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LISTENING WITH THE THIRD EAR: EXPLORING THE PRACTICAL PHILOSOPHY OF TRANSCULTURAL UNDERSTANDING

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LISTENING WITH THE THIRD EAR: EXPLORING THE PRACTICAL PHILOSOPHY OF TRANSCULTURAL UNDERSTANDING

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Dedicated to Christy, my prime interlocutor.

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LISTENING WITH THE THIRD EAR: EXPLORING THE PRACTICAL PHILOSOPHY OF TRANSCULTURAL UNDERSTANDING

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The problem of crosscultural misunderstanding in clinical contexts has given rise to a thriving field of "cultural competency" training and materials. With few exceptions, experts and institutions in this field have defined cultural competency using instrumental forms of reason and have studied the problem of crosscultural understanding and communication from within a positivist framework. This reduction has in turn spawned positivist and empiricist methods of teaching cultural competency that mimic the methods used to teach natural and social science.

Herein I argue that cultural competency should not be seen in terms of a model of technical knowledge as derived from the natural sciences, but rather be understood as an instance of what Aristotle termed *phronesis* or practical wisdom. As such, culturally competent medical practice is dialogical engagement between patient and health-care provider with the aim of mutual understanding that then facilitates health promotion.

Aristotle's concept of *phronesis* was a central tenet of Hans-Georg Gadamer's philosophical hermeneutics, which focuses on mutual understanding through dialogue. Gadamer argues that true understanding in the health-care context can come only through conversation and engagement with our interlocutors. Too often cultural competency materials and education attempt to alleviate the burden that health-care professionals shoulder: the work involved in understanding patients who are different from themselves. This work, however, is part and parcel of the understanding, and while it may be honed and improved upon with education in cultural competency, the work of understanding cannot be delegated or circumvented. Thus, any program of cultural competency that attempts to hand the health-care professional an encapsulated knowledge that would otherwise have taken work in conversation, listening, narrative sensibility, or interpretation, is not only ineffective, but may also be detrimental to cross cultural understanding.

In this dissertation I explore what a curriculum in cultural-competency based on Gadamerian dialogical engagement might look like and whether it is better suited than other education models of cultural competency to achieve the goal of increasing understanding between patient and physician. I conclude that it is indeed better suited as a basis for education and practice in cultural competence.

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INTRODUCTION

How best should we care for the sick? In what is essentially a very uncertain discipline, there are many questions on which there is continuous debate in medical journals, in clinical rounds, and at conferences, but the idea of good care and the virtues that describe excellent health-care practitioners are not hotly disputed among those in the field. Among patients, however, it is a different story.

In surveys among health care practitioners, *competence*—in a variety of clinical tasks—is among the most frequently uttered and highest ranked marks of a *good practitioner*.[1] However, when asked to describe what constitutes a good *doctor*, patients rarely cite competencies or skill sets mentioned by practitioners. Much more often, patients and their families mention qualities such as approachability, empathy, caring, understanding, and the quality and amount of time the doctor spent with the patient.[2] These incommensurate measures of the good physician between caregivers and the cared for may be a clue as to why there is such a low level of satisfaction in the doctor-patient encounter—from both sides of the hyphen.[3] And the measure of satisfaction drops

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[1] Sandra G. Boodman, "New Doctors Develop an Old Skill: They Call It Clinical Empathy, Previously Known as Bedside Manner," *Washington Post*, Tuesday, May 15, 2007, 1.

[2] Ibid.

[3] Gregory Makoul, Edward Krupat, and Chih-Hung Chang, "Measuring Patient Views of Physician Communication Skills: Development and Testing of the Communication Assessment Tool," *Patient Education and Counseling* 67, no. 3 (2007): 333-42.

markedly when doctor and patient come from different backgrounds, whether these are economic, racial, or cultural.[4]

There are many things that contribute to the widening gap between patient and health-care professional in America today. One is the ever-increasing burden placed on physicians to see more patients in smaller time slots. Each shrinking consultative session now has to cover more ground across a growingly diverse patient population where cultural and language barriers are now more often the norm than the exception. All of these exigencies within these time constraints are doubtless major contributors to the dissatisfaction quotient mentioned previously.

Now if one multiplies these unfavorable odds by the relentless technical and technological demands on physicians in light of the expansion of biomedical scientific knowledge and the field's subsequent splintering into varied and narrow disciplines and subdisciplines, one starts to understand why it is that the very qualities that patients rank highest for their health-care professionals—empathy, approachability, care, and understanding—have become scarce commodities these days. For even if a patient is lucky enough to find a physician who is attuned to the more artful excellences in caring for patients, it remains unlikely that she will be able to care for the patient solely or longitudinally throughout the patient's life or even illness.

Nonetheless, the medical establishment continues to tout the centrality of empathic understanding to medical education and to the larger enterprise of good

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[4] Thomas A. Laveist and Amani Nuru-Jeter, "Is Doctor-Patient Race Concordance Associated with Greater Satisfaction with Care?," *Journal of Health and Social Behavior* 43, no. 3 (2002): 296-303.

doctoring. In 1994, the Accreditation Council for Graduate Medical Education (ACGME), which sets the educational agenda for residency training programs in the United States, incorporated "interpersonal and communication skills" into its six "core competencies" in which each new doctor should show mastery.[5] Likewise, the American Board of Medical Specialties (ABMS) has also included understanding, especially in crosscultural contexts, in their guide that member boards must use in constructing and maintaining Maintenance of Certification (MOC) programs.[6] And while these guidelines have the potential to affect every practicing physician in America, every medical student is also being affected by the new guidelines set for by the Association of American Medical Colleges (AAMC), the accreditation agency for medical schools in the United States, which, in 1999, included crosscultural understanding and empathic care as educational goals of member institutions under their Medical School Objectives Project (MSOP), a program that dictates the educational objectives of every medical student in an accredited American medical school .[7]

Even more universal in scope, the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) and for Culturally

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[5] *General Core Competencies*, (Accreditation Council for Graduate Medical Education, 1999, accessed July 8 2007); available from http://www.acgme.org/outcome/comp/compFull.asp#4.

[6] American Board of Medical Specialties, *Maintenance of Certification (Moc)*(2006, accessed May 20 2007); available from Maintenance of Certification (MOC). Since the ABMS MOC guidelines were promulgated in 1998, they have been adopted by many boards of certification in the health-care field including, but not limited to the American Medical Association, the American Hospital Association, the National Board of Medical Examiners, the Federation of State Medical Boards, the Joint Commission on Accreditation of Healthcare Organizations, the Accreditation Council for Graduate Medical Education, and the Association of American Medical Colleges.

[7] Association of American Medical Colleges, *Report Iii: Contemporary Issues in Medicine: Communication in Medicine* (Association of American Medical Colleges, 1999).

and Linguistically Appropriate Services and Clinical Trials (CLAS-ACT Standards) promoted by the U.S. Department of Health and Human Services' Office of Minority Health dictate that crosscultural understanding should be fostered in all clinical and research contexts throughout postgraduate education and training.[8]

All of these guidelines and accreditation standards are obvious markers of how pluralistic and culturally aware the modern American medical system has become. Of course, this renewed awareness does not necessarily mean that the clinic has become an optimal place for crosscultural care.

Cultural Competency as a Corrective for Health Disparities

According to the 2002 Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, racial, ethnic, and/or cultural minority populations suffer from disparities and discrimination in access to health care, the quality of the care they receive, and that care's eventual outcome. This is true even after adjustment for socioeconomic differences and other health-care access-related factors.[9] One of the main culprits cited in this and other studies is the fact that these

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[8] U.S. Department of Health and Human Services Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (Washington, DC: Office of Minority Health, 2001), Report. Available at: http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15 (accessed September 11, 2007); As a postdoctoral fellow at Baylor College of Medicine, I helped in the formulation of the CLAS-ACT standards in collaboration with the Department of Health and Human Services' Office of Minority Health and the Eliminating Disparities in Clinical Trials (EDICT) project. The CLAS-ACT standards have not yet been released in report format as of this writing.

[9] Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: Institute of Medicine, National Academy Press, 2003).

groups are far more likely to encounter physicians whose race/religion/ethnicity/culture is different from their own.[10] These cultural differences in the clinical encounter often result in misunderstanding and ineffective communication. While these clashes sometimes stem from intolerance, they may also be attributable to a simple lack of familiarity with another's values and beliefs. In either case, these unfruitful encounters may ultimately lead to frustration for both caregiver and patient and serve to thwart the healing process.

Quite aside from these persuasive reasons as to why health-care practitioners should be comfortable in crosscultural contexts as they care for their patients, there is the paramount concern that physicians and other health-care professionals should be striving to achieve excellence in their chosen profession—what Aristotle termed *arête*—and transcultural competence is part of what an excellent practitioner is. Nonetheless, crosscultural misunderstanding is a rampant problem in today's health-care field—one that threatens to become more pressing as America's population grows in diversity. This escalating problem has given rise to a thriving field of "cultural competency" training and materials.

Yet, is it possible that these admirable programs might actually stand in the way of a culturally competent health care? With few exceptions, experts and institutions in this field have defined, operationalized, and measured the outcomes of cultural competency using instrumental forms of reason from within a positivist framework. Could the methodological training that makes up the majority of these kinds of programs

[10] Laveist and Nuru-Jeter.

actually be teaching health-care practitioners to avoid engaging and, by extension, *understanding* the patient?

Herein I argue that cultural competency should not be seen in terms of a technical knowledge model as derived from the natural sciences, but rather be understood as an anthropological instance of what Aristotle termed *phronesis* or practical wisdom. This *phronetic* activity should be conceived of as a dialogical engagement between patient and health-care professional with the aim of mutual understanding that then leads to (or at least facilitates) the health promotion of the former.

Aristotle's concept of *phronesis* is a central tenet of Hans-Georg Gadamer's philosophical hermeneutics, which focuses on mutual understanding through dialogue. I will explore what education in cultural-competence based on Gadamerian dialogical engagement might look like and whether it is better suited than other education models of cultural competency to achieve the goal of increasing understanding between patient and physician. Ultimately, I demonstrate that a cultural-competency model based on Gadamer's philosophical hermeneutics and Aristotle's *phronesis* does achieve this purpose.

CHAPTER ONE: THE PROBLEM OF THE OTHER

Thanks to the linguistic nature of all interpretation every interpretation includes the possibility of a relationship with others. There can be no speech that does not bind the speaker and the person spoken to.

–Gadamer, *Truth and Method*

Homo sum: humani nihil a me alienum puto.
I am human; I judge nothing human to be alien to me.

–Cicero, De Officiis *I, 30*

Introduction

In the science-fiction television show *Star Trek: The Next Generation*, broadcast in America from 1987 to 1994, the most daunting enemy that the intrepid crew of the Starship Enterprise ever encountered was the Borg. This scary looking troupe would zoom around the galaxy devouring civilizations for no apparent reason. It was not that the Borg were malicious, for that would imply that they experienced something akin to human emotion. No, the Borg were a rather unreflective bunch of half-human/half-automaton cyborgs that traveled by way of what looked like Paris's Pompidou center and assimilated whole cultures by enslaving the inhabitants and making them the same as themselves. Whenever the Borg met up with a civilization that had the audacity to fight back, they would turn on their loudspeaker and play a monotone, robotic recording, in whatever language the defiant targeted race happened to speak, which said "RESISTANCE IS FUTILE: YOU WILL BE ASSIMILATED."

Of course the crew of the Enterprise could not acquiesce and so it more-or-less successfully fended off the Borg for several seasons until viewers lost interest. I always

thought that the Borg were not the only villains in this scenario. I felt this way not because the Borg had been misunderstood (they almost certainly were not), or because what they were doing was not despicable (it was), but simply because the swashbuckling Enterprise crew, wearing regal red and gold, was being touted as the "good guy" and the Borg, their ashen, stoic faces wrapped in black metal and tubing, were the "bad guys." As far as I was concerned, the U.S.S. Enterprise was the torch-wielding mob and the Borg, Frankenstein's monster.

I felt this way because of the hypocrisy of the crew of the Starship Enterprise. Here was a group of mostly Earthlings from Western culture with a "galactic" Federation that spoke only English and was based in San Francisco. Whatever aliens were on board were forced to speak English (even the French captain spoke only English with a British accent) and wear Western clothes (with a sash here or there to add a little multicultural spice). Who were these people to be speaking out against Borgian assimilation? As far as I was concerned, these two powers were opposite sides of the same coin—hegemonic monsters assimilating the Other.

This show was a good barometer of the end of the twentieth century as to what some have characterized "the very heart of the work of every major twentieth-century continental philosopher."[11] "The problem of the Other," according to Michael Theunissen in his book *The Other*,

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[11] Richard J. Bernstein, "Incommensurability and Otherness Revisited," in *Culture and Modernity: East-West Philosophic Perspectives*, ed. Eliot Deutsch (Honolulu: University of Hawaii Press, 1991), 94.

> has at times been accorded a prominent place in ethics and anthropology, in legal and political philosophy. But the problem of the Other has certainly never penetrated as deeply as today into the foundations of philosophical thought—the question of the Other cannot be separated from the most primordial questions raised by modern thought.[12]

So what exactly is this problem of the Other? As most broad themes that span decades of discussion, it does not admit of one definition. It is best described as a cluster of problems revolving around a core problematic that I take to be the difference and/or similarity of other human beings, and the implications these problems have on the identity of the subject.[13] I will look at the challenge posed by this problem of whether the Other can (and whether she should) be encapsulated within the paradigms or thought forms of the subject, how a dialogical, narratively based hermeneutics can help to elucidate and resolve this dilemma, and what the implications of all of these problems might be for modern health care.

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[12] Michael Theunissen, *The Other: Studies in the Social Ontology of Husserl, Heidegger, Sartre, and Buber*, trans. Christopher Macann, Studies in Contemporary German Social Thought (Cambridge, MA: MIT Press, 1984), 1.

[13] This formulation of the problem owes much to the definition of "the Other" given in Ted Honderich, *The Oxford Companion to Philosophy* (New York: Oxford University Press, 1995), 637.

The Philosophical Problem of the Other in History

A certain malaise is palpable in twentieth-century philosophy. It was spawned by what philosopher Richard Bernstein called a "Cartesian anxiety,"[14] the existential dread that comes from a belief in the (false) dichotomy between absolute certainty and radical uncertainty: "It is the seductive Either/Or. *Either* there is some support for our being, a fixed foundation for our knowledge, *or* we cannot escape the forces of darkness that envelop us with madness, with intellectual and moral chaos."[15] This rigid bifurcation, in turn, has spawned the most pernicious false dichotomy of twentieth-century moral philosophy: Absolutism versus Relativism.

This anxiety has also taken shape in what the German philosopher Martin Heidegger called a *Stimmung*[16] or a "mood of deconstruction, destabilization, rupture, and fracture—of resistance to all forms of *abstract* totality, universalism, and rationalism."[17] This morose mood is the mood that existential philosophers elevated to an art form in the twentieth century, with questions that Bernstein thinks grapple

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[14] Richard J. Bernstein, *Beyond Objectivism and Relativism: Science, Hermeneutics, and Praxis* (Philadelphia: University of Pennsylvania Press, 1983), 16.

[15] Ibid., 18.

[16] Martin Heidegger, *Being and Time*, trans. John Macquarrie and Edward Robinson (New York: Harper, 1962), 172.

[17] Bernstein, "Incommensurability and Otherness Revisited," 85.

