ethnic Health Disparities for Women*, Kaiser Network, http://www.kaisernetwork.org/health_cast/uploaded_files/071405_wpi_disparities.pdf (accessed on April 12, 2008).

> culturally competent curriculum that addresses health disparities. Additionally, the curricula should be supplemented with knowledge and skills drawn from other disciplines such as the behavioral and social sciences. Educating health professional students about cultural competence, including cultural knowledge, awareness, and sensitivity, may help to bridge the gaps between provider and patient relationships.[818]

The American Medical Association (2006):

> The following guidelines are intended to help reduce racial and ethnic disparities in health care.... Physicians should seek to gain greater understanding of cultural or ethnic characteristics that can influence patients' health care decisions.[819]

Suzanne Selig, Elizabeth Tropiano, and Ella Greene-Moton (2006):

> Cultural competency has become recognized as an important contributing factor in health disparities, particularly in the patient-provider interaction, affecting diagnosis, treatment, and other aspects of care delivery.[820]

The Board on Population Health and Public Health Practice, Institute of Medicine (2008):

> [The American Conference on Diversity] acts as a laboratory in many ways, working to achieve goals that few other organizations are attempting and seeks innovative methods for changing deep-rooted beliefs and institutional procedures that can affect health disparities. A recent project focused on developing a Cultural Competency Training Program and educating trainers to administer the program in hospitals throughout New Jersey.[821]

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[818] Fadia T. Shaya and Confidence M. Gbarayor, "The Case for Cultural Competence in Health Professions Education," *American Journal of Pharmaceutical Education* 70, no. 6 (December 15, 2006): 6.

[819] American Medical Association, *Code of Medical Ethics*, 298.

[820] Suzanne Selig, Elizabeth Tropiano, and Ella Greene-Moton, "Teaching Cultural Competence to Reduce Health Disparities," *Health Promotion Practice* 7, no. 3 Suppl. (July 2006): 248S.

[821] Jennifer A. Cohen, *Challenges and Successes in Reducing Health Disparities: Workshop Summary* (Washington, DC: National Academies Press, 2008), 91-92.

Appendix B: Knowledge Deficits

Sometimes conflicts do arise that are the direct result of a knowledge deficit. In these cases, education may quickly remedy the situation. When working for an early childhood intervention program, I was responsible for facilitating communication between English-speaking educators and evaluators and Spanish-speaking families. While I began with a simple understanding of my role, I quickly discovered that in most cases more was required than simply interpreting from one language to another.

On one occasion, a child was being evaluated for her eligibility for a particular program that was available to children who had advanced to a certain stage of linguistic development. One of the indicators was the child's ability to build and use phrases of three words. The evaluator, who had a rudimentary grasp of the Spanish language, observed the child over the course of several days. In his notes, he indicated that the child was capable of speaking only in one- or two-word utterances and was therefore ineligible for placement in the early childhood enrichment program.

Stepping somewhat outside of my role as interpreter, I asked the evaluator if the criteria required that the child's utterances be composed of three distinct words (graphemes) or if there was an allowance for utterances that were composed of three distinct units of meaning (morphemes) regardless of the individual word count. The evaluator, at first, did not understand my question but was willing to engage me in the conversation as I explained.

During those same observations, I had repeatedly overheard the child utter (in Spanish) words such as *dámelo*. In the Spanish language, the imperative (i.e., command)

mood of a verb is formed by using the root of the verb and appending the pronouns for both the direct and indirect objects. In this case, *dámelo*, is the product of joining *dar* (to give), *me* (me), and *lo* (it)—three distinct units of meaning. A common translation for *dámelo* is "give it to me." In a pattern that parallels English-language development in children, as Spanish-speaking children develop their language abilities, they only gradually develop the understanding necessary to create these compound words. In this case, a younger child would typically say only *da* (give). As she developed her language skills, she would then use *dame* (give me). And only later would she learn to incorporate the additional pronoun and say *dámelo*.

When I was able to explain this to the evaluator, he realized the limitations of the evaluation tool and changed his assessment of the child's eligibility for the early childhood enrichment program. He also recommended that the agency reevaluate its assessment tools.

Appendix C: "The Cariboo Cafe"

The Cariboo Cafe

I

They arrived in the secrecy of night, as displaced people often do, stopping over for a week, a month, eventually staying a lifetime. The plan was simple. Mother would work, too, until they saved enough to move into a finer future where the toilet was one's own and the children needn't be frightened. In the meantime, they played in the back alleys, among the broken glass, wise to the ways of the streets. Rule one: never talk to strangers, not even the neighbor who paced up and down the hallways talking to himself. Rule two: the police, or "polie" as Sonya's popi pronounced the word, was La Migra in disguise and thus should always be avoided. Rule three: keep your key with you at all times—the four walls of the apartment were the only protection against the streets until Popi returned home.