> with understanding what underlies and pervades the multiplicity, diversity, and sheer contingency that we encounter in our everyday lives. … Is there a one, *eidos*, universal, form, genus that is essential to the multiplicity of particulars? What is the character of this essential unity?[18]

The question that Bernstein faces is the big question facing a world that is more ineradicably plural than ever before. Instead of valuing the differences between people, difference becomes a division that alienates, fosters misunderstanding, and precipitates violence. Currently, a renewed penchant for xenophobia and isolationism in America, one of the most diverse nations on Earth, serves to further distance people and re-entrench ethnocentrisms. It can erode international, crosscultural, and interpersonal communion that had been painstakingly forged over the years. These misunderstandings can also stand between health-care practitioners and their patients as a hindrance to beneficial care and healing.

But the pendulum of twentieth-century philosophy also swung in the opposite direction from radical otherness. In the nineteenth century, Georg Hegel (1770-1831) claimed that all of Western philosophy "achieved its *telos* with the unity of identity with difference."[19] Hegel's overarching belief was that all of humanity, through the use of right reason, could come to know itself. He saw a collective Mind (*Geist*) that is an active force throughout history, and he believed that all intellectual work is a manifestation of the *Geist* coming to know itself.[20] This optimism about humankind's

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[18] Ibid., 86.

[19] Ibid.

[20] Honderich, 341-43.

prospects to overcoming misunderstanding and conflict was criticized by the French philosopher Emmanuel Lévinas (1906-1995) as pre-formative of the twentieth-century's drive to assimilate the Other into the Same.[21] For example, Hegel made the point of the "sameness" of the Other by the thought experiment that if we can differentiate ourselves into an alter ego, we come to the conclusion that in fact there is, while an alterity, no *difference*—thus understanding is possible. Lévinas sees this as an insidious imperialism whereby difference and otherness disappear. Under Lévinas's reading, the seemingly friendly notion of reducing the Other to the Same is in reality, in Borglike fashion, a violence perpetrated by colonization and mastery of the Other. Thus, Lévinas instituted the notion of an Absolute Other.[22]

Another way to look at this problem is through what Seyla Benhabib describes as the reduction to the "generalized other."[23] The liberal notion of acknowledging the differences of others, what Charles Taylor calls the "politics of difference,"[24] can in fact reduce "concrete others" to abstractions and "straw persons," further marginalizing the other. This reduction, in effect (again through the guise of genuine respect for the other), ends up mastering and controlling the interlocutor. I will show that modern notions of cultural competency are forms of Benhabib's "generalized other."

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[21] Emmanuel Lévinas, *Totality and Infinity: An Essay on Exteriority* (Pittsburgh: Duquesne University Press, 1969).

[22] Ibid.

[23] Seyla Benhabib, "The Generalized and the Concrete Other," in *Situating the Self: Gender, Community, and Postmodernism in Contemporary Ethics* (New York: Routledge, 1992), 158-59.

[24] Charles Taylor and Amy Gutmann, *Multiculturalism: Examining the Politics of Recognition* (Princeton, NJ: Princeton University Press, 1994).

With all of these competing theories as to how to understand the Other—each fraught with difficulties and fallacies—it should be no surprise then, that many are giving up altogether on the project of understanding the Other. This nihilistic acquiescence to the notion of radical alterity and difference, though not what Lévinas intended, nonetheless has taken hold in the ethical theories of subjectivism and relativism and is typified in the public's response to Thomas Kuhn's (1922-1996) theory of the "incommensurability" between scientific paradigms.[25]

In his landmark work *The Structure of Scientific Revolutions*, Kuhn controversially proposed that "the proponents of competing paradigms practice their trades in different worlds":

> Practicing in different worlds, the two groups of scientists see different things when they look from the same point in the same direction. Again that is not to say that they can see anything they please. Both are looking at the world, and what they look at has not changed. But in some areas they see different things, and they see them in different relations to the other. That is why a law that cannot even be demonstrated to one group of scientists may occasionally seem intuitively obvious to another. Equally, it is why, before they can hope to communicate fully, one group or the other must experience the conversion that we have been calling a paradigm shift.[26]

Many have misunderstood Kuhn as falling prey to "the myth of the framework" wherein the observer becomes so entangled in her own frame(s) of reference that

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[25] Thomas S. Kuhn, *The Structure of Scientific Revolutions*, 3d ed. (Chicago: University of Chicago Press, 1996).

[26] Ibid., 150.

communication with others in other frameworks is impossible.[27] But Kuhn was making the far more modest claim that incommensurate paradigms were not amenable to "point-by-point comparisons."[28] This claim, I think, makes sense. Languages, for example—the thing that most closely resembles the structure or paradigm of human thought—are incommensurable in the Kuhnian sense. They cannot be "transliterated" or systematically ported into another language by word-for-word substitutions. There are always idiomatic sayings, word plays, puns, and colloquialisms that will be remaindered in that equation. This is not to say, however, that people cannot understand each other's language; it just means that doing so will usually involve a paradigm shift.

Jacques Derrida (1930-2004) comes close to the spirit of Kuhn's theory by conceding that there is *both* a sameness and difference in humans. "In short," Bernstein characterizes Derrida as saying, "there is both sameness and radical alterity, symmetry and asymmetry, and identity and difference in my relation with "the Other," and above all in the ethical relation."[29] This comfort with an ambiguity in interpersonal relations opens the door toward a "golden mean" between absolutism and relativism, between radical alterity and sameness. It is also more genuinely reflective of how people know life to be.

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[27] Karl Popper, "Normal Science and Its Dangers," in *Criticism and the Growth of Knowledge*, ed. Imre Lakatos and Alan Musgrave (Cambridge: Cambridge University Press, 1970), 56.

[28] Bernstein, "Incommensurability and Otherness Revisited," 87. Quoting Thomas S. Kuhn, "Theory-Change as Structure-Change: Comments on the Sneed Formalism," *Erkenntnis* 10 (1976): 190-91.

[29] Bernstein, "Incommensurability and Otherness Revisited," 98.

In other words, acknowledging the alterity of the Other does not mean that understanding is impossible, for even an imperfect or asymmetrical communion is still communion. There will, of course, always be something (maybe quite a lot) lost in translation, but it may still be possible to get the gist of what is being said. This chance of understanding also means that there will always be at least a kernel (usually much more) of commonality between interlocutors. Grant Gillet says that "[i]t is plausible that if we examine some of the things that are basic to human life—the actual experiences of nurturing, being welcomed, having one's hurts tended, having one's greetings snubbed, pain, loneliness, and so on—we can erect a common ground in lived experience for some of our moral intuitions."[30] As Giambattista Vico (1668-1744) is rumored to have said, "Nothing human can be alien to me."[31]

Of course we should also take Lévinas' chastisement to heart by acknowledging that to see *only* more of the same in the other is a pernicious form of ethnocentrism—a cultural imperialism that theologian David Tracy calls "the terror of that otherness."[32]

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[30] Grant Gillett, "'We Be of One Blood, You and I': Commentary on Kopelman," in *Philosophy of Medicine and Bioethics: A Twenty-Year Retrospective and Critical Appraisal*, ed. Ronald A. Carson and Chester R. Burns, Philosophy and Medicine (Boston: Kluwer Academic Publishers, 1997), 241.

[31] See Isaiah Berlin, "Giambattista Vico and Cultural History," in *The Crooked Timber of Humanity: Chapters in the History of Ideas* (London: Pimlico, 2003), 49-69.

[32] David Tracy, *Plurality and Ambiguity: Hermeneutics, Religion, Hope* (Chicago: University of Chicago Press, 1994), 79.

So how exactly can we hope to understand each other in this pluralistic society? Not only are we all speaking different languages that are incommensurate, but we have different ways of talking. Our language is shaped by our upbringing at the same time that our upbringing is shaped by our language. It is one thing to wax poetical about commensurability and understanding, but how, practically, can we and health care providers in particular, use this knowledge to effectuate interpersonal and crosscultural understanding? I believe that an interpretive hermeneutics based on narrative competence is the answer, if perhaps not an absolute one, to the question of understanding in the face of otherness.

Hermeneutics as Corrective

Martin Heidegger (1889-1976) knew we could never transcend our historicity or, to use his term, *thrown-ness*, for we are invariably thrown into a social context not of our choosing, nor of our design.[33] This historical "situated-ness" shapes who we are and how we think. It shapes the way we talk and our *Lebenswelt* or "lifeworld."[34] It makes us who we are.

The German philosopher Hans-Georg Gadamer (1900-2002), a student as well as critic of Heidegger, suggests:

> In fact history does not belong to us, but we belong to it. Long before we understand ourselves through the process of self-examination, we understand

[33] Heidegger, 174.

[34] Ibid., 195.

> ourselves in a self-evident way in the family, society, and state in which we live. … *That is why the prejudices of the individual, far more than his judgments, constitute the historical reality of his being*.[35]

These prejudices are inevitable and affect how we see the world. Like Kuhnian paradigms they are formative of our *Erlebnis*, or experience, as well as further altered by this experience.[36] However, we should not despair of this incommensurability. While Hegel's notion of an overarching *Geist* which all of us are somehow plugged into has long ago lost whatever luster it may once have had. Difference is acknowledged, but it does not mean that we cannot communicate. It merely puts the last nail in the coffin of our quaint notion that there can be a perfect—and perfectly transparent—translation. We can understand each other, but we can never become a native of the other's land.

Michael Hofman, in his review of an essay by Umberto Eco, sees the job of an interpreter as that of conspicuous mediator:[37]

> The trouble [with the illusion of a "transparent translator"], it seems to me, is that translation is perceived as a function, not an agency. It's not fully personalised and accredited work. No one sees it. [The translator is] an ambulance driver, not a surgeon… . When people buy a book, they want to read the author, not a centaur or a Chapman brothers figure—the work, and not the product of something I once described as "the strange bi-authorship of translation." If the book was written in a different language, then there will, perforce, have to have been a translator involved in it, but the reader prefers to remain unaware of that. It may even be disagreeable to be informed or reminded of the fact.[38]

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[35] Hans-Georg Gadamer, *Truth and Method*, 2nd rev. ed. (New York: Continuum, 1989), 276-77. Emphasis in original.

[36] Heidegger, 72.

[37] Michael Hofman, "Speaking in Tongues: Making the Foreign Accessible Is an Overlooked Art. Michael Hofman on Mouse or Rat?, Umberto Eco's Essay on Translation," in *Guardian Unlimited* (London: Guardian Unlimited, 2003).

[38] Ibid.

Hofman's idea of "bi-authorship" shows that every attempt at understanding is a construction of meaning—understanding is an edifice built, not a land discovered. To a greater or lesser extent, everyone speaks an idiolect, which means that every hearing, translation, and understanding places an unavoidable gloss on the reading. Thus, readings may be more or less accurate, but they will never mirror the author's intent or the situation they describe.

Unfortunately, while exegetical axioms exist, no quick formula for understanding between people exists. If we are going to be successful at peeling away the layers of meaning to get to some semblence of the "truth," then it will have to be through something like what Gilbert Ryle and Clifford Geertz call "thick description," which "is (or should be) guessing at meanings, assessing the guesses, and drawing explanatory conclusions from the better guesses."[39] For the truth that Gadamer thinks is available to us through dialogue is what Ronald A. Carson describes as "the kind of provisional, customary understanding aimed at [in] an ordinary conversation," … [T]he aim is not to get "back" to some foundational principle or "up" to some higher principle but to strive toward some common ground, shared at least long enough to keep the conversation going."[40]

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[39] Clifford Geertz, *The Interpretation of Cultures: Selected Essays* (New York: Basic Books, 1973), 20.

[40] Ronald A. Carson, "Interpretation," in *Encyclopedia of Bioethics*, ed. Warren T. Reich (New York: Simon & Schuster Macmillan, 1995), 1284.

Even then, thick description will not be able to transport us into the native's skin. We can never (nor should we ever try to) assimilate the other, nor can we reduce her alterity to sameness. This is not to say that a better or more accurate understanding of our interlocutor or target culture is impossible, for perfect identicalness of meaning is not necessary to understanding. In fact, according to Gadamer, it is *through* our difference that we are ever able to understand the other.

Understanding through Difference

Gadamer holds that it is impossible to keep our preconceptions at bay when engaging the other. For Gadamer a primordial understanding always already precedes our interpretive project:

> There is always a world already interpreted, already organized in its basic relations, into which experience steps as something new, upsetting what has led our expectations and undergoing reorganization itself in the upheaval. Misunderstanding and strangeness are not the first factors, so that avoiding misunderstanding can be regarded as the specific task of hermeneutics. Just the reverse is the case. Only the support of the familiar and common understanding makes possible the venture into the alien, the lifting up of something out of the alien, and thus the broadening and enrichment of our own experience of the world.[41]

Being confined to (though not imprisoned by) our situation, we attempt to inhabit the realm of the other not by a transcendence of our situations, but *through* them. Gadamer believes that

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[41] Hans-Georg Gadamer, "The Universality of the Hermeneutical Problem," in *The Interpretation of Texts*, ed. David E. Klemm (Atlanta: Scholars Press, 1966).

> [o]nly by virtue of [dialogical] reflection can I escape being a slave to myself, am I able to judge freely of the validity or invalidity of my preconceptions—even if "freely" means only that from my encounter with a prejudiced view of things I am able to come away with nothing more than yet another conception of them. This implies, however, that the prejudices which govern my preconception are always at stake along with it—to the extent, indeed, of their abandonment, which of course can always mean mere rehabilitation as well. For that is the inexhaustible power of experience, that in every process of learning we constantly form a new preconception.[42]

In a beautiful way, it is precisely when we bring our presuppositions into play in a conversation that they are then amenable to refinement, reification, or rejection. In any case, the encounter with the Other helps to define who we are. It is through our encounters with the foreign and alien that we construct our own identity.

Gadamer, then, calls for a "rehabilitation of prejudice"[43] that plays a part in the co-constructive, interpretive task—where we crossgerminate our two distinct lifeworlds in what he calls a "fusion of horizons" that will afford us a "higher universality[44] that overcomes, not only our own particularity, but also that of the other."[45]

This "fusion of horizons" is not a synthesis of two disparate points of view into one hybrid compromise. It is rather a dynamic alteration of the two original positions toward a third more harmonious understanding. Gadamer stresses that this understanding

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[42] Hans-Georg Gadamer, "The Historicity of Understanding," in *The Hermeneutics Reader*, ed. Kurt Mueller-Vollmer (New York: Continuum, 1997), 288.

[43] Ibid., 261.

[44] In his usage here, *universality* does not mean universalism, but a more intersubjective universality shared by the interlocutors.

[45] Gadamer, "The Historicity of Understanding," 271.

through the fusion of horizons is an essentially dialogical task. Carson likens this task to the co-constructed narrative in the context of a doctor-patient relationship:

> approach[ing the lived experience of illness] in this way, as a text requiring reading—ideally, by a patient and a caregiver comparing notes. Thus construed, the patient-caregiver relationship is collaborative, and the work of healing commences not when the caregiver makes the diagnosis but when text and readers converge in a common narrative.[46]

This convergence happens through what is known as the "hermeneutic circle" which Carson contends

> [c]onsist[s] of an oscillating movement—conjecturing …, then comparing this conjecture with similar previous experiences, conjecturing, comparing, and so on—talking with the text of experience until an understanding is reached. "The hermeneutical principle … is that just as the whole is understood from its parts, so the parts can be understood only from the whole."[47]

Medicine is well accustomed to the hermeneutic circle even if physicians have never heard of the phrase. This oscillation between particular cases and previous experience is, according to Kathryn Montgomery, the "narrative structure of medical knowledge."[48] She likens this mode of knowing to the narrative heuristic followed by Sherlock Holmes as he tacks between knowledge of the 1,000 previous cases and the

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[46] Carson, 1287.