Sonya considered her key a guardian saint and she wore it around her neck as such until this afternoon. Gone was the string with the big knot. Gone was the key. She hadn't noticed its disappearance until she picked up Macky from Mrs. Avila's house and walked home. She remembered playing with it as Amá walked her to school. But lunch break came, and Lalo wrestled her down so that he could see her underwear, and it probably fell somewhere between the iron rings and sandbox. Sitting on the front steps of the apartment building, she considered how to explain the missing key without having to reveal what Lalo had seen, for she wasn't quite sure which offense carried the worse penalty.

She watched people piling in and spilling out of the buses, watched an old man asleep on the bus bench across the street. He resembled a crumbled ball of paper, huddled up in the security of a tattered coat. She became aware of their

mutual loneliness and she rested her head against her knees, blackened by the soot of the playground asphalt.

The old man eventually awoke, yawned like a lion's roar, unfolded his limbs and staggered to the alley where he urinated between two trash bins. (She wanted to peek, but it was Macky who turned to look.) He zipped up, drank from a paper bag, and she watched him until he disappeared around the corner. As time passed, buses came less frequently, and every other person seemed to resemble Popi. Macky became bored. He picked through the trash barrel; later, and to Sonya's fright, he ran into the street after a pigeon. She understood his restlessness, for waiting was as relentless as long lines to the bathroom. When a small boy walked by, licking away at a scoop of vanilla ice cream, Macky ran after him. In his haste to outrun Sonya's grasp, he fell and tore the knee of his denim jeans. He began to cry, wiping snot against his sweater sleeve.

"See?" she asked, dragging him back to the porch steps by his wrist. "See? God punished you!" It was a thing she always said because it seemed to work. Terrified by the scrawny tortured man on the cross, Macky wanted to avoid His wrath as much as possible. She sat him on the steps in one gruff jerk. Seeing his torn jeans and her own scraped knees, she wanted to join in his sorrow and cry. Instead, she snuggled so close to him she could hear his stomach growling.

"Coke," he said. Mrs. Avila gave him an afternoon snack which usually held him over until dinner. But sometimes Macky got lost in the midst of her own six children and...

Mrs. Avila! It took Sonya a few moments to realize the depth of her idea. They could wait there, at Mrs. Avila's. And she'd probably have a stack of flour tortillas, fresh off the comal, ready to eat with butter and salt. She grabbed his hand. "Mrs. Avila has Coke."

"Coke!" He jumped up to follow his sister. "Coke," he cooed.

At the major intersection, Sonya quietly calculated their next move while the scores of adults hurried to their own destinations. She scratched one knee as she tried retracing her journey home in the labyrinth of her memory. Things never looked the same when backwards and she searched for familiar scenes. She looked for the newspaperman who sat in a little house with a little T.V. on and sold magazines with naked

girls holding beach balls. But he was gone. What remained was a little closet-like shed with chains and locks, and she wondered what happened to him, for she thought he lived there with the naked ladies.

They finally crossed the street at a cautious pace, the colors of the street lights brighter as darkness descended, a stereo store blaring music from two huge, blasting speakers. She thought it was the disco store she passed, but she didn't remember if the sign was green or red. And she didn't remember it flashing like it was now. Studying the neon light, she bumped into a tall, lanky dark man. Maybe it was Raoul's Popi. Raoul was a dark boy in her class that she felt sorry for because everyone called him spongehead. Maybe she could ask Raoul's Popi where Mrs. Avila lived, but before she could think it all out, red sirens flashed in their faces and she shielded her eyes to see the polie.

The polie are men in black who get kids and send them to Tijuana, says Popi. Whenever you see them, run, because they hate you, says Popi. She grabs Macky by his sleeve and they crawl under a table of bargain cassettes. Macky's nose is running, and when he sniffles, she puts her finger to her lips. She peeks from behind the poster of Vincente Fernandez to see Raoul's father putting keys and stuff from his pockets onto the hood of the polie car. And it's true, they're putting him in the car and taking him to Tijuana. Popi, she murmured to herself. Mamá.

"Coke." Macky whispered, as if she had failed to remember.

"Ssssh. Mi'jo, when I say run, you run, okay?" She waited for the tires to turn out, and as the black and white drove off, she whispered "Now," and they scurried out from under the table and ran across the street, oblivious to the horns.

They entered a maze of alleys and dead ends, the long, abandoned warehouses shadowing any light. Macky stumbled and she continued to drag him until his crying, his untied sneakers, and his raspy breathing finally forced her to stop. She scanned the boarded-up boxcars, the rows of rusted rails to make sure the polie wasn't following them. Tired, her heart bursting, she leaned him against a tall chain-link fence. Except for the rambling of some railcars, silence prevailed, and she could hear Macky sniffling in the darkness. Her mouth was parched and she swallowed to rid herself of the

metallic taste of fear. The shadows stalked them, hovering like nightmares. Across the tracks, in the distance, was a room with a yellow glow, like a beacon light at the end of a dark sea. She pinched Macky's nose with the corner of her dress, took hold of his sleeve. At least the shadows will be gone, she concluded, at the zero-zero place.