[47] Ibid., 1284. Quoting Friedrich D.E. Schleiermacher, "The Academy Addresses of 1829: On the Concept of Hermeneutics with Reference to F.A. Wolf's Instruction and Ast's Textbook," in *The Interpretation of Texts*, ed. David E. Klemm (Atlanta: Scholars Press, 1986), 75.

[48] Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton: Princeton University Press, 1991).

1,001st.[49] A good physician performs the same movement, to and fro between her inner compendium of case histories and the engagement with the patient at hand—never reducing this particular patient to a subset or category in the storehouse of knowledge.

A good example of this investigation is given by Carson:

> [I]n the therapeutic encounter the caregiver turns a trained ear to a particular patient's account of misfortune or malaise, places it in the company of similar accounts he or she has heard before, and then attends not only to what is said but also to what is unspoken and to what is unspeakable, all the while conversing with the patient to test the fit of the patient's experience with similar experiences. This requires a capacity to imagine illness or injury from the patient's perspective and an awareness of the impossibility of identifying with the patient's experience: a kind of listening with the third ear—an awareness of setting and significance and an alertness to narrative possibility.[50]

It is this imaginative capacity, or "listening with the third ear" that accomplishes what Geertz calls "expos[ing the Other's] normalness without reducing their particularity." [51] It is that precarious dance between the two worlds of radical alterity, on the one hand, and sameness, on the other, that Derrida talks about and Gadamer calls the fusion of horizons. For health care practitioners it means that a narrative competence and hermeneutic oscillation yield the promise of a new understanding. This type of understanding is not a perfect translation or assimilation of the other, but rather a tentative foray into the liminal space between health-care provider and patient—

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[49] Ibid.

[50] Carson, 1285.

[51] Geertz, 14.

essentially the only place that, to use Martin Buber's terminology, is co-inhabitable by both I and Thou.[52]

Running Headlong into the Other

We no longer need to look toward remote and exotic locales to encounter the other; we need only to look as far away as across the street to encounter diversity. Now, even within our own house, we are often running headlong into the other. Today, millions of Americans lay claim to more than one cultural, ethnic and/or racial identity and heritage.[53] The blendedness not only of our nations but of our own families and of ourselves is a hint of the future, a future whose cultural landscape will be *all* borderland.

Thus, the importance for renewed efforts at understanding one another should be apparent. Radical isolationism, marginalization, and rejection of the Other are no longer tenable positions in our world, if they ever were. This is especially true of the medical practitioner. Never has the probability of encountering foreign tongues, customs, and beliefs in his clinical practice been so high as it is today. If medicine is in any meaningful way going to care for the infirm in our midst, it seems more incumbent upon us than ever to talk *with* each other, that is to say, to nurture a dialogical, engaging spirit in clinical settings.

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[52] See Martin Buber, *I and Thou*, ed. Walter Arnold Kaufmann, trans. Walter Arnold Kaufmann (New York: Touchstone, 1970).

[53] While miscegenation and crosscultural upbringing have been around for millennia, astoundingly it was not until the 2000 census that the U.S. Census Bureau allowed citizens to identify themselves with more than one racial classification. See www.census.gov for more information.

What Is Culture?

The word *culture* has many different meanings and connotations for different people, and not only is it contingent on the situation or the context, but the word can also be hijacked for ideological purposes. Not unlike Humpty Dumpty's word usage in Lewis Carroll's *Through the Looking Glass*, the word *culture* often means whatever the speaker wants it to mean.

Each clinical case or encounter at the bedside or consultation room is unique. Each clinical encounter's peculiarities can never be glossed over in order to extract some idealized version that will then correspond to our preconceived notions of what that slice of culture should resemble. The world is irretrievably complex and its people are much too diverse for heavy handed abstractions made by health-care providers who are trained to paint with broad strokes when it comes to disease. Even seemingly tautological statements, such as "All Spanish-speakers speak the same language," are rendered untrue by the sheer complexity of today's world.

Providers are often taught to employ a version of *Ockham's Razor* when diagnosing a patient. This method teaches that science is most accurate when the simplest explanations for the patient's symptoms are accounted for first. Ockham's Razor is a very necessary heuristic when certain causative hypotheses can be ruled out by subsequent testing and retesting, as, for example, is the case when a middle-aged, overweight Hispanic man comes in complaining of chest pains, a cold sweat, and shortness of breath. It would be inefficient for a physician to start her questioning, lab testing, and physical examination from nowhere; she would be well-advised to ask

questions, order lab tests, and examine the patient with an eye toward the possibility of heart attack. Statistics should be heeded. However, if the answers, lab results, and physical traits rule out that possibility, then it is on to the next most probable cause, and so on. Health-care professionals may go astray in misusing Ockham's Razor when a patient's personal preferences, familial structure, religious practices, diet, temperament, level of literacy or understanding, and worldview are in question. It may become much easier for a physician to attribute some stereotypical traits to the patient despite the lack of any evidence (other than the notoriously misleading one of race) in support of or in contradiction of the generalization. This attribution is sometimes exacerbated when there is a language barrier between the caregiver and the patient. If the patient cannot verbally dissuade the caregiver that his view of the patient is misconceived, then it becomes even easier to assume that the stereotype applies.

Sympathy, Empathy, and Clinical Understanding: Clarifying the Concepts and Setting the Stage.

Unfortunately, the increasing demands upon the finite time and resources of health caregivers has largely crowded out the teaching and the practice of the humanistic qualities that once were the hallmark of good doctoring for physicians. "Much of the empathy role has been delegated to nurses, who call it 'caring for the patient,'" says David S. Leong, the chair of a theater department at an academic institution where medical students are being taught the verbal and nonverbal acuities necessary for

empathic understanding.[54] "Doctors don't know how to listen to, or talk to, patients," Leong continues, "they know how to diagnose."[55]

But how did this most essential of clinical competencies become relegated to an unnecessary virtue and delegable to nurses? Ellen Singer More offers a telling look at the history of the devaluation of a virtue in the book she coedited titled *The Empathic Practitioner*.[56] In her study of the evolution of the concept of *empathy*, More notes that for centuries, *sympathy* had been a reliable and useful term to describe the health-care practitioner/patient relationship.[57] Citing numerous examples, More shows how the male-dominated vocation of medicine in the West held sympathy to be the "chief moral quality of the humane physician."[58] It enjoyed connotations of the benevolent fellow-feeling and concern that pervaded the public perception of good doctoring.[59] However, by the late nineteenth century, there was a shift in the connotation of the word *sympathy* toward the discursively feminine.[60] *Sympathy* was feminized as a household virtue that emotional (and often hysterical) women practiced away from the important business of medicine. As such, the term was not only feminized, but devalued and marginalized at

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[54] Quoted in Boodman, 1.

[55] Ibid.

[56] Ellen Singer More, "'Empathy' Enters the Profession of Medicine," in *The Empathic Practitioner: Empathy, Gender, and Medicine*, ed. Ellen Singer More and Maureen A. Milligan (New Brunswick, NJ: Rutgers University Press, 1994), 19-39.

[57] Ibid., 20.

[58] Ibid., 22.

[59] Ibid.

[60] Ibid., 23.

the same time.[61] Sympathy became a badge of dishonor among physicians. Women attempting to enter the health care professions were told by Marie Zakrzewska that "[sympathy] will never be the right motive from which the student must start [in her pursuit of success in practice]. This predominating, sentimentalizing sympathy, will dwarf or confuse the reason … and will be pernicious to logic."[62]

Note that at this point, it is not just that an outdated nomenclature was being supplanted, but that a paradigm shift is occurring in medicine as a result of the positivist push of modernity. It is not simply the term *sympathy* that is losing credibility, but an entire ethic of health care is falling into disfavor by the dominant discourse in a field that is becoming more "professionalized" and "scientific" than ever before. The largely intuitive, artful, discerning, interpretive, and discursive form of health care had fallen out of favor. At this point, the paternalistic profession of medicine sought a new way to indicate the fellow-feeling and (by now) the professional distance between doctor and patient. This distantiation, argues More, was a direct result of the quantification, experimentalism, and scientific theories that marginalized the previous holistic paradigms.[63] The recently coined term *empathy* came to the rescue as a term that still offered hope of "understanding" the patient and the genus of his illness, "while

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[61] Ibid.

[62] Ibid., 25. Quoting Arleen Tuchman, "Gender and Scientific Medicine at a Crossroad? Marie Elizabeth Zakrzewska and the Culture of Medicine," (paper presented at the annual meeting of the American Association for the History of Medicine, Seattle, WA, May 3, 1992).

[63] More., 23

simultaneously enforcing the *dis*connections, neutrality, and scientific claims essential to [the profession]."[64]

Soon after being introduced in the late nineteenth century as part of the psychology of aesthetics, the term empathy was appropriated by Sigmund Freud (1856-1939) for the burgeoning field of psychoanalysis.[65] So far had the pendulum swung in making modern medicine a scientific discipline that even this newly "masculinized" term was attacked by those who considered it "an unscientific relaxation of the boundaries separating subject from object … an unprofessional identification with the Other.[66] For this and other reasons, More suggests that the term became the banner for a strictly "detached concern" that became one of the fundamental organizing principles of the new modern medicine in the twentieth century. It was saddled with the responsibility to convey a precarious balance between a physician's humane concern and compassion for a patient and the perceived need to remain objective and detached.

The preceding notwithstanding, empathy in clinical practice is experiencing a renaissance of late.[67] Recent interest in the psychology of empathy and its contribution to

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[64] Ibid., 27

[65] Ibid.

[66] Ibid.

[67] See generally, Ellen Singer More and Maureen A. Milligan, *The Empathic Practitioner: Empathy, Gender, and Medicine* (New Brunswick, NJ: Rutgers University Press, 1994); Dorothy M. Owens, *Hospitality to Strangers: Empathy in the Physician-Patient Relationship*, American Academy of Religion Academy Series ; No. 100 (Atlanta: Scholars Press, 1999); Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice* (Oxford: Oxford University Press, 2001); Arthur W. Frank, *The Renewal of Generosity: Illness, Medicine, and How to Live* (Chicago: University of Chicago Press, 2004); H. David Watts, *Bedside Manners: One Doctor's Reflections on the Oddly Intimate Encounters between Patient and Healer* (New York: Harmony Books, 2005); Kam-Shing Yip, *Clinical Practice for People with Schizophrenia: A Humanistic and Empathetic Encounter* (New York: Nova Science Publishers, 2006);

rebuilding and reconnecting doctor and patient has been seen in the fields of medical humanities,[68] gender studies,[69] and hermeneutics.[70] A renewed awareness of the lost virtue of empathic care is especially being felt in the field of medical education.[71]

Yet efforts to (re)instill empathic care in medical training are thwarted by the ambivalent and conflicting connotations that "empathy" carry in Western culture and in

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Mohammadreza Hojat, *Empathy in Patient Care: Antecedents, Development, Measurement, and Outcomes* (New York: Springer, 2007); Boodman.

[68] See generally, Judith Andre, "The Medical Humanities as Contributing to Moral Growth and Development," in *Practicing the Medical Humanities: Engaging Physicians and Patients*, ed. Ronald A. Carson, Chester R. Burns, and Thomas R. Cole (Hagerstown, MD: University Publishing Group, 2003), 48; Anatole Broyard, *Intoxicated by My Illness: And Other Writings on Life and Death* (New York: Ballantine Books, 1993); Oliver W. Sacks, *A Leg to Stand On* (New York: Summit Books, 1984); Mark Johnson, *Moral Imagination: Implications of Cognitive Science for Ethics* (Chicago: University of Chicago Press, 1993); Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995).

[69] See generally, Seyla Benhabib, "The Generalized and the Concrete Other: The Kohlberg-Gilligan Controversy and Moral Theory," in *Situating the Self: Gender, Community, and Postmodernism in Contemporary Ethics* (New York: Routledge, 1992); More and Milligan, *The Empathic Practitioner*.; Robert L. Schwartz, "Multiculturalism, Medicine, and the Limits of Autonomy: The Practice of Female Circumcision," *Cambridge Quarterly of Healthcare Ethics* 3, no. 3 (1994): 431-39; Lorraine Code, *Feminist Interpretations of Hans-Georg Gadamer*, Re-Reading the Canon (University Park, PA: Pennsylvania State University Press, 2003); Sayantani DasGupta and Rita Charon, "Personal Illness Narratives: Using Reflective Writing to Teach Empathy," *Academic Medicine* 79, no. 4 (2004): 351-56.

[70] See generally, Richard D. Chessick, "What Constitutes Our Understanding of a Patient?," *Journal of the American Academy of Psychoanalysis* 21, no. 2 (1993): 253-72; Hans-Georg Gadamer, *The Enigma of Health: The Art of Healing in a Scientific Age*, trans. Jason Gaiger and Nicholas Walker (Stanford, CA: Stanford University Press, 1996); Vilhjálmur Árnason, "Gadamerian Dialogue in the Patient-Professional Interaction," *Medicine, Health Care and Philosophy* 3, no. 1 (2000): 17-23; Richard J. Baron, "Medical Hermeneutics: Where Is The "Text" We Are Interpreting?," *Theoretical Medicine* 11, no. 1 (1990): 25-28; Adriana Berger, "Cultural Hermeneutics: The Concept of Imagination in the Phenomenological Approaches of Henry Corbin and Mircea Eliade," *The Journal of Religion* 66, no. 2 (1986): 141-56; Rita Charon, "To Listen, to Recognize," *Pharos Alpha Omega Alpha Honor Medical Society* 49, no. 4 (1986): 10-13; Linda P. Finch, "Understanding Patients' Lived Experiences: The Interrelationship of Rhetoric and Hermeneutics," *Nursing Philosophy* 5, no. 3 (2004): 251-57.

[71] See generally, Johanna Shapiro, Elizabeth H. Morrison, and John R. Boker, "Teaching Empathy to First Year Medical Students: Evaluation of an Elective Literature and Medicine Course," *Education for Health (Abingdon)* 17, no. 1 (2004): 73-84; Mohammadreza Hojat and others, "An Empirical Study of Decline in Empathy in Medical School," *Medical Education* 38, no. 9 (2004): 934-41; Gary A. Salzman, "Empathy: Can It Be Taught?," *Annals of Internal Medicine* 117, no. 8 (1992): 700-01; John W. Griffin, "Teaching and Learning Empathy," *Nature Clinical Practice Neurology* 2, no. 10 (2006): 517.

the culture of physicians today.[72] More suggests that in Western culture, "empathy" stands for a set of feminine traits, namely, emotional attunement and identification with the feelings of others. In everyday parlance, it can be expressed as akin to a "woman's intuition." This has opened the door to a rationalization by a paternalistic profession to delegate this feature of health caring to the health profession most closely associated in popular culture with femininity and empathic care—nursing.[73]

On the other hand, health professions have been using the term to connote something quite different from what Western culture has prescribed. In describing the professionalism of the health caring fields, practitioners usually attempt to define and analyze empathy from the perspective of scientific objectivity.[74] In this usage, empathy does not explicitly mean the identification with another that the phrase "I empathize with you" usually connotes. Instead, in the often opaque medico-scientific jargon of professional journals, "empathy" is used in increasingly precise ways that more often mean a technical skill set that is discursively male-gendered and does not foster identification with another but rather whose function is to increase the awareness of a patient's experience within a professionalism model that remains emotionally detached, neutral, and scientifically objective.[75]

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[72] More, "'Empathy' Enters the Profession of Medicine," 19.