II

Don't look at me. I didn't give it the name. It was passed on. Didn't even know what it meant until I looked it up in some library dictionary. But I kinda liked the name. It's, well, romantic, almost like the name of a song, you know, so I kept it. That was before JoJo turned fourteen even. But now if you take a look at the sign, the paint's peeled off 'cept for the two O's. The double zero cafe. Story of my life. But who cares, right? As long as everyone 'round the factories knows I run an honest business.

The place is clean. That's more than I can say for some people who walk through that door. And I offer the best prices on double-burger deluxes this side of Main Street. Okay, so it's not pure beef. Big deal, most meat markets do the same. But I make no bones 'bout it. I tell them up front, 'yeah, it ain't dogmeat, but it ain't sirloin either.' Cause that's the sort of guy I am. Honest.

That's the trouble. It never pays to be honest. I tried scrubbing the stains off the floor, so that my customers won't be reminded of what happened. But they keep walking as if my cafe ain't fit for lepers. And that's the thanks I get for being a fair guy.

Not once did I hang up all those stupid signs. You know, like 'We reserve the right to refuse service to anyone,' or 'No shirt, no shoes, no service.' To tell you the truth—which is what I always do though it don't pay—I wouldn't have nobody walking through that door. The streets are full of scum, but scum gotta eat too is the way I see it. Now, listen. I ain't talking 'bout out-of-luckers, weirdos, whores, you know. I'm talking 'bout five-to-lifers out of some tech. I'm talking Paulie.

I swear Paulie is thirty-five, or six. JoJo's age if he were still alive, but he don't look a day over ninety. Maybe why I let him hang out is 'cause he's JoJo's age. Shit, he's okay as long as he don't bring his wigged-out friends whose voices

sound like a record at low speed. Paulie's got too many stories and they all get jammed up in his mouth so I can't make out what he's saying. He scares the other customers, too, acting like he is shadow boxing, or like a monkey hopping on a frying pan. You know, nervous, jumpy, his jaw all falling and his eyes bulgy and dirt-yellow. I give him the last booth, coffee, and yesterday's donut holes to keep him quiet. After a few minutes, out he goes, before lunch. I'm too old, you know, too busy making ends meet to be nursing the kid. And so is Delia.

That Delia's got these unique titties. One is bigger than the other. Like an orange and grapefruit. I kid you not. They're like that on account of when she was real young she had some babies, and they all sucked only one favorite tittie. So one is bigger than the other, and when she used to walk in with Paulie, huggy-huggy and wearing those tight leotard blouses that show the nipple dots, you could see the difference. You could tell right off that Paulie was proud of them, the way he'd hang his arm over her shoulder and squeeze the grapefruit. They kill me, her knockers. She'd come in real queen-like, smacking gum and chewing the fat with the illegals who work in that garment warehouse. They come in real queen-like, too, sitting in the best booth near the window, and order cokes. That's all. Cokes. Hey, but I'm a nice guy. So what if they mess up my table, bring their own lunches and only order small cokes, leaving a dime as tip? So sometimes the place ain't crawling with people, you comprende, buddy? A dime's a dime as long as it's in my pocket.

Like I gotta pay my bills, too. I gotta eat. So like I serve anybody who's got the greens, including that crazy lady and the two kids that started all the trouble. If only I had closed early. But I had to wash the dinner dishes on account of I can't afford a dishwasher. I was scraping off some birdshit glue stuck to this plate, see, when I hear the bells jingle against the door. I hate those fucking bells. That was Nell's idea. Nell's my wife; my ex-wife. So people won't sneak up on you, says my ex. Anyway, I'm standing behind the counter staring at this short woman. Already I know that she's bad news because she looks street to me. Round face, burnt-toast color, black hair that hangs like straight ropes. Weirdo, I've had enough to last me a lifetime. She's wearing a shawl and a dirty slip is hanging out. Shit if I have to dish out a free meal. Funny thing, but I didn't see the two kids 'til I got to the

booth. All of a sudden I see these big eyes looking over the table's edge at me. It shook me up, the way they kinda appeared. Aw, maybe they were there all the time.

The boy's a sweetheart. Short Order don't look nothing like his mom. He's got dried snot all over his dirty cheeks and his hair ain't seen a comb for years. She can't take care of herself, much less him or the doggie of a sister. But he's a tough one, and I pinch his nose 'cause he's a real sweetheart like JoJo. You know, my boy.

It's his sister I don't like. She's got these poking eyes that follow you 'round 'cause she don't trust no one. Like when I reach for Short Order, she flinches like I'm 'bout to tear his nose off, gives me a nasty, squinty look. She's maybe five, maybe six, I don't know, and she acts like she owns him. Even when I bring the burgers, she doesn't let go of his hand. Finally, the fellow bites it and I wink at him. A real sweetheart.

In the next booth, I'm twisting the black crud off the top of the ketchup bottle when I hear the lady saying something in Spanish. Right off I know she's illegal, which explains why she looks like a weirdo. Anyway, she says something nice to them 'cause it's in the same tone that Nell used when I'd rest my head on her lap. I'm surprised the illegal's got a fiver to pay, but she and her tail leave no tip. I see Short Order's small bites on the bun.

You know, a cafe's the kinda business that moves. You get some regulars, but most of them are on the move, so I don't pay much attention to them. But this lady's face sticks like egg yolk on a plate. It ain't 'til I open a beer and sit in front of the B & W to check out the wrestling matches that I see this news bulletin 'bout two missing kids. I recognize the mugs right away. Short Order and his doggie sister. And all of a sudden her face is out of my mind. Aw, fuck, I say, and put my beer down so hard that the foam spills onto last month's Hustler. Aw, fuck.

See, if Nell was here, she'd know what to do: call the cops. But I don't know. Cops ain't exactly my friends, and all I need is for bacon to be crawling all over my place. And seeing how her face is vague now, I decide to wait 'til the late news. Short Order don't look right neither. I'll have another beer and wait for the late news. The alarm rings at four and I have this headache, see, from the sixpack, and I gotta get up. I was sup-

posed to do something, but I got all suck-faced and forgot. Turn off the T.V., take a shower, but that don't help my memory any.

Hear sirens near the railroad tracks. Cops. I'm supposed to call the cops. I'll do it after I make the coffee, put away the eggs, get the donuts out. But Paulie strolls in looking partied out. We actually talk 'bout last night's wrestling match between BoBo Brazil and the Crusher. I slept through it, you see. Paulie orders an O.J. on account of he's catching a cold. I open up my big mouth and ask about De. Drinks the rest of his O.J., says real calm-like, that he caught her eaglespread with the vegetable fatso down the block. Then, very polite-like, Paulie excuses himself. That's one thing I gotta say about Paulie. He may be one big Fuck-Up, but he's got manners. Juice gave him shit cramps, he says.

Well, leave it to Paulie. Good ole Mr. Fuck-Up himself to help me with the cops. The prick O.D.'s in my crapper; vomits and shits are all over—I mean all over the fuckin' walls. That's the thanks I get for being Mr. Nice Guy. I had the cops looking up my ass for the stash. Says one, the one wearing a mortician's suit, We'll be back, we'll be back when you ain't looking. If I was pushing, would I be burning my goddamn balls off with spitting grease? So fuck 'em, I think. I ain't gonna tell you nothing 'bout the lady. Fuck you, I say to them as they drive away. Fuck your mother.

That's why Nell was good to have 'round. She could be a pain in the ass, you know, like making me hang those stupid bells, but mostly she knew what to do. See, I go bananas. Like my mind fries with the potatoes and by the end of the day, I'm deader than dogshit. Let me tell you what I mean. A few hours later, after I swore I wouldn't give the fuckin' pigs the time of day, the green vans roll up across the street. While I'm stirring the chili con carne, I see all these illegals running out of the factory to hide, like roaches when the lightswitch goes on. I taste the chile, but I really can't taste nothing on account of I've lost my appetite after cleaning out the crapper, when three of them run into the Cariboo. They look at me as if I'm gonna stop them, but when I go on stirring the chile, they run to the bathroom. Now look, I'm a nice guy, but I don't like to be used, you know? Just 'cause they're regulars don't mean jackshit. I run an honest business. And that's what I told them agents. See, by that time, my stomach being all dizzy,

and the cops all over the place, and the three illegals running in here, I was all confused, you know. That's how it was, and well, I haven't seen Nell for years, and I guess that's why I pointed to the bathroom.

I don't know. I didn't expect handcuffs and them agents putting their hands up and down their thighs. When they walked passed me, they didn't look at me. That is, the two young ones. The older one, the one that looked silly in the handcuffs on account of she's old enough to be my grandma's grandma, looks straight at my face with the same eyes Short Order's sister gave me yesterday. What a day. Then, to top off the potatoes with the gravy, the bells jingle against the door and in enters the lady again with the two kids.