[73] Boodman, 1.

[74] More, "'Empathy' Enters the Profession of Medicine."

[75] This definition is an amalgam of what I take to be the logico-scientific definitions prevalent in health professions journals today. For some of the source articles, see: Diane Kunyk and Joanne K. Olson, "Clarification of Conceptualizations of Empathy," *Journal of Advanced Nursing* 35, no. 3 (2001): 317-25, Patsy Yates and others, "Exploring Empathy as a Variable in the Evaluation of Professional Development Programs for Palliative Care Nurses," *Cancer Nursing* 21, no. 6 (1998): 402-10.

Thus, what originally meant the innately human ability to imagine the suffering, elation, pain, joy, anger, and sorrow, of a fellow human being became, in the late nineteenth's and twentieth century's fascination with modern science, an apparatus by which we collect and measure epistemic data from a patient. Empathy has become the main vehicle for the noncommittal and vague notion of *detached concern* that has remained the banner of modern medicine.

It was not until the feminist and critical social theorist movements of the 1970s that people really began to question the possibility and desirability of basing our health-care professions on the Cartesian dream of complete detachment between subject and object. Gadamer and other philosophers of phenomenology and hermeneutics had opened the door to this questioning by (re)legitimizing intersubjective forms of knowledge like empathy. As a result, empathy has had a resurgence, but it remains an ambiguous term in medicine today. For many, the tightrope that the term has had to walk between marginalizing itself into a purely intuitive (and therefore a feminine) sense on the one hand, and a mere data-gathering (and therefore masculine) technique on the other.[76] More believes that

> [o]ur cultural bifurcation of "masculine" and "feminine" contributed to the dichotomized meanings assigned to the concept of empathy: a male-gendered, objective, value-neutral technique—a clinical analogue to empirical data collection; or a female-gendered, relational modality.[77]

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[76] More, "'Empathy' Enters the Profession of Medicine," 32-33.

[77] Ibid., 34.

I argue that both of these etymological veins of the term *empathy* should be rejected. It is dismissive, misleading, prejudicial, and conceptually stunting to think of empathy as akin to feminine intuition, especially when it becomes a misogynistic code word for the irrational, overly emotional, subjective, and therefore unscientific intimacy that is anathema to the paternalistic detached concern of the health-care professional. Neither is it productive to reduce the very human, emotional, and imaginative engagement that is empathic care to a sterile communication pattern or algorithm teachable to students. It is my contention that empathy should be reclaimed and rehabilitated in the medical professions and specifically in the cultural competency movement taking place therein. The term should be rehabilitated to connote not the undisciplined emotive identification with patients, nor the social-scientific colonization of the object by way of method, but to signify once again the "*human* enterprise of deconstructing the differences and reducing the distances between practitioner and patient in modern health care"[78]

[78] Ibid.

CHAPTER TWO: METHOD IN THE ASCENDENT

"The exception proves the rule," runs the proverb; but why, I wonder, is it that you always only believe in the rule, and are always utterly skeptical of the exception?

—Ouida, *Wisdom, Wit, and Pathos:* Puck

We would know much more about things if we weren't intent on discerning them too precisely.

—Johann Wolfgang von Goethe, *Maxims and Reflections*

For thinkers like Plato, Descartes, and Husserl, universal, eternally unchanging and absolute truths not only existed, but were verifiable through rigorous method.[79] A mathematician as was Descartes before him, Edmund Husserl (1859-1938) used a heuristic from his day job to solve the problem of understanding. He argued for a "bracketing" of the observer's prejudices and preconceptions about the world to find an objective purchase from which to survey the object of interest.[80] These Enlightenment projects helped spawn the dangerously hegemonic *idée fixe* known as the Grand Narrative that welcomed a blind faith in technology and science and the marginalization of any knowledge that was not ascertainable by these rigorous methods.

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[79] Jerry L. Jennings, "Husserl Revisited: The Forgotten Distinction between Psychology and Phenomenology," *American Psychologist* 41, no. 11 (1986): 1231-40.

[80] Michael J. Inwood, "Edmund Husserl," in *The Oxford Companion to Philosophy*, ed. Ted Honderich (New York: Oxford University Press, 2005).

Our Modern Predicament

Shortly before his death in 1938, Husserl spoke of the crisis gripping European humanity.[81] This German philosopher saw the European identity (in which he included America and other Western peoples) as the mindset spawned from Greek antiquity and, having rummaged its way through thousands of years, picking up many layers of cultural patina, ambled through the Renaissance and Enlightenment to arrive in the twentieth century an optimistic if somewhat naïve and bullying giant. This giant had, in Husserl's opinion, largely forgotten its classical upbringing and fixated on the triumphalism ushered in by Galileo and Descartes at the beginning of its Modern Era. For Husserl, the European Crisis was due to the one-sided nature of the natural sciences (*Naturwissenschaften*), which reduced the universe and everything in it to mere objects of a scientific gaze that rendered our intersubjective life-world (*Lebenswelt*), the world that we experience and in which we move as social beings, beyond its mechanistic investigations and, by implication, beyond objective reality. This deligitimization of the life-world, argued Husserl, is naïve of the historicity of the new science's understanding as having grown up as the offspring of ancient Greek life-world, which, inevitably carries this intersubjectivity in its marrow.[82]

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[81] Edmund Husserl, *Phenomenology and the Crisis of Philosophy: Philosophy as a Rigorous Science, and Philosophy and the Crisis of European Man*, trans. Quentin Lauer (New York: Harper & Row, 1965).

[82] See Ted Honderich, ed., *The Oxford Companion to Philosophy*, 2d ed. (New York: Oxford University Press, 2005).

This cognitive myopia, brought on by the allegiance-demanding sovereignty and hegemony of the *Naturwissenschaften*, spawned the nineteenth and twentieth century's push for a social science.

The Rise of "Cultural Competency"

Since the pivotal decade of the 1960s, there has been a growing interest in diversity in the academy at large and specifically in American medical campuses. In the 1960s culture studies became the newest and "hottest" major area of study on university campuses.[83] Under this umbrella term, women's studies, Chicano studies, and many other courses devoted to addressing the difference that is part of the American social landscape became the face of a new liberal education whose insistence on globalism, cosmopolitanism, and sensitivity to cultural and religious difference paved the way for severe criticism of modern medicine's apparent failure to recognize or respect the cultural identities of patients.[84]

This criticism led to a nearly universal fervor about cultural competency in medical schools and hospitals.[85] This new focus, aided in no small part by the increasing diversity one now encounters in medical contexts, has prompted no shortage of textbooks, pocket guidebooks, Web sites, task forces, and training curricula in cultural

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[83] Taylor and Gutmann, 51-52.

[84] Rachel E. Spector, *Culture Diversity in Health & Illness*, 6th ed. (Upper Saddle River, NJ: Pearson Prentice Hall, 2004), i-ii.

[85] 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 (2006): 542.

competency.[86] These programs have become more and more sophisticated in their language, research, and science. The programs are now well known for their expediency in satisfying certain regulations and guidelines, as well as appeasing boards of directors that all is being done to ensure a culturally competent workplace. [87]

Defining the Terms

While *cultural competency* has become a commonplace term in medical settings, no one has yet defined this term with the precision that is expected in the field of medical education. This imprecision has made it difficult to implement and measure as other core competencies are expected to do in this field.[88] For most students and clinicians, cultural competency remains a nebulous thing that everyone thinks he understands, but few can articulate.

Nonetheless, multiculturalism in health care has generated quite a few terms that might benefit from definition for our discussion. Many of these terms are of course difficult to define and are quite debatable, but for the purposes of this dissertation, I will mostly adopt the definitions given by the Office of Minority Health (OMH) in its

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[86] For a good overview of the cultural competency field and its resources, see *Cultural Competency in Medicine*, (American Medical Student Association, 2007, accessed September 17, 2007); available from http://www.amsa.org/programs/gpit/cultural.cfm.

[87] U.S. DHHS, Office of Minority Health.

[88] Arthur Kleinman and Peter Benson, "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It," *PLoS Medicine* 3, no. 10 (2006): 1673.

National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) with a few notable exceptions.[89]

Defining Culture

First of all, the OMH defines *culture* as

> the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central to the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture.[90]

In short, *culture* is what noted cultural anthropologist Clifford Geertz terms "webs of significance." "[M]an," according to Geertz, "is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search

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[89] U.S. DHHS, Office of Minority Health.

[90] Ibid., 4.

of meaning."[91] Culture cannot, therefore, be seen as self-contained and homogenous or as a synonym for race, nationality, or ethnicity.

It should be clear that culture is of the utmost importance in a clinical encounter. It is often essential in diagnosing and devising treatment and always of the essence when caring for the patient. It also is favorable (if not crucial) for the patient to attend to the various cultures within which the physician or caregiver is situated. Culture helps shape health beliefs, values, perception, and behavior. Culture helps determine how we form interpersonal relationships[92] and the cultivation of collective as well as individual identities.[93] Culture helps define and is often itself defined in part by a person's religious practices, beliefs, and observances.[94] And yet these cultural features differ widely within the same racial, ethnic, or social group.[95]

However, the current conception of culture used in the health profession's cultural competency efforts seems to misperceive the nature of the phenomenon (if it can even be reduced to that) and to treat it very much like any other object of the scientific gaze. For example, while the OMH apparently does a formidable job of defining culture, it succumbs to the misperception of culture as one more bullet on the patient's chart. Medical anthropologist and physician Arthur Kleinman says that the current failure of

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[91] Geertz, 5.

[92] Cheryl Mattingly and Linda C. Garro, *Narrative and the Cultural Construction of Illness and Healing* (Berkeley and Los Angeles: University of California Press, 2000).

[93] Dorothy C. Holland, *Identity and Agency in Cultural Worlds* (Cambridge, MA: Harvard University Press, 1998).

[94] Berger.

[95] Kleinman and Benson.

cultural competency to make health care better for patients "stems from how culture is defined in medicine, which contrasts strikingly with its current use in anthropology—the field in which the concept of culture originated."[96] He argues that the term *culture* in medicine is often synonymous with ethnicity, nationality, and language. "For example, patients of a certain ethnicity—such as the 'Mexican patient'—are assumed to have a core set of beliefs about illness owing to fixed ethnic traits."[97] This stereotyping, born of an ostensibly culturally informed sensitivity, is in reality a thinly veneered version of the kind of uninformed prejudice that these training programs are meant to combat. The dominant methodology for cultural competency programs is just this kind of blind generalization—blind, that is, to the intricacies, vagaries, and unpredictability that more accurately describe a human being. The very idea of a culture or society that shares a common perception, sensitivity, like, dislike, belief, want, is fantastic. And yet how often is it that medical professionals can be heard uttering possibility-foreclosing banalities such as "Asians believe this," or "Blacks distrust doctors"?

It is only if one defines a culture so narrowly as to limit its inhabitants to a mere handful that one can reliably speak of cultural beliefs and meanings writ large. Current cultural competency pedagogies are nearly universally unreflexive in their study of culture. Historically in medicine, culture has referred almost exclusively to the patient. In fact, in some popular cultural competency books, culture is defined simply as the

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[96] Ibid.: 1673.

[97] Ibid.

patient's perspective. In the therapeutic dyad,[98] culture is not used to describe the other half, as if doctors, nurses, allied health professionals, and the health care professions were not deeply imbedded in their personal various cultural backgrounds and also in the culture of Western biomedicine and the culture of their respective professions or fields.[99]

Current biomedical culture, born of modernity and having matured during the post-war ascendancy of science and technology, can be characterized as an unreflexive culture or a culture that many within it cannot or refuse to see as a culture.[100] The biomedical cultural perceptions, ways-of-thinking, and prejudices to which health professionals are often blind, must be probed when speaking of cultural competency in medicine, and not just because this blindness will jeopardize a better understanding of the patient, but because the culture of biomedicine has been shown to be one of the major culprits in the cultivation and transmission of stigma and racial bias as well as a root cause of health disparities in general.[101]

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[98] Even "dyad" is too reductive of many if not most clinical situations.

[99] Janelle S. Taylor, "Confronting 'Culture' in Medicine's 'Culture of No Culture'," *Academic Medicine* 78, no. 6 (2003): 555-59.

[100] I concede that this is just the kind of generalization of what is undoubtedly a complex culture that this dissertation criticizes. But I continue to see this iatro-cultural blindness in the medical discourse. I believe that it stems from the vexing misperception that medicine is an unbiased *science*.

[101] See generally, Kimlin T. Ashing-Giwa, "Can a Culturally Responsive Model for Research Design Bring Us Closer to Addressing Participation Disparities? Lessons Learned from Cancer Survivorship Studies," *Ethnicity and Disease* 15, no. 1 (2005): 130-37; Joseph R. Betancourt and others, "Cultural Competence and Health Care Disparities: Key Perspectives and Trends," *Health Affairs* 24, no. 2 (2005): 499-505; Gerald T. Keusch, Joan Wilentz, and Arthur Kleinman, "Stigma and Global Health: Developing a Research Agenda," *Lancet* 367, no. 9509 (2006): 525-27; Stephanie L. Taylor and Nicole Lurie, "The Role of Culturally Competent Communication in Reducing Ethnic and Racial Healthcare Disparities," *American Journal of Managed Care* 10 (2004): 499-505; Keith Wailoo, *Dying in the City of*

Defining Cultural Competency

While the OMH has an interesting and useful notion of what the term *culture* means for purposes of cultural competency, it has a far too instrumental definition of cultural competence. It sees cultural competency as being a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in crosscultural situations."[102] This seems to propose that competence means a certain set of skills or tools that may then be implemented to get a culturally appropriate result. The language of a "set of tools" reminds the health-care student of the toolbox metaphor commonly used in scientific and medical education to denote a limited and particular knowledge set (often accompanied by checklists and flowcharts) that once applied properly and in the correct order, will give correct, accurate, and dependable results. When the various methods and algorithms the student memorized or conveniently pocketed in her white coat don't seem to apply in the invariably complex lives of her patients, the student is tempted (by her scientistic, empiricist models of knowledge) to shoehorn the patient into the restrictive mold given by the cultural competency guide or to abandon the project altogether. Both of these alternatives fail to deliver culturally sensitive care.

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the Blues: Sickle Cell Anemia and the Politics of Race and Health, Studies in Social Medicine (Chapel Hill: University of North Carolina Press, 2001).

[102] U.S. DHHS, Office of Minority Health, 4.

Curiously, though the initial definition of cultural competency by the OMH shows the same instrumental flavor that afflicts most of contemporary models of cultural competency, a far better conception of cultural competency is furthered by subsequent wording in the OMH's CLAS standards guidelines: "having the capacity to function effectively as an individual … within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."[103] My purposes herein will be served ably by this more intuitive notion of cultural competency.

[103] Ibid., 5.

CHAPTER THREE: THE TRANSLATION OF A QUALITATIVE PARADIGM INTO A QUANTITATIVE ONE

Logic is the art of going wrong with confidence.
—Anonymous. *Quoted in W. H. Auden,* A Certain World

What Happened?