III

He's got lice. Probably from living in the detainers. Those are the rooms where they round up the children and make them work for their food. I saw them from the window. Their eyes are cut glass, and no one looks for sympathy. They take turns, sorting out the arms from the legs, heads from the torsos. Is that one your mother? one guard asks, holding a mummified head with eyes shut tighter than coffins. But the children no longer cry. They just continue sorting as if they were salvaging cans from a heap of trash. They do this until time is up and they drift into a tunnel, back to the womb of sleep, while a new group comes in. It is all very organized. I bite my fist to keep from retching. Please, God, please don't let Geraldo be there.

For you see, they took Geraldo. By mistake, of course. It was my fault. I shouldn't have sent him out to fetch me a mango. But it was just to the corner. I didn't even bother to put his sweater on. I hear his sandals flapping against the gravel. I follow him with my eyes, see him scratching his buttocks when the wind picks up swiftly, as it often does at such unstable times, and I have to close the door.

The darkness becomes a serpent's tongue, swallowing us whole. It is the night of La Llorona. The women come up from the depths of sorrow to search for their children. I join them, frantic, desperate, and our eyes become scrutinizers, our bodies opiated with the scent of their smiles. Descending from door to door, the wind whips our faces. I hear the wailing of

the women and know it to be my own. Geraldo is nowhere to be found.

Dawn is not welcomed. It is a drunkard wavering between consciousness and sleep. My life is fleeing, moving south towards the sea. My tears are now hushed and faint.

The boy, barely a few years older than Geraldo, lights a cigarette, rests it on the edge of his desk, next to all the other cigarette burns. The blinds are down to keep the room cool. Above him hangs a single bulb that shades and shadows his face in such a way as to mask his expressions. He is not to be trusted. He fills in the information, for I cannot write. Statements delivered, we discuss motives.

"Spies," says he, flicking a long burning ash from the cigarette onto the floor, then wolfing the smoke in as if his lungs had an unquenchable thirst for nicotine. "We arrest spies. Criminals." He says this with cigarette smoke spurting out from his nostrils like a nosebleed. "Spies? Criminal?" My shawl falls to the ground. "He is only five and a half years old." I plead for logic with my hands. "What kind of crimes could a five-year-old commit?"

"Anyone who so willfully supports the Contras in any form must be arrested and punished without delay." He knows the line by heart. I think about moths and their stupidity. Always attracted by light, they fly into fires, or singe their wings with the heat of the single bulb and fall on his desk, writhing in pain. I don't understand why nature has been so cruel as to prevent them from feeling warmth. He dismisses them with a sweep of a hand. "This," he continues, "is what we plan to do with the Contras and those who aid them." He inhales again.

"But, Señor, he's just a baby."

"Contras are tricksters. They exploit the ignorance of people like you. Perhaps they convinced your son to circulate pamphlets. You should be talking to them, not us." The cigarette is down to his yellow finger tips, to where he can no longer continue to hold it without burning himself. He throws the stub on the floor, crushes it under his boot. "This," he says, screwing his boot into the ground, "is what the Contras do to people like you."

"Señor. I am a washerwoman. You yourself see I cannot read or write. There is my X. Do you think my son can read?" How can I explain to this man that we are poor, that we live

as best we can? "If such a thing has happened, perhaps he wanted to make a few centavos for his mamá. He's just a baby."

"So you are admitting his guilt?"

"So you are admitting he is here?" I promise, once I see him, hold him in my arms again, I will never, never scold him for wanting more than I can give. "You see, he needs his sweater... " The sweater lies limp on my lap.

"Your assumption is incorrect."

"May I check the detainers for myself?"

"In time."

"And what about my Geraldo?"

"In time." He dismisses me, placing the forms in a big envelope crinkled by the day's humidity.

"When?" I am wringing the sweater with my hands.

"Don't be foolish, woman. Now off with your nonsense. We will try to locate your Pedro."

"Geraldo."

Maria came by today with a bowl of hot soup. She reports, in her usual excited way, that the soldiers are now eating the brains of their victims. It is unlike her to be so scandalous. So insane. Geraldo must be cold without his sweater.

"Why?" I ask as the soup gets cold. I will write Tavo tonight.

At the plaza, a group of people are whispering. They are quiet when I pass, turn to one another and put their finger to their lips to cage their voices. They continue as I reach the church steps. To be associated with me is condemnation.

Today I felt like killing myself, Lord. But I am too much of a coward. I am a washerwoman, Lord. My mother was one, and hers, too. We have lived as best we can, washing other people's laundry, rinsing off other people's dirt until our hands crust and chap. When my son wanted to hold my hand, I held soap instead. When he wanted to play, my feet were in pools of water. It takes such little courage, being a washerwoman. Give me strength, Lord.