Why has such a promising and laudable effort as cultural competency, whose ostensible objective is to humanize and particularize modern medicine, so often turned into a poorly executed arm of the positivist, scientific enterprise? Larry R. Churchill thinks that the co-optation and subsequent reduction of an originally illuminating concept is what commonly occurs when a concept is popularized.

In his article dealing with how Elisabeth Kübler-Ross's book *On Death and Dying* had been misused by modern medicine, Churchill explains how a well-intentioned medical profession will co-opt a qualitative research study and translate it into a quantitative model.[104] This co-optation no doubt makes for an easier application of the data for these scientists, but the rigidity that this translation forces upon the original work can turn a helpful heuristic (as are Kübler-Ross's stages of dying) into a harmful template when practitioners impose it upon patients. Studies have shown how some health-care

[104] Larry R. Churchill, "The Human Experience of Dying: The Moral Primacy of Stories over Stages," *Soundings* 62, no. 1 (1979): 24-37. Though dealing with a different reduction problem than that with which I am dealing here (specifically, Elisabeth Kübler-Ross's stages of dying), I am indebted to Churchill's article for explaining the temptation to ossify what are essentially flexible descriptive categorizations into prescriptive ones.

practitioners will all but demand that a patient experience all of Kübler-Ross's stages of berievement in chronological order and for the amount of time described in *On Death and Dying*; sometimes going so far as to actively intervene in a person's grieving process if it strays from the path outlined in the book.[105]

The same can be said of mainstream cultural competency programs and educational materials. Cultural competency programs often use short, descriptive accounts of what the author or authors think are the main features of a particular culture. Along with statistical demographic and geographic data, these accounts will usually focus on the predominant religion, customs, diet, medical beliefs, and average income for the target culture. While these statistics may be helpful to orient the discussion between doctor and patient, especially if the patient is of an ethnicity or culture never before encountered in the health-care practitioner's practice, it is easy to see how doctors and other care providers might read these descriptions as normative for a person, thereby prematurely attributing these characteristics to the patient. As such, the cultural competency materials and education that are thought to correct the harmful prejudices of health-care professionals may in fact contribute to new and perhaps more pernicious ones due to their "empirical" provenance.[106]

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[105] Ibid; K. Kellie Goldsworthy, "Grief and Loss Theory in Social Work Practice: All Changes Involve Loss, Just as All Losses Require Change," *Australian Social Work* 58, no. 2 (2005): 167-78.

[106] I use quotation marks around the term empirical here because the prevailing notions of cultural competency training are in fact *less* empirical if one adheres to the definition that empiricism is "based on, guided by, or employing observation and experiment rather than theory"; or "[d]erived from or verifiable by experience, esp. sense-experience." William R. Trumble, Angus Stevenson, and Lesley Brown, *Shorter Oxford English Dictionary on Historical Principles*, 5th ed. (Oxford: Oxford University Press, 2002). s.v. "empirical".

Geertz sees this kind of reductionist thinking as ridiculous: "The notion that one can find the essence of national societies, civilizations, great religions, or whatever summed up and simplified in so-called 'typical' [categorizations] is palpable nonsense."[107] Thus, more nuanced ways of arousing the awareness in the student of the storied ways in which we live and make sense of our lives is essential in cultivating a transculturally competent practitioner.

Ways of Ordering Experience

Identity is essentially a narrative matter[108] and remains the primordial human way of making sense of experience.[109] When a person tells and interprets experiences, narrative acts as the mediator between the inner world of that person where his various and ambiguous voices find a univocal, if sometimes conflicting, presence and the outer world of interpersonal connections.[110] The philosopher David Carr goes so far as to argue that "narrative structure pervades our very experience of time and social existence."[111] Even the ostensibly neutral and value-free narratives of science are

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[107] Geertz, 22.

[108] Alasdair C. MacIntyre, *After Virtue: A Study in Moral Theory*, 3rd ed. (Notre Dame, IN: University of Notre Dame Press, 2007); Donald E. Polkinghorne, *Narrative Knowing and the Human Sciences* (Albany, NY: State University of New York Press, 1988).

[109] David Carr, *Time, Narrative, and History*, Studies in Phenomenology and Existential Philosophy (Bloomington: Indiana University Press, 1986).

[110] Jerome S. Bruner, *Actual Minds, Possible Worlds* (Cambridge, MA: Harvard University Press, 1986).

[111] Carr, 9.

themselves another storytelling enterprise.[112] The main difference between these two ways of ordering experience is, to me, the attention that each gives to the particulars of the case. Jerome Bruner makes the same distinction in his book *Actual Minds, Possible Worlds* when he calls the "scientific" modality "paradigmatic" and the other the "narrative mode of knowing."[113] According to Bruner, each of these ways of knowing provides "distinctive ways of ordering experience, of constructing reality."[114] The paradigmatic mode attempts to "represent categories, concepts and propositional knowledge"[115] shorn of context and interpretation, and "seeks to transcend the particular by higher and higher reaching for abstraction."[116] Bruner's narrative mode of knowing, on the other hand, tends to dwell on the "particulars of experience located in time and place."[117] Bruner believes that both of these modes of thinking are needed in order to make sense of our experience and our world and, that these two modes cannot be antithetical to the other.[118] This also means, however, that paying heed to only one or the other of these modes of ordering experience, without due regard for the contributions of its converse, will make for a less-than-complete vision of the whole of experience.

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[112] Lewis P. Hinchman and Sandra Hinchman, *Memory, Identity, Community: The Idea of Narrative in the Human Sciences*, Suny Series in the Philosophy of the Social Sciences (Albany, NY: State University of New York Press, 1997).

[113] Bruner.

[114] Ibid.

[115] Viv Martin, "Dialogue in the Narrative Process," *Journal of Medical Ethics; Medical Humanities* 1, no. 33 (2007): 49.

[116] Bruner, 13.

[117] Ibid.

[118] Ibid.

Unfortunately, most cultural competency education and training, as they are undertaken in American medical centers today, take a decidedly paradigmatic mode to both teach and do cultural competence at the expense of the narrative approach. In so doing, they often fail to impart an awareness in the student of the "situatendess," contextuality, and particularity that are the most prominent features of an encounter with another person.

Critical Typology of the Literature of Cultural Competency

In my admittedly nonexhaustive and preliminary survey of what I will term cultural competency programs and literature,[119] I have found that these tend to approach the problem of understanding in the face of cultural diversity in medical settings in one of three ways.[120]

1. The first category is composed of catalogs of nationalities that, within a usually limited space, say, 500 words, attempt to depict the main features of that "culture" for the medical practitioner.[121] I put the word culture in quotations here because

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[119] Currently, Amazon.com lists 3,762 books on this topic.

[120] Some may argue that a dissertation on how reductivist many cultural competency programs are falls prey to the same reductive paradigm in encapsulating such a varied field into three categories. This criticism is well taken (and not without merit!), yet I believe that this abstraction is indeed *generally*, not universally true, and also believe that categorization is much more defensible when dealing with a relatively small and homogenous number of materials than when dealing with cultures, races, and ethnicities writ large.

[121] Among these, some of the most popular are Carolyn Erickson D'Avanzo and Elaine Marie Geissler, *Pocket Guide to Cultural Health Assessment*, 3rd ed., Mosby's Pocket Guide Series (St. Louis: Mosby, 2003); Joseph R. Betancourt and Roderick K. King, "Unequal Treatment: The Institute of Medicine Report and Its Public Health Implications," *Public Health Report* 118, no. 4 (2003); and Joseph R. Betancourt, "Cross-Cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation," *Academic Medicine* 78, no. 6 (2003).

these guides, usually written in "pocket guide" size so as to fit into a white coat pocket, usually conflate the word culture with nationality, race, or ethnicity. For example, implying that Mexico consists of one culture instead of the innumerable cultures that cluster around indices such as religion, region, socioeconomic class, level of education, race, language, tribal affiliation, previous nationality, *etc.*. Some of the handbooks in this category will attempt an even larger leap when, for example, they describe as a culture a multinational, multicultural, multilingual, multiracial group such as Latino/Hispanic. These guides are generally reductive to the extreme. They tend to be based on stereotypy and are designed for quick reference for health-care providers in time-pressed clinical situations.

2. The second category is populated with more rigorous books and materials that incorporate recent anthropological essays and even some chapters written by natives of the target culture.[122] These often have disclaimers that the contents are by necessity generalizations of what are always richly diverse cultures, but they fail to explain how a health-care provider can best endeavor to understand the patient's particular situation. They focus on cultivating in the practitioner an awareness of difference and an analogical method to distinguish between the cultural descriptions under which the patient may be categorized.

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[122] Some popular representatives of this category are Geri-Ann Galanti, *Caring for Patients from Different Cultures*, 3rd ed. (Philadelphia: University of Pennsylvania Press, 2004); Pamela A. Minarik, *Culture & Nursing Care: A Pocket Guide* (San Francisco: University of California San Francisco, 1996); and Anne Knights Rundle, Maria Carvalho, and Mary Robinson, *Cultural Competence in Health Care: A Practice Guide* (San Francisco: Jossey-Bass, 1999).

3. Last are guides and programs that attempt to instill in the student an awareness of the obstacles to understanding inherent in crosscultural health care, and foster an interpretive, dialogical way to understand patients.[123] These guides state explicitly that the descriptions of different cultures found within are never the final word but rather a likely and constructive starting point for the dialogue to begin.

Table 1. Typology of Cultural Competency Literature

Category 1: "Catalog"	Category 2: Social Scientific	Category 3: Interpretive, Dialogical
Materials that usually attempt to describe a "culture" (which is often confused with nationality, race, or ethnicity) in a very reductive and concise way so as to prove expedient and accessible to practitioners on their way into a patient's room or before a consultation.	Materials that delve deeper into the lifeworlds of typical people within a culture. Attempt to cultivate an awareness of difference by highlighting instances where the patient's culture and the iatroculture of the health-care professional may diverge.	Materials that attempt to instill an interpretive, dialogical means by which health-care practitioners might understand their patients. These materials highlight the fact that any descriptions of cultures are only statistically probable starting points from which to start the conversation.

The first and, to a lesser extent, the second category of cultural competency materials I have outlined above adhere to the mainstream social science paradigm that is

[123] Larry D. Purnell and Betty J. Paulanka, *Transcultural Health Care: A Culturally Competent Approach*, 2nd ed. (Philadelphia, PA: F. A. Davis, 2003). See also Rena C. Gropper, *Culture and the Clinical Encounter: An Intercultural Sensitizer for the Health Professions* (Yarmouth, ME: Intercultural Press, 1996).

rooted in the traditional epistemology of positivism.[124] According to Churchill, under this rubric, labels such as the ones found in cultural competency guides are used to "categorize and control."[125] They are used to manage the subject under observation and also to control the meaning of the subject's experience.[126] When misused in this way, social scientific categorizations "in the hands of an expert or professional … , studies, describes and inevitably *prescribes* for us."[127] The philosopher Charles Taylor sees this as reason enough to abandon the positivist methodology for a more interpretive model: "We need to go beyond the bounds of a science based on verification to one which would study the inter-subjective and common meanings embedded in social reality."[128]

Of course, abandoning the social scientific model with its perceived boon of verifiability is exactly what those who believe that empiricist methodologies are the only scientific ways of knowing (and thus the only ones that disclose objective truth) do not want. A science based on verification is replicable and predictable. It eschews the vicissitudes of interpretation for the bedrock of commensurability. But while empiricism is ideal for the bench sciences, it glosses over too much of human experience to be of much use to us in cultural competency. "To yield to this temptation," warns Taylor,

> is to fall into a distorted conception of what we are doing in social science. And this has a cost. We generate not only bogus explanations and specious

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[124] Charles Taylor, "Interpretation and the Sciences of Man," in *Philosophy and the Human Sciences* (New York: Cambridge University Press, 1985), 52.

[125] Churchill: 27.

[126] Ibid.

[127] Ibid.

[128] Taylor, "Interpretation and the Sciences of Man," 52.

> knowledge, but we also encourage ourselves to look for technological solutions to our deepest social problems, which are frequently aggravated by our misguided attempts to manipulate their parameters.[129]

Our endeavor to understand the other cannot but rely on human interpretation and dialogic engagement—an empirical science of cultural competency is, in Taylor's words, "radically impossible."[130]

The third category of materials uses the descriptive power of these social-scientific classifications of culture and softens them with a core requirement: to take the time to engage the patient in conversation. In the Purnell model of cultural competence, these abstract typologies are used only as starting points for conversation. The student is warned to see them as merely general descriptions that should be readily discarded if conversation proves them faulty or misleading. In this way cultural competency training and materials can be seen as equipping health-care providers with a directional nudge toward statistically probable (or possible) descriptions to better begin a line of inquiry.

The Work of Understanding Cannot Be Delegated or Circumvented

While most of the cultural competency programs and literature may have good intentions, they are often written by clinicians or social scientists who wrongly attempt to apply the same reductionist, scientific classification schemas to the problem of cultural diversity that are practiced in medical nosology. This reduction, in effect, perpetuates the

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[129] Charles Taylor, "Understanding and Ethnocentricity," in *Philosophy and the Human Sciences* (New York: Cambridge University Press, 1985), 130.

[130] Taylor, "Interpretation and the Sciences of Man," 52-57.

dangerous fallacy of stereotyping when encountering people from different cultural or socioeconomic backgrounds.

Too often cultural competency guidebooks and training attempt to alleviate the burden that health-care professionals shoulder: the work involved in understanding patients different from themselves. This work, however, is part and parcel of the understanding; while it may be honed and improved upon with cultural competency education, the work of understanding cannot be delegated or circumvented. The folly of the circumvention method is not in wanting the lofty result of understanding or culturally-appropriate care, but in thinking that these results can be reached directly through the application of a precise and succinct algorithm. The truth that consists of a patient's lifeworld cannot be arrived at directly; it is far too complex and interpretive a "thing" to lay itself open to such crude inquiry. The fallacy of understanding another by way of rapid ingestion of a bolus of social scientific data (one that the great historian and essayist Jacques Barzun termed "preposterism") is that it seeks to "obtain straight off what can only be the fruit of some effort, putting an end before the beginning. … [These] are conditions *sine qua non*."[131] Thus, any cultural competency program that attempts to hand the health-care professional an encapsulated knowledge that would otherwise have taken work in conversation, listening, narrative sensibility, or interpretation, is wrong-headed. This is true for at least three different reasons:

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[131] Jacques Barzun, "The Centrality of Reading," in *A Jacques Barzun Reader: Selections from His Works*, ed. Michael Murray (New York: HarperCollins, 2002), 398.

1. As mentioned above, any cultural competency program that circumvents the work needed to understand attempts to relieve the health-care professional from an integral part of understanding—hence making the resulting form of knowledge something less than understanding.
2. The application of a cultural nosology to help the physician understand the patient is helpful only if the patient happens to be sufficiently similar to the description in the cultural competency material. Yet since there is more cultural diversity *within* an ethnicity than there is *between* ethnicities,[132] a health-care professional who relies on a cultural competence caricature of what a particular patient thinks or believes without finding out for herself is taking as granted something that may or may not be true about this patient. This *mis*understanding can have dangerous implications for diagnosis and treatment (not to mention the physician-patient relationship).
3. The mainstream notion of cultural competency education inculcates a form of prejudice that, having arisen from supposedly culturally- sensitive training and materials may prove more pernicious and difficult to dispel. This is because of how the subject tends to believe that his or her previously-held prejudice has been erased and replaced with an empirically-derived (and therefore "true") understanding of the target culture. Having the imprimatur of a "culturally-

[132] Kleinman and Benson.

competent" guide gives the belief an authority that makes it less likely to be reexamined even when experience may contradict it.[133]

Resisting the Temptation to Reduce the Other

Encountering disparate cultures in the clinic, it is tempting for those brought up in the current logico scientific culture of modernity to attempt to flatten out the moonscape made up of the peaks and valleys of so many stories into one abstract plain, the *essence* of a race or culture. But this is a temptation that we must resist. For however useful such reduction may be to the actuary or statistician, it is a dangerous distillation whose boons to the health care professional—efficiency, ease of use and tidiness—come at the too-high expense of irrelevance to the particular case.