What have I done to deserve this, Lord? Raising a child is like building a kite. You must bend the twigs enough, but not too much, for you might break them. You must find paper that is delicate and light enough to wave on the breath of the wind, yet must withstand the ravages of a storm. You must

tie the strings gently but firmly so that it may not fall apart. You must let the string go, eventually, so that the kite will stretch its ambition. It is such delicate work, Lord, being a mother. This I understand, Lord, because I am. But you have snapped the cord, Lord. It was only a matter of minutes and my life is lost somewhere in the clouds. I don't know, I don't know what games you play, Lord.

These four walls are no longer my house; the earth beneath it, no longer my home. Weeds have replaced all good crops. The irrigation ditches are clodded with bodies. No matter where we turn, there are rumors facing us, and we try to live as best we can under the rule of men who rape women then rip their fetuses form their bellies. Is this our home? Is this our country? I ask Maria. Don't these men have mothers, lovers, babies, sisters? Don't they see what they are doing? Later, Maria says, these men are babes farted out from the Devil's ass. We check to make sure no one has heard her say this.

Without Geraldo, this is not my home; the earth beneath it, not my country. This is why I have to leave. Maria begins to cry. Not because I am going, but because she is staying.

Tavo. Sweet Tavo. He has sold his car to send me the money. He has just married and he sold his car for me. Thank you, Tavo. Not just for the money. But also for making me believe in the goodness of people again...The money is enough to buy off the border soldiers. The rest will come from the can. I have saved for Geraldo's schooling and it is enough for a bus ticket to Juarez. I am to wait for Tavo there.

I spit. I do not turn back.

Perhaps I am wrong in coming. I worry that Geraldo will not have a home to return to, no mother to cradle his nightmares away, soothe the scars, stop the hemorrhaging of his heart. Tavo is happy I am here, but it is crowded with the three of us, and I hear them arguing behind their closed door. There is only so much a nephew can provide. I must find work. I have two hands willing to work. But the heart. The heart wills only to watch the children playing in the street.

The machines, their speed and dust, make me ill. But I can clean. I clean toilets, dump trash cans, sweep. Disinfect the sinks. I will gladly do whatever is necessary to repay Tavo. The baby is due any time and money is tight. I volunteer for odd hours, weekends, since I really have very little to

do. When the baby comes, I know Tavo's wife will not let me hold it, for she thinks I am a bad omen. I know it.

Why would God play such a cruel joke, if he isn't my son? I jumped the curb, dashed out into the street, but the street is becoming wider and wider. I've lost him once and can't lose him again and to hell with the screeching tires and the horns and the headlights barely touching my hips. I can't take my eyes off him because, you see, they are swift and cunning and can take your life with a snap of a finger. But God is a just man and His mistakes can be undone.

My heart pounds in my head like a sledgehammer against the asphalt. What if it isn't Geraldo? What if he is still in the detainer waiting for me? A million questions, one answer: Yes. Geraldo, yes. I want to touch his hand first, have it disappear in my own because it is so small. His eyes look at me in total bewilderment. I grab him because the earth is crumbling beneath us and I must save him. We both fall to the ground.

A hot meal is in store. A festival. The cook, a man with shrunken cheeks and the hands of a car mechanic, takes a liking to Geraldo. Its like birthing you again, mi'jo. My baby.

I bathe him. He flutters in excitement, the water gray around him. I scrub his head with lye to kill off the lice, comb his hair out with a fine-tooth comb. I wash his rubbery penis, wrap him in a towel, and he stands in front of the window, shriveling and sucking milk from a carton, his hair shiny from the dampness.

He finally sleeps. So easily, she thinks. On her bed next to the open window he coos in the night. Below, the sounds of the city become as monotonous as the ocean waves. She rubs his back with warm oil, each stroke making up for the days of his absence. She hums to him softly so that her breath brushes against his face, tunes that are rusted and crack in her throat. The hotel neon shines on his back and she covers him.

All the while the young girl watches her brother sleeping. She removes her sneakers, climbs into the bed, snuggles up to her brother, and soon her breathing is raspy, her arms under her stomach.

The couch is her bed tonight. Before switching the light off, she checks once more to make sure this is not a joke. Tomorrow she will make arrangements to go home. Maria

will be the same, the mango stand on the corner next to the church plaza will be the same. It will all be the way it was before. But enough excitement. For the first time in years, her mind is quiet of all noise and she has the desire to sleep.

The bells jingle when the screen door slaps shut behind them. The cook wrings his hands in his apron, looking at them. Geraldo is in the middle, and they sit in the booth farthest away from the window, near the hall where the toilets are, and right away the small boy, his hair now neatly combed and split to the side like an adult, wrinkles his nose at the peculiar smell. The cook wipes perspiration off his forehead with the corner of his apron, finally comes over to the table.

She looks so different, so young. Her hair is combed slick back into one thick braid and her earrings hang like baskets of golden pears on her finely sculptured ears. He can't believe how different she looks. Almost beautiful. She points to what she wants on the menu with a white, clean fingernail. Although confused, the cook is sure of one thing—it's Short Order all right, pointing to him with a commanding finger, saying his only English word: coke.

His hands tremble as he slaps the meat on the grill; the patties hiss instantly. He feels like vomiting. The chile overboils and singes the fires, deep red trail of chile crawling to the floor and puddling there. He grabs the handles, burns himself, drops the pot on the wooden racks of the floor. He sucks his fingers, the patties blackening and sputtering grease. He flips them, and the burgers hiss anew. In some strange way he hopes they have disappeared, and he takes a quick look only to see Short Order's sister, still in the same dress, still holding her brother's hand. She is craning her neck to peek at what is going on in the kitchen.

Aw, fuck, he says, in a fog of smoke, his eyes burning tears. He can't believe it, but he's crying. For the first time since JoJo's death, he's crying. He becomes angry at the lady for returning. At JoJo. At Nell for leaving him. He wishes Nell here, but doesn't know where she's at or what part of Vietnam JoJo is all crumbled up in. Children gotta be with their parents, family gotta be together, he thinks. It's only right. The emergency line is ringing.

Two black and whites roll up and skid the front tires against the curb. The flashing lights carousel inside the cafe.

She sees them opening the screen door, their guns taught and cold like steel erections. Something is wrong, and she looks to the cowering cook. She has been betrayed, and her heart is pounding like footsteps running, faster, louder, faster, and she can't hear what they are saying to her. She jumps up from the table, grabs Geraldo by the wrist, his sister dragged along because, like her, she refuses to release his hand. Their lips are mouthing words she can't hear, can't comprehend. Run, Run is all she can think of to do, Run through the hallway, out to the alley, Run because they will never take him away again.

But her legs are heavy and she crushes Geraldo against her, so tight, as if she wants to conceal him in her body again, return him to her belly so that they will not castrate him and hang his small blue penis on her door, not crush his face so that he is unrecognizable, not bury him among the heaps of bones, and ears, and teeth, and jaws, because no one but she cared to know that he cried. For years he cried and she could hear him day and night. Screaming, howling, sobbing, shriveling and crying because he is only five years old, and all she wanted was a mango.

But the crying begins all over again. In the distance, she hears crying.

She refuses to let go. For they will have to cut her arms off to take him, rip her mouth off to keep her from screaming for help. Without thinking, she reaches over to where two pots of coffee are brewing and throws the steaming coffee into their faces. Outside, people begin to gather, pressing their faces against the window glass to get a good view. The cook huddles behind the counter, frightened, trembling. Their faces become distorted and she doesn't see the huge hand that takes hold of Geraldo and she begins screaming all over again, screaming so that the walls shake, screaming enough for all the women of murdered children, screaming, pleading for help from the people outside, and she pushes an open hand against an officer's nose, because no one will stop them and he pushes the gun barrel to her face.

And I laugh at his ignorance. How stupid of him to think that I will let them take my Geraldo away just because he waves that gun like a flag. Well, to hell with you, you pieces of shit, do you hear me? Stupid, cruel pigs. To hell with you all, because you can no longer frighten me. I will fight you for my

son until I have no hands left to hold a knife. I will fight you all because you're all farted out of the Devil's ass, and you'll not take us with you. I am laughing, howling at their stupidity because they should know by now that I will never let my son go. And then I hear something crunching like broken glass against my forehead and I am blinded by the liquid darkness. But I hold onto his hand. That I can feel, you see, I'll never let go. Because we are going home. My son and I.

Glossary

Acculturation	A process that often occurs when two societies maintain contact over a prolonged period of time. It refers to the significant cultural changes that often occur to one or both groups. In the case of immigrant groups, this is the process by which the cultural values and priorities of the host group often replace their own.
Classism	A biased or discriminatory attitude based on perceived distinctions between social or economic classes.
Cultural Competence	The reported ability to interact with persons of various cultural backgrounds.
Cultural Humility	The acknowledgement of the limits of one's knowledge and understanding about the cultural practices and perspectives of another person.
Cultural Knowledge	Familiarity with the cultural characteristics, values, tradition, customs, history, and behaviors of select cultural groups.
Cultural Relativism	Judging and interpreting the behavior and belief of others in terms of their own traditions and experiences (see *ethnocentrism*).
Cultural Sensitivity	An understanding that each culture has its strengths and its weaknesses but that no culture, as a whole, is to be valued over any other.
Culture	**"**Culture consists of patterns, explicitly and implicitly, of and for behavior acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional (i.e., historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as patterns of action, on the other as conditioning elements of further action." (Kroeber and Kluckhohn, 357)
Egocentrism	The belief that one's perspective, values, and goals are shared by all other persons.