This "tendency toward essentialism" is evident whenever we attempt to substitute theory for narrative.[134] Not that this kind of inquiry standard is inappropriate for all subjects—it has proven extremely useful in those fields to which it properly belongs. In mathematics and astronomy, in chemistry as well as physics this scientific ironing-out of the complex and the superfluous has given us more precise knowledge as to the essence of a thing. Through the reductive lens of fractal geometry we can make sense of the seeming chaos of biology and find a mathematical simplicity. The dauntingly complex movement of things in both outer and inner space is uncovered by elegant formulas,

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[133] Gregg and Saha: 543.

[134] Richard Rorty, "Philosophers, Novelists, and Intercultural Comparisons: Heidegger, Kundera, and Dickens," in *Culture and Modernity: East-West Philosophic Perspectives*, ed. Eliot Deutsch (Honolulu: University of Hawaii Press, 1991), 3.

which then allow us to reliably predict and faithfully model those movements. With all of these precious discoveries in the "hard" sciences its no wonder that we have become true believers in the power of essentialist thinking.

CHAPTER FOUR: PHILOSOPHICAL HERMENEUTICS

> *[I]t is impossible for anyone to find the correct usefulness of any part unless he is perfectly acquainted long before with the action of the whole instrument.*
>
> —Galen

> *To divest oneself of some prejudices would be like taking off the skin to feel better.*
>
> —Fulke Greville*, Maxims, Characters and Reflections*

Introduction

It might be tempting to relegate *hermeneutics*, the study of the interpretation and understanding of meaning in signs and symbols,[135] to the insular realms of literary theory, religion, or semiotics, but to do so is to ignore the great impact that hermeneutic theory has on the practical and quotidian. In fact, every act has as its foundation an element of interpretation—a deciphering of stimuli and codes from which we derive meaning and relevance for our lives. This makes interpretation an universal and "unending task."[136] Even purely mental acts such as ideas or thoughts can be viewed as encounters with the

[135] David E. Klemm, *Hermeneutical Inquiry: The Interpretation of Texts*, ed. Charley Hardwick and James O. Duke, American Academy of Religion: Studies in Religion, vol. 1 (Atlanta, GA: Scholars Press, 1986), 2.

[136] See Kurt Mueller-Vollmer, *The Hermeneutics Reader: Texts of the German Tradition from the Enlightenment to the Present* (New York: Continuum, 1985), 9. Quoting Schleiermacher in *Hermeneutics, The Handwritten Manuscripts*, ed. Heinz Kimmerle, trans. by James Duke and Jack Forstmann, p. 41 (Sect. A, Bibl.).

artifacts of external information that are in essence understandings of the world around us.[137]

We can then at once see the import and applicability of hermeneutics to any endeavor in which one individual attempts to understand another, from the trivial and unreflective interactions that take place in our everyday lives to communication fraught with importance for both parties.

Illustration 1. Hermes: Messenger of the Gods.

Public Domain. Reprinted from Mara L. Pratt, *Myths of Old Greece* (New York: Anon 1896), 12.

What Is Hermeneutics?

Hermeneutics is not an easy term to define—ironically inviting its own interpretation. The best way to understand the term is probably to first attempt to understand its etymology. Carrying an obvious reference to the Greek messenger god Hermes, *hermeneutics* also sports

[137] Husserl explored the interaction between the object of thought and how the thinker thinks about it. This he called *intentionality* and declared that no matter what a person may think, she is always thinking about something.

connotations such as translation, explanation, communication, understanding, and interpretation—all necessary talents for a god whose task was conveying communiqués between gods and mortals across an epistemic gap.

But in the absence of a fleet-footed Hermes figure—one whose perfect understanding of both the speaker and the listener can bridge the gap of knowledge—what chance do we have of truly understanding each other? This is the domain where hermeneutic theory has earned its keep—as a replacement for Hermes.

Philosophical Underpinnings of Hermeneutics

Galen (130-200 C.E.), "[t]he most influential physician of the Roman Empire,"[138] while never abandoning his spirituality, was first and foremost an empiricist. Yet he warned against the reductivist thinking that would later become the bane of modern scientific thought: "And I shall now say again what I said at the beginning of the whole work, namely, that it is impossible for anyone to find the correct usefulness of any part unless he is perfectly acquainted long before with the action of the whole instrument."[139] Here Galen not only presaged the Cartesian rift that would develop between the subject and the object, but also posited perhaps the first instance of what became known as the hermeneutic circle—that a constant and repeating broadening and constricting of focus between the whole and its parts is necessary for understanding.

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[138] Stanley Finger, *Origins of Neuroscience* (New York: Oxford University Press, 1994), 16.

[139] Galen, *Galen on the Usefulness of the Parts of the Body. Peri Chreias Moriåon [Romanized Form] De Usu Partium*, trans. Margaret Tallmadge May, Cornell Publications in the History of Science (Ithaca, NY: Cornell University Press, 1968), 432.

It was not, however, until René Descartes (1596-1650) that the subject and object were irreparably riven. Descartes implied a sharp line of demarcation between the body and the mind, the known and the knower.[140] Bernstein defines this objectivism as

> a basic metaphysical or epistemological distinction between the subject and the object. What is "out there" (objective) is presumed to be independent of us (subjects), and knowledge is achieved when a subject correctly mirrors or represents objective reality.[141]

Thus, after Descartes, a chasm opened up between empiricism and rationalism. This divide was roughly mirrored by the division between two schools of hermeneutic theory: the epistemological and the ontological.

The Structuralist Methodologies of Schleiermacher and Dilthey

For interpreters of sacred scripture and of legal texts in premodern times, a fixed and solid foundation for reality was a convenient and unspoken prerequisite for the objectivity needed to decree authoritative laws. This bedrock was hardly a tough sell for hermeneuts. There seemed to be wide-ranging agreement as to the nature of reality and

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[140] While it is generally accepted that Descartes' theory caused a far-reaching change in perspective from a unified mind/body instantiation to a "dualism" paradigm, the contention that Descartes believed in such a dichotomy is the subject of heated debate among scholars, having recently fallen from favor. See Grant Duncan, "Mind-Body Dualism and the Biopsychosocial Model of Pain: What Did Descartes Really Say?," *Journal of Medicine and Philosophy* 25, no. 4 (2000): 485-513; and Richard M. Zaner, *Ethics and the Clinical Encounter* (Lima, OH: Academic Renewal Press, 2003), 104-29. And while Descartes' writings were inarguably the most influential in the innovation of dualism, they were by no means the first. See Stanley Finger, *Minds Behind the Brain: A History of the Pioneers and Their Discoveries* (New York: Oxford University Press, 2000), 69-83; and Gert-Jan C. Lokhorst and Timo Kaitaro, "The Originality of Descartes' Theory About the Pineal Gland," *Journal of the History of the Neurosciences* 10, no. 1 (2001): 6-18.

[141] Bernstein, *Beyond Objectivism and Relativism: Science, Hermeneutics, and Praxis*, 12.

to the congruence of perceptions among communities. The thoughts, mores, and proclivities of people and the agreed-upon ineffability of transcendent truths served as a common ground upon which to understand each other.

The culmination of empiricist thought in the Scientific Revolution provided that sure footing. The "knowability quotient" of the world seemed to soar ever higher as scientists replaced priests as the messengers of the gods. At roughly the same time, however, a notable shift in biblical exegesis was taking shape. Since the Middle Ages the Bible's interpretation had been solely the province of clerics steeped in religious tradition. Unsurprisingly, these theologians preached the inerrancy not only of scripture, but of their divinely inspired interpretations of the text. Thus, when Martin Luther (1483-1546) seized the opportunity afforded by Gutenberg's moveable type and argued for a personal, individual exegesis of the Bible, the Church responded that the Holy Scriptures were just too abstruse to be read without clergy mediation.[142] But there was little that the Catholic Church could do to keep its dominion over the interpretation of scripture.

The subsequent Protestant exegesis then focused on a *personal* interpretation of the text. By personal I do not simply mean that it was undertaken on an individual basis—though for the first time, this was indeed possible—but that it was predicated on an *empathic understanding*. This is suggested by what one of the reader's guides to Luther's Bible proposed: that when the reader was confronted with seemingly

[142] *See* Tracy.

contradictory passages, he or she should compare the possible meanings with contemporaneous and equivalent scenarios—in other words—project the self into the author's space.[143] It was just this sort of empathic understanding that hermeneuts Schleiermacher and Dilthey touted as the foundational principle of their methodologies.

Friedrich D. E. Schleiermacher (1768-1834) attempted to create a general theory of hermeneutics that combined both a structured grammatical or linguistic analysis of the text as well as a "psychological moment."[144] Schleiermacher's methodological approach assumed that the speaker and listener were "on the same page" or could, with some work, get there. He thought that a listener, by his comprehension of the words and grammatical rules which undoubtedly structured the speaker's speech, coupled with recognition and empathy of the similar human experience, would be able to *understand* the speaker.

Similarly, Wilhelm Dilthey (1833-1911) believed in the possibility, indeed the duty, for the interpreter to *know* the speaker's meaning. Dilthey was aware of how a reductive, maxim-based methodology of hermeneutics could devolve into a cold, unfeeling, ahistorical model reminiscent of the scientific method, and so he adapted Schleiermacher's schemata to an integrative approach that distinguished between the knowledge of science (*Erkennen*) and the understanding of human intentions (*Verstehen*). To be sure, Dilthey recognized more fully than Schleiermacher that peoples' perceptions

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[143] John C. Mallery, Roger Hurwitz, and Gavan Duffy, "Hermeneutics: From Textual Explication to Computer Understanding?," in *The Encyclopedia of Artificial Intelligence*, ed. Stuart C. Shapiro (New York: John Wiley & Sons, 1987), 264.

[144] Schleiermacher, 83.

and values changed over time and cultural distance.[145] Dilthey conceded that meanings are colored by the author's worldview or "*Welthanschauung*," that is uniquely situated in a temporal and social context, but that through rigorous application of the hermeneutic circle—going back and forth from text to context—and an empathic understanding of life experience (*Erlebnis*), an objective interpretation was still possible.[146]

However, both of these theories were devised to address, as most subaltern theories are, the perceived shortcomings of the mainstream ideology, and in so doing, reified that which they ostensibly railed against. Both Schleiermacher's and Dilthey's theories were based on the progressivist notion of the perfectibility of knowledge through the application of rigorous method; and while both[147] were aware of the decreased reliability of understanding due to distance (temporal, historical, linguistic and cultural) between the subject and object, both attempted to elevate hermeneutics to the level of a science—the notion that with the application of right method one could achieve a True and Correct interpretation.

The Epistemological Phenomenology of Husserl

Edmund Husserl (1859-1938) took Schleiermacher's and Dilthey's innovations in hermeneutic theory and extended them to a comprehensive phenomenology of the world.

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[145] Mallery, Hurwitz, and Duffy.

[146] Wilhelm Dilthey, "The Understanding of Other Persons and Their Life-Expressions," in *The Hermeneutics Reader*, ed. Kurt Mueller-Vollmer (New York: Continuum Publishing, 1926), 152-64.

[147] Though this is clearer in Dilthey's philosophy.

Husserlian phenomenology is also a direct descendent of the Cartesian tradition of the subject-object split.[148] Husserl, a former mathematician, believed in "essences" that were "… universal, eternally unchanging over time, and absolute."[149] Like Platonic Forms, or Cartesian geometry, these essences are idealized, metaphysical conceptions of reality whose perception was attainable through rigorous method. In order to apprehend the essence of a thing, Husserl put forth the revolutionary idea of "phenomenological reduction," or as it has more commonly become known: "bracketing." Bracketing involves (as it does in mathematics) placing a term or condition within brackets (e.g.: [*term*]) to be treated differently than the rest of the equation. Consciously bracketing a thing will then leave it untouched by the operations done to the rest of the material, and conversely, anything outside the brackets will remain untarnished by anything within. Husserl proposed that the hermeneut bracket his prejudices and preconceptions about the world (the interpreter's *life-world* (*Lebenswelt*)) when attempting to decipher meaning. In this way, Husserl thought that the reader could achieve an active objectivity—a perch unencumbered by the experiential baggage that we all carry—from which we can achieve a mathematical precision in our objectivity.

Those in the health-care fields who subscribe to the Husserlian ideal (most of us), are, in effect, forever "trying to wash the language of their respective tribes off their

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[148] Hubert L. Dreyfus, "Husserl, Heidegger and Modern Existentialism," in *The Great Philosophers: An Introduction to Western Philosophy*, ed. Bryan Magee (London: BBC Books, 1987), 254-77.

[149] Jennings.

tongues."[150] This move, undertaken in service to theory, structure, and abstraction to afford that seductive (and reductive) simplicity by which the subject is laid bare, is partly what hinders the full possibility of crosscultural understanding in health care. For true understanding (which is to say, provisional and tentative) does not serve the ideological certitudes that govern the Husserlian, scientific ideal. Instead, crosscultural understanding stands in bold contradiction to it.

Husserlian phenomenology has had extensive influence in both the sciences and the "human sciences." Most pertinent to my discussion, medical research has embraced the Husserlian notion of an ideal observer in the case of the clinical researcher who objectively surveys the research question and its possible answers free from prejudice and bias. To further bolster the notion of the necessity of an impartial investigator, modern medical science has touted a gold standard of empirical research where double-blind studies render the research untainted and objective. This concept of an innocent observer in modern science lingers today and while it has of course been extremely successful in the hard sciences, this mindset continually acts to legitimate a medical research enterprise that is blind to its ideological orientation and force.[151]

The Ontological Hermeneutic of Heidegger

While Husserl believed in a life-world composed of discrete subjects and objects,

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[150] Rorty, 8.

[151] *See* Kuhn, *The Structure of Scientific Revolutions*.

Martin Heidegger (1889-1976), a student of Husserl, believed that it was impossible and unnecessary to divest or bracket oneself of the very constitutive experiences that make one who one is (*Lebenswelt*) in order to comprehend the object. Heidegger argued that instead of inquiry being founded on the epistemological push to validate knowledge (of which he was skeptical), that understanding was better predicated on ontology or the knowledge of "being." In Heidegger's ontology, *Being* refers to the everyday life experience of people. This situatedness of human existence he termed "*Dasein*," or "being-there," which emphasized the commonsensical fact that people are in and of the world, not subjects free floating among objects.[152] Heidegger's hermeneutic approach differed from Husserl's in that he denied the possibility of the bracketing of preconceptions and, in fact, argued that true understanding was indeed impossible without bringing life experiences to bear on the text.[153] For Heidegger then, hermeneutics was not a special inquiry to be undertaken with a definitive prescriptive method, but rather it was the primary source of understanding at all times.[154] Interpretation cannot (and should not) occur without seeing through the tinted lenses of our own lived experience. Consequently, Dilthey's methodological hermeneutic circle was superseded by the more basic ontological hermeneutic circle that oscillates between an existential understanding of our life-world and an interpretation that is always self-

[152] Heidegger, 26-30.