Ethnicity	A social category applied to a group of people who share cultural and social characteristics. While it is common for members of such groups to share physical characteristics, this similarity is an accident of social proximity. The transmission of ethnic identity is purely social and not biological.
Ethnocentrism	Judging and interpreting the beliefs and behavior of others in terms of one's own cultural values and traditions with the assumption that one's own culture is superior (see *cultural relativism*).
Health Disparities	Differences in health and health care across racial and socioeconomic groups. When speaking of health disparities, one may be referring to one of several different (but related) issues: 1) disparity in access to medical services, 2) disparity in quality of medical services received, or 3) disparity in health outcomes.
Heterocentrism	The often unconscious belief that all persons are heterosexual.
Heterosexism	The overt belief that all persons should be heterosexual.
Marginalization	The social and political process of being relegated to a lower social category. Marginalization includes the limitation of access to material and social goods.
Oppression	The act by which one group (or individual) gains more social, economic, or political power at the expense of another group (or person).
Race	A method of classifying people who have similar physical characteristics. From a scientific perspective, race is not a biologically determined category. However, as a social convention, race continues to be used to categorize persons. Many social scientist maintain that the primary purpose of racial categories is to establish dominant and subordinate groups in society.
Racism	The belief that some human population groups are inherently superior or inferior to others because of genetically transmitted characteristics

Social Injustice	The unfairness or injustice of how a society divides burdens and resources.
Stereotype	A simplified and generalized understanding held by one group about another group. Stereotypes may be positive or negative and are often based on limited information.
Vulnerability	The state of being susceptible to harm—to be at risk. One can be susceptible to any number of harms: physical injury, disease, exploitation, or loss. Vulnerability is a fluid quality that all human beings possess in degrees, and it is a quality that is itself open to change across time within the same person. Historically, vulnerable groups have been those with limited political, economic, or social power.

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Vita

John Ernest (Ernie) Aguilar was born on Dyess Air Force Base in Abilene, Texas, on February 18, 1972. Ernie is the son of Mr. and Mrs. Juan and Margarita Aguilar and the husband of Dr. David Emil Aguilar. Ernie spent the earliest years of his childhood living in his family's hometown in Mathis, Texas. After leaving Texas when he was very young, Ernie was raised primarily in northeastern Spain in the city of Zaragoza.

Before coming to the University of Texas Medical Branch (UTMB), Ernie attended the University of Texas at Austin where he earned a Bachelor of Science in Applied Learning and Development with a specialization in Spanish language education and bilingual education. During his years in Austin, Ernie tutored high school students from the largely Mexican neighborhoods in East Austin. There he served as a mentor for Mexican-American students who were hoping to be the first in their families to pursue a college education. Ernie was also certified as a Court Appointed Special Advocate (CASA) and testified on behalf of children in legal proceedings.

After completing his undergraduate studies, he attended the Washington Theological Union, Washington, DC, where he earned a Master of Divinity. While in Washington, Ernie worked at a number of social service agencies. Among these were the Healthcare for the Homeless Project (he volunteered with the mobile clinic unit and spent nights working with homeless persons who needed urgent care), Christ House (a medical recovery center for persons who were homeless), and the Special Care Unit (a homeless shelter for persons with AIDS). Upon completing his studies, Ernie then moved to New York City where he served as the associate pastor of a large, multicultural, multilingual church community, the director of pastoral care for a nursing home for persons with AIDS, and a visiting hospice chaplain.

While at UTMB, Ernie earned a great deal of teaching experience in each of the four schools. As both a teaching assistant and an instructor, he introduced students to topics ranging from patient spirituality to medical professionalism. Ernie also had the unique opportunity to work with the medical students enrolled in the *HABLE* program (Healing in a Bilingual Learning Environment). These students are fluent in both English and Spanish and have agreed to receive their clinical and professional training in both languages. For two years, Ernie instructed several of these small groups in a course titled Humanities, Ethics, and Professionalism.

As a student leader, Ernie founded the SAFE Project. This program provides training for faculty, staff, and students who wish to be identified as allies and advocates for gay, lesbian, bisexual, and transgender persons. Additionally, Ernie served as a volunteer on-call chaplain at the UTMB hospitals and as a consultant/community educator at St. Vincent's Episcopal House. In recognition of his academic success and his service to the local community, Ernie received a number of special awards: Who's Who of American College and University Students, William Bennet Bean Medical Humanities Award, Dr. David C. Eiland, Jr. Award in Health Care and Humanities Scholarship, and Martin Luther King, Jr. Award for Diversity. These many service opportunities were experiences of integration for Ernie as he often found that he was able to apply the theories that he was studying in these various contexts.

Upon completion of his doctoral work at the Institute for the Medical Humanities, Ernie will begin a post-doctoral fellowship with the Sealy Center on Aging at UTMB. This dissertation was typed by Ernie Aguilar.

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