[153] Ibid., 188-95.

[154] Ibid., 189.

conscious and embracing of that *Lebenswelt* and never attempts to achieve a transcendent objectivism.

Methodological Implications for Epistemological and Ontological Hermeneutics of Medicine

Epistemology versus Ontology

While Heideggerian ontological hermeneutics attempts to derail the more methodological approaches of Schleiermacher, Dilthey, and Husserl, as I have already shown, modern medicine and medical research have never lost their foothold in the epistemological hermeneutical methods. In fact, it could be argued that epistemological hermeneutics and phenomenology are ideally suited for (if not formative of) the progressivist enterprise that is modern medical research and health care. Hubert L. Dreyfus contends that if one wants to interpret experience, epistemological hermeneutics gives one both the license and the method to do it.[155] Medical research, driven by a self-perceived and self-imposed need to be as empirical and objective as possible, assumes that there is a solid foundation of unfiltered objective reality upon which to build its enterprise and, moreover, assumes that this reality is knowable through method.

There are two major practical problems with this premise, even if one assumes *arguendo* that such objectivity exists. One problem is how cold and impersonal medicine

[155] Dreyfus, 270.

is rendered by such a paradigm. Patients are reduced to the currency of mathematics—precise, determinable, units of investigation. But humans defy such reduction.

Heidegger, in his 1954 essay titled *Science and Meditation,* shows that modernity's science is a theory of the "real" and argues that for science, what is real is only that which can be measured and calculated, in other words, the "objective."[156] Ominously, this implies that there may be certain aspects of humanity that are then un-embraceable or inaccessible for science precisely because they are immeasurable.[157] This is not alarming in itself as long as those dimensions of life are not ignored in the clinical setting, but in a modern society that worships at the altar of science, an entire facet of our life-world can be left out of the equation. What is human is forsaken for what is organism.

Mauricio González Suárez laments that "… we have now passed from astonishment to certitude. With this step we have gained much, but we have also lost much."[158] Suárez argues that

> what we have lost is no less than the capacity for amazement and with it, part of our liberty. In what sense? In the sense that we have become incapable of questioning the certitudes which science throws at us, everyday it becomes more and more difficult to meditate on the very things that are no longer proper objects of the new science's gaze—to know all that which cannot be measured, quantified, or projected. And it is then when we fall victims to the sad paradox of asking science to prove truths that it cannot provide us with; we ask it why we

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[156] Martin Heidegger, "Wissenschaft und Besinnung (Ciencia y Meditación)," in *Ciencia y Técnica (Vorträge und Aufsätze)* (Santiago de Chile: Editorial Universitaria, 1983), 18.

[157] Mauricio González Suárez, "Fundamentos y Consecuencias Éticas del Principio de Autonomía [Ethical Foundations and Consequences of the Autonomy Principle]," *Vera Humanitas* 16, no. 31 (2001): 144.

[158] Ibid. Translation by Daniel Bustillos.

> suffer and why we enjoy; we demand formulas for cruelty and equations for charity; plottings of what is base and the atomic structure of the sublime. But all of that is un-embraceable by science. She has no answer for our queries.[159]

What we see is that the logicopositivist scientism so richly deserving of praise when doing its work within the *Naturwissenschaften* has imperiously colonized the *Geisteswissenschaften* as well. This imperialism is evident in two fundamental problems that continue to stand in the way of a crosscultural understanding. (1) The Husserlian concept of bracketing our experience has led to the unwitting blindness to prejudices and preconceptions on the part of practitioners. It has also exacerbated the problems that stem from a profession's blindness to its own culture when confronting another. (2) The neat categorization of large swaths of the population into manageable units that can then be handled or compared with ease. This categorization is a pernicious vestige of the false dichotomy of the either-or that stems from the inability (or inconvenience) of seeing the essential (thus, nonreducible) complexity of humanity. Both of these fundamental errors are close to the root of the problem of the Other in health care. Unfortunately, the means devised to correct these problems are predicated on the very roots of the problem. A cultural competency program that assumes and reaffirms these two predicates is doomed from the start as a possible corrective.

Yet another problem with epistemological approaches is that history has shown that time and again empirical medicine and medical research are still very much laden

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[159] Ibid. Translation by Daniel Bustillos.

with the prejudices and preconceptions that encounters between health professionals and patients or research participants are supposed to bracket. Even for double-blind studies, the gold standard for objective medical science, the formulation of the research question can often be seen to belie a skewed perspective that often contains the biased assumption of what the outcome will be. For example, Allan Brandt, in writing about racism and the Tuskegee syphilis experiment, chronicles the myriad ways that medicine, either wittingly or unwittingly, contributed to the race polemic by coupling the pseudoscience of social Darwinism with ostensibly empirical observations of the physiological, neurological, and behavioral differences between the races and how these differences affected health.[160] According to Brandt, scientists in the late nineteenth and early twentieth centuries had found and documented many "racial differences"[161] such as the report of a comparative anatomist who described the "body of the negro [as] a mass of minor defects and imperfections from the crown of the head to the soles of the feet."[162] Brandt argues that "findings" such as this endowed scientific legitimacy upon the already popular view that blacks were evolutionarily underdeveloped—a forebear of modern man who was intellectually stunted.[163]

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[160] Allan M. Brandt, "Racism and Research: The Case of the Tuskegee Syphilis Experiment," in *Tuskegee's Truths: Rethinking the Tuskegee Syphilis Study*, ed. Susan Reverby, Studies in Social Medicine (Chapel Hill: University of North Carolina Press, 2000), 15-33.

[161] Ibid. Especially 16-18.

[162] W. T. English, "Racial Anatomical Peculiarities," *New York Medical Journal* 63 (1896). Quoted in Brandt, 16.

[163] In English. Quoted in Brandt, 16. It was estimated that "gray matter of the negro brain" was at least 1,000 years behind white brain development.

Thus, the authority that empirical medical science imbued upon the view that blacks were naturally diseased can be seen as merely a conveniently "scientific" imprimatur of racism, and convincing evidence that bracketing of such prejudices is not always successful.[164]

Similarly, Gerald Oppenheimer writes of the way that initial studies into the H.I.V./A.I.D.S. outbreak in the early 1980s prematurely and insufficiently framed the question of the disease's etymology as somehow intimately and exclusively tied to homosexual behavior. Oppenheimer says that the bold assertion that a "gay plague" was underway "… was made on the basis of five cases from a single community—a broad generalization indeed to formulate from so small a sample."[165]

All of this, however, does little to prove that the Heideggerian alternative is any better. While an ontological hermeneutical approach to medical encounters seems a more realistic approach (in that physicians/investigators are not expected to achieve an ideal and unattainable objectivity), it does not preclude the possibility of the same kind of abuses seen above.[166] While Heidegger seems more perspicacious in his view of the "human-ness" of social interaction, does the mere act of trying to be aware of your

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[164] See generally James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: Free Press, 1993). Especially chapters 2 and 3.

[165] Gerald M. Oppenheimer, "In the Eye of the Storm: The Epidemiological Construction of A.I.D.S.," in *A.I.D.S.: The Burdens of History*, ed. Elizabeth Fee and Daniel M. Fox (Berkeley and Los Angeles: University of California Press, 1988), 271.

[166] One might rightly say that this is indeed the pitfall that trapped Heidegger himself in Nazi Germany. His complicity in (1) staying silent when fellow academics were targeted for their Jewish identity or sympathies, and (2) actively pursuing his professional ends at the expense of the Jews around him is compelling evidence that being acutely aware of the myriad ways empathic understanding can be subverted is not the same as being immune to the problem. For a riveting account of Heidegger's actions in

situatedness and foreknowledge achieve better outcomes in research and patient care? In fact, couldn't the researcher's embracing of his own life-world also legitimate any biases he or she chose to indulge in?

Nazi Germany and a condemnation of his culpability, see Berel Lang, *Heidegger's Silence* (Ithaca, NY: Cornell University Press, 1996).

CHAPTER FIVE: DISCOVERING A GADAMERIAN HERMENEUTICS OF THE CLINICAL ENCOUNTER

> *The patient-caregiver relationship is collaborative, and the work of healing commences not when the caregiver makes the diagnosis but when text and readers converge in a common narrative.*
>
> –Ronald A. Carson, *Encyclopedia of Bioethics*: 'Interpretation'

All of the difficulties inherent in crosscultural communication that I have detailed above notwithstanding, it is important to emphasize that perfect identicalness of meaning in the interlocutors is not necessary for comprehension. Rather than demoralize the practitioner or her patient, the inherent impossibility of objective, unambiguous precision and accuracy in understanding should be seen as nonetheless affording the opportunity for fruitful understanding. In fact, as Heidegger suggested, it may be *through* our differences that we are able to understand each other.

Hans-Georg Gadamer's Philosophical Hermeneutics

As mentioned previously, Heidegger's notion of *Dasein*, or "being-in-the-world" and the ineluctable situatedness of lived life, profoundly influenced Gadamer's philosophy of understanding, especially his concepts of prejudice, horizon, and play that I will show are pivotal to a better understanding of how a Gadamerian philosophical hermeneutic can help us achieve a better and more culturally sensitive understanding.

Prejudice

One might be tempted to think that a dissertation on crosscultural understanding would deal with the issue of prejudice in a negative light, and one would be right, if it is the common usage of the word of which one speaks. However, Gadamer, influenced by Heideggerian *Dasein* as he was, encourages those investigating the phenomenon of interpersonal understanding to reserve pre-judgment, as it were, and rehabilitate the word *prejudice*.

In his masterwork *Truth and Method*, Gadamer takes the common definition of *prejudice* at face value as being a judgment that is "rendered before all the elements that determine a situation have been fully examined."[167] This strict yet charitable reading of prejudice is necessarily value neutral because of the hermeneutic circle as Heidegger worked it out. Heidegger envisioned the hermeneutic circle not as a prescriptive methodology in order to achieve more truthful knowledge, but as a description of the way successful understanding is always already achieved. He writes that the hermeneutic circle "is not to be reduced to the level of a vicious circle. …"

> In the circle is hidden a positive possibility of the most primordial kind of knowing. To be sure, we genuinely take hold of this possibility only when, in our interpretation, we have understood that our first, last, and constant task is never to allow our fore-having, fore-sight, and fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves."[168]

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[167] Gadamer, *Truth and Method*, 270.

[168] Heidegger, *Being and Time*, 195.

This strikes me as wisdom of the utmost importance for those attempting a crosscultural understanding. Gadamer builds upon Heidegger's meaningful insight, saying that preunderstandings and preconceptions are always already present in understanding. For Gadamer, all understanding begins with fore-conceptions that are then replaced by more suitable ones if the project of understanding is undertaken in an earnest, open-minded fashion.[169] This interpretive oscillation between a fore-conception, and either the internal dissonance or consonance generated by what emerges from our experiential observation and conversation will then cause either a revision in the fore-conception to reduce the dissonance, or a reification of the fore-conception by receiving affirming data.[170] This winnowing down of possibilities toward a truthful and meaningful interpretation depends, according to Gadamer, on keeping one's gaze fixed on the person whom we are attempting to know. If, as often happens in crosscultural contexts, especially those where mainstream cultural competency education or materials are used, the health-care practitioner instead has his gaze fixed upon his preconception of the person, the interpretive oscillation generates only a specious reaffirmation of what is essentially an unreflective, untested prejudice that, regardless of its accuracy in describing this particular patient, is not understanding *per se*.

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[169] Gadamer, *Truth and Method*.

[170] Ibid.

Gadamer argues:

> Working out appropriate projections, anticipatory in nature, to be confirmed "by the things" themselves, is the constant task of understanding. The only "objectivity" here is the confirmation of a fore-meaning in its being worked out. Indeed, what characterizes the arbitrariness of inappropriate fore-meanings if not that they come to nothing in being worked out? But understanding realizes its full potential only when the fore-meanings that it begins with are not arbitrary. Thus it is quite right for the interpreter not to approach the text directly, relying solely on the fore-meaning already available to him, but rather explicitly to examine the legitimacy—i.e., the origin and validity—of the fore-meanings dwelling within him.[171]

In this context, prejudice then means the universal fore-understandings that we bring to bear at all times when attempting to understand something or someone. It is thus a basic requirement of any understanding. The rigorous testing of these "hypotheses" against new data generated in the encounter is not just what scientists do in laboratories, but is reflective of what we all should do everyday to achieve better understanding.

This revelation prompts at least two pertinent questions for the purposes of enriching the medical practitioner-patient encounter: first, a question remains as to how this basic, dialogical ethic can be fulfilled in a clinical encounter constrained by all of the pressing demands and distractions of modern biomedicine. Secondly, we should wonder how the basic requirement of a reflexive hermeneutic can best be taught to health-care professionals to improve their competence in providing appropriate crosscultural care.

Before these two questions are answered however, an important threshold question remains of whether such a dialectical approach as the one hinted at by Gadamer

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[171] Ibid., 267.

would in fact improve the crosscultural competence of health care practitioners. It is to this preliminary matter that I now turn.

Fusion of Horizons

It is common to speak of a horizon of knowledge as being the perspectival limits to a person's worldview. But it might be tempting to think that when Gadamer then speaks of a "fusion of horizons," he is speaking of the object being accurately perceived by the subject. This is not what Gadamer has in mind. He speaks of "coming to an understanding" instead of any privileged perception of truth. In this sense, coming to an understanding is dependent on both parties in a conversation and the resulting understanding will never be identical to either one of the interlocutor's horizon at the start of the conversation. For we always make things comprehensible through our own terms and horizons, never through anyone else's. That is why Gadamer's metaphor of "fusion of horizons" entails a movement toward a new horizon—not one that encapsulates the interlocutor's life-world—but a new plateau in which we can both navigate and converse, and from which stems the possibility of understanding. This new horizon is not simply a "broadening of horizons" where party A is now aware of the party B in party A's thought forms. Instead, Gadamer envisions an event where parties A and B have co-constructed a new language in which to speak of the situation in which they find themselves. The new language is made up of the thought forms of both parties which makes for the possibility of understanding whereby neither party is assimilating, subsuming, and reducing the

ineffability of the other into the thought forms of the subject, but where a co-constructed reality is formed. Consequently, the more one undertakes to fuse horizons with others, the more comprehensible a wider range of perspectives becomes. This comprehension we sometimes call a "worldliness" or "cosmopolitanism" in the charitable sense that one has engaged many differently situated people and one therefore has an experiential wisdom (later we'll see it as a *phronetic* wisdom) that allows one to excel at crosscultural understandings (a cultural competency).

In these cases, it is not *despite* the fact that there are differences that parties can come to understandings, but rather *through* our different horizons that we can gain a perspective of a wider band of horizons in other people.

Difference as a Means to Understanding

For example, Gadamer holds that not only is it impossible to divorce ourselves from the preconceptions and presuppositions that are formative and constitutive of ourselves, but also that this fore knowledge is the vehicle that affords us a purchase from which to engage the other constructively. For Gadamer, communication (i.e., "language") is finding the words or symbols to speak—and is fundamentally a mediated, interpretive project. This is what he terms "the mode of the whole human experience of the world."[172] We are inexorably situated in a continuum of interpretation. As he describes it,

[172] Gadamer, "The Universality of the Hermeneutical Problem," 188.

> [t]here is always a world already interpreted, already organized in its basic relations, into which experience steps as something new, upsetting what has led our expectations and undergoing reorganization itself in the upheaval. Misunderstanding and strangeness are not the first factors, so that avoiding misunderstanding can be regarded as the specific task of hermeneutics. Just the reverse is the case. Only the support of the familiar and common understanding makes possible the venture into the alien, the lifting up of something out of the alien, and thus the broadening and enrichment of our own experience of the world.[173]

We are confined to our situation but this is not as restrictive as it may sound. We try to inhabit the realm of the other not by a divestment of our own situation, but *through* our situation.

The notion of a divestment of our situation, as we saw earlier, is a fraud. This pronouncement comes from a healthy realization of the impossibility of what philosopher and theologian Rudolf Bultmann calls "presuppositionless understanding,"[174] but not in an overly cynical way in which novel understandings are also rendered impossible. Similarly, Gadamer envisions an Aristotelian golden mean between the two extremes of objective understanding and a nihilistic subjectivism. He believes that

> [o]nly by virtue of [dialogical] reflection can I escape being a slave to myself, am I able to judge freely of the validity or invalidity of my preconceptions—even if "freely" means only that from my encounter with a prejudiced view of things I am able to come away with nothing more than yet another conception of them. This implies, however, that the prejudices which govern my preconception are always at stake along with it—to the extent, indeed, of their abandonment, which of course can always mean mere rehabilitation as well. For that is the inexhaustible

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[173] Ibid.

[174] Rudolf Bultmann, "Is Exegesis without Presuppositions Possible?," in *The Hermeneutics Reader: Texts of the German Tradition from the Enlightenment to the Present*, ed. Kurt Mueller-Vollmer (New York: Continuum, 1997), 242-48.

> power of experience, that in every process of learning we constantly form a new preconception.[175]

It is precisely when we bring our presuppositions into play in a conversation that they are then amenable to refinement, reification, or rejection.

And so it is unsurprising that when approaching the foreign, the difference between conversants will be obvious. But instead of trying to smooth over our differences, these are the very contours that should shape our understanding of the other. There will be times when the difference will necessitate a third party interlocutor—a translator or mediator to help us, though not to smooth out the conversational terrain's protrusions and fill its voids but rather shed light on those contours so they will be more navigable in conversation. The need for a mediator is doubly true for crosscultural encounters where layers of complexity abound and a topography of the Other may look like a moonscape to us.

Gadamer, then, calls for a "rehabilitation of prejudice"[176] that is aware of our re-creative and interpretive task. And in so doing, we crossbreed our two distinct life-worlds in what he calls a "fusion of horizons" that will afford us a "higher universality that overcomes, not only our own particularity, but also that of the other."[177]

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[175] Gadamer, "The Historicity of Understanding," 288.

[176] Ibid., 261.

[177] Ibid., 271.

I-Thou Engagement

When we open ourselves to engaging another in conversation, we open ourselves to the possibility of being changed by our partner in dialogue. In conversation, we are like Don Quixote and his faithful Sancho Panza—we listen to each other on our joint journey and are each, in turn, changed through our receptivity and reciprocity.[178] But this will require much more than an open mind. It necessitates nothing less than a surrender of sorts to the other, the giving of oneself that Buber calls the I-Thou relationship.

The term *surrender* used above connotes not only a kind of tentative agreement with my interlocutor's assertion of the truth of her position, but also a more intimate kind of bond. Anatole Broyard, the famous critic and editor, once quipped that his ideal doctor "would resemble Oliver Sacks, the neurologist who wrote Awakenings and The Man Who Mistook His Wife for a Hat."[179] Broyard muses:

> I can imagine Dr. Sacks *entering* my condition, looking around at it from the inside like a benevolent landlord with a tenant, trying to see how he could make the premises more livable for me. He would see the genius of my illness. He would mingle his dæmon with mine: we would wrestle with my fate together.[180]

Notice the intimacy between the doctor and his patient; how they are willing to co-mingle their indwelling spirits[181] in order to "wrestle with [Broyard's] fate

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[178] Harold Bloom, "The Knight in the Mirror," *Guardian*, December 17, 2003, 1.

[179] Anatole Broyard, "Doctor Talk to Me," *New York Times Magazine*, August 26 1990, 36.

[180] Ibid.

[181] No doubt that Broyard's quizzical word choice of *dæmon* is akin to Shakespeare's usage of the word in *Antony & Cleopatra* to describe a "Noble, courageous, high, unmatchable" spirit.

together."[182] Notice Broyard's surrender to the penetration of the doctor into his life-world. Notice also the physician's surrender to Broyard's point of view.

What Broyard admires in Sacks's manner is the particular discursive method that Sacks calls a "trajective" approach:

> Such an approach is neither "subjective" nor "objective"; it is (in Rosenstock-Huessy's term) "*trajective.*" Neither seeing the patient as an impersonal object nor subjecting him to identifications and projections of himself, the physician must proceed by sympathy or empathy, proceeding in company with the patient, *sharing* his experiences and feelings and thoughts, the inner conceptions which shape his behaviour. He must feel (or imagine) how his patient is feeling, without ever losing the sense of himself; he must inhabit, simultaneously, two frames of reference, and make it possible for the patient to do likewise.[183]

Arthur Frank likens serious illness to a "loss of the 'destination and map' that had previously guided the ill person's life[.]"[184] Similarly, Sacks believes that in order to "reach out into the realm" inhabited by patients, the physician must become "a fellow traveler, a fellow explorer, continually moving *with* his patients, discovering with

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[182] Broyard, "Doctor Talk to Me."

[183] Oliver W. Sacks, *Awakenings* (New York: Vintage Books, 1999), 226. Emphasis in the original.

[184] Frank, *The Wounded Storyteller*, 1. Quoting personal correspondence from Judith Zaruches.

them."[185] Sacks sees himself as an explorer of "the furthest Arctics and Tropics of neurological disorder."[186]

[185] Sacks, *Awakenings*, 225-26.

[186] Sacks, *A Leg to Stand On*, 110.

CHAPTER SIX: *PHRONESIS* AND PRACTICE

> *The accounts we demand must be in accordance with the subject matter; matters concerned with conduct and questions of what is good for us have no fixity any more than matters of health. The general account being of this nature, the account of particular cases is yet more lacking in exactness; for they do not fall under any technical skill or set of precepts but the agents themselves must in each case consider what is appropriate to the occasion, as happens also in the arts of medicine and navigation.*
>
> –Aristotle, *The Nicomachean Ethics*

Introduction

The goal of Gadamer's philosophical hermeneutics is not *true* understanding, as might be defined by the positivist notion of accurate correspondence between fact and its representation, but rather *good* understanding. It is not that this is a more modest pursuit, simply a more realistic one given what we know about knowledge and its limits. This feature of Gadamer's hermeneutics is implied in his appropriation of the Aristotelian concept of *phronesis* as a hermeneutic virtue.[187]

Praxis

For Gadamer, the notion of application is at the core of his philosophical hermeneutics and understanding. This emphasis remains true despite saying that his real concern in writing *Truth and Method* "was and is philosophic: *not what we do or what we*

[187] Frederik Svenaeus, "Hermeneutics of Medicine in the Wake of Gadamer: The Issue of *Phronesis*," *Theoretical Medicine and Bioethics* 24, no. 5 (2003): 408.

ought to do, but what happens to us over and above our wanting and doing."[188] Gadamer does not give interpretive maxims to employ or rules to follow in order to get at the truth, but the universality of his philosophical hermeneutics—the veracity of its account of what actually happens in every instance of knowledge being sought—implicates itself in every practical and quotidian event. If one is persuaded by the phenomenological stance that Gadamer's philosophical hermeneutics provides, then new perspectives on previously unexamined events throughout life are inevitable.

The universal applicability of Gadamer's hermeneutic awareness is something to which the philosopher devoted the bulk of his later writings. Many of these have direct applicability for our inquiry here. For example, in his essay "The limitations of the expert," Gadamer criticizes the logicoscientific worldview for its hegemonic power to overshadow and marginalize alternative ways of being and knowing.[189] Specialists of knowledge then use the legitimacy conferred upon them by their adherence to the scientific power structure to erect boundaries around knowledge and patrol these in order to exclude others. Gadamer illustrates this and the universality and application of his philosophical hermeneutics in the area of health care in the collection of essays entitled "The Enigma of Health."[190]

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[188] Gadamer, *Truth and Method*, xxviii.

[189] Chris Lawn, *Gadamer: A Guide for the Perplexed* (New York: Continuum, 2006), 112-13.

[190] Gadamer, *The Enigma of Health*.

The Art of Medicine

In the modern idiom, the health-care practitioner is a professional; that is, she considers herself (and is considered by the profession and the public) a specialist technologist of disease. Gadamer eschews this ultimately distancing conception for the ancient notion that health-care practitioners are *artists* or practitioners of the hermeneutical *art* of medicine. He grants that today's physicians are well-advised to be experts at *using* technology in service to the art, but that this need for expertise does not change the fundamental identity of the hermeneutical art of medicine. Even with the mountains of scientific knowledge, tests, instruments, and techniques, medicine continues to be an inexact and often mysterious human endeavor. Thus, the doctor-patient relationship should not be seen as a subject-object relationship as modern biomedicine is prone to see it, but rather as a collaborative, interpretive relationship in search of maintaining or regaining the healthful balance necessary for human flourishing.

Techne *and* Phronesis

Unmasking the scientific specialist paradigm of modern biomedicine is important in understanding Gadamer's reemphasis on Aristotle's notion of practical wisdom or *phronesis*. If we trace technology's etymology back to the ancient Greek, we see the misapplication of this paradigm to medicine. Gadamer takes Aristotle's notions of *techne* and *praxis* from The Nicomachean Ethics to show that these two notions form the foundation of modern biomedicine and that they distort the notion of the health-care provider/patient relationship. *Techne* was reserved for the process used by ancient

craftspeople in producing an object. These craftspeople applied knowledge to produce a pre-planned object.[191] This object was the direct result of the practical skill (*techne*). Aristotle knew that this technical expertise was not what physicians practiced. The specialized knowledge that doctors possessed did not result in an artifact since health cannot be reduced to such tangible terms. Thus, medicine cannot be reduced to a practical skill in the *techne* sense. Now since the skills necessary for modern medicine are both sometimes technologically based and practical, it is easy to think of medicine as *techne*. But this is fundamentally misleading since, in most instances, the patient's health is not achieved solely because of the doctor's technical skill. It is more accurate to think of the doctor's skill as aiding the natural healing process to regain control of the situation, and aiding the patient during the healing process. For this, the health-care practitioner specializes in something more tentative, interpretive, and discerning than the less-nuanced *techne*. The doctor uses *phronesis* in aiding the restorative process. The predominance of phronetic activity is not to say that physicians do not employ technical skills in the healing process, but that the overall problems presented with the health care of a patient nearly always present hermeneutical problems where *phronesis* is required. Gadamer, after all, says that the question is "of finding the right balance between our technical capacities and the need for responsible actions and choices."[192] However, he feels that we are in constant danger of having the hegemony of the technically

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[191] Hans-Georg Gadamer, "Theory, Technology, Praxis," in *The Enigma of Health: The Art of Healing in a Scientific Age* (Stanford, CA: Stanford University Press, 1996), 1-30.

[192] Gadamer, *The Enigma of Health*, viii-ix.

methodized practice of medicine discourage the *phronetic* hermeneutical judgment and practical experience necessary for true healing to take place.[193]

Phronesis, according to Aristotle, is essential to ethical decision making.[194] This is true because, unlike *techne*, when confronted with complex situations that require action, the wise person does not merely rely on a static set of ethical norms or principles and then apply them to the case at hand. Instead, the *phronimos* or wise practitioner will use the discernment that comes from immersion in the lifeworlds of the stakeholders and her knowledge of what the good life consists in to judge the right course of action.[195]

And since illness is much more a social and cultural construct "than a fact that is determinable from within the natural sciences," it is a different kind of understanding that practitioners are aiming for in health care.[196] This understanding is not the brute understanding of the scientific gaze but the tentative, provisional, dialogical, narratively

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[193] Ibid., 20.

[194] Aristotle, *The Ethics of Aristotle: The Nicomachean Ethics*, trans. J. A. K. Thomson, Revised ed. (Harmondsworth, NY: Penguin, 1976), VI, 3.

[195] Svenaeus: 409.

[196] Gadamer, *The Enigma of Health*, 20.

based understanding that Gadamer's philosophical hermeneutics deems to be the basis of the doctor-patient relationship. As such, *phronesis* has been described as the hallmark of the good physician and prudent, ethical decisionmaker.[197]

[197] F. D. Davis, "Phronesis, Clinical Reasoning, and Pellegrino's Philosophy of Medicine," *Theoretical Medicine* 18, no. 1-2 (1997): 173-95; Albert R. Jonsen and Stephen Edelston Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Berkeley: University of California Press, 1988); Ineke Widdershoven-Heerding, "Medicine as a Form of Practical Understanding," *Theoretical Medicine* 8, no. 2 (1987): 179-85. Note: I did find one article that differed on whether medicine was a phronetic activity based on strict semantics. This is, however, the minority view: Duff Waring, "Why the Practice of Medicine Is Not a Phronetic Activity," *Theoretical Medicine and Bioethics* 21, no. 2 (2000): 139-51.

CHAPTER SEVEN: RESOLVING THE MORAL TENSION IN CULTURALLY COMPETENT HEALTH CARE

Do not do unto others as you would they should do unto you. Their tastes may not be the same.

—George Bernard Shaw, Man and Superman*, 'Maxims for Revolutionists': 'The golden Rule'*

Introduction

As we have seen in the previous chapter, *phronesis* is considered the defining trait of the good physician due to, among other reasons, the necessity of practical wisdom in applying general rules to the particular case. In this chapter I explore the relevance of this ability to successfully navigate the waters of crosscultural bioethics to our particular interest in crosscultural competence and practice. Crosscultural situations are especially difficult for ethics since the philosophical problem of how to justify moral claims or ethical standards is difficult in the best of circumstances and more so in a pluralistic society with diverse conceptions of the good or the right. A portion of this debate centers around two opposing positions in philosophical ethics, that is, moral relativism and moral absolutism (or universalism). In an era of increasing attention to cultural and ethnic diversity, the tensions between these two positions have escalated and are particularly significant in the field of clinical ethics and cultural competency. At the core of this debate is the question of whether reliance on universal ethical principles constitutes the best way to resolve culturally laden value disputes.

The Principles of Cultural Competency

Though these are rarely stated in the myriad cultural competency curricula and training materials, the essential principles of cultural competence are (1) acknowledgment of the importance and prevalence of culture in people's lives, (2) respect for cultural differences, and (3) minimization of the negative consequences arising from cultural differences.[198] Generally, these three principles are seen to be in line with Western notions of medical ethics—specifically, they are perceived as promoting patient autonomy and justice, two of the four principles typically touted as foundational for biomedical ethics.[199] However, some have argued that teaching physicians that they should be accommodating to patient beliefs and preferences to every extent possible, promotes an undisciplined kind of "ethical relativism" among practitioners.[200]

In this chapter, I will explore the question of whether cultural competency endorses cultural relativity, and what would be necessary in cultural competency education to avoid this while still adhering to the three previously stated normative principles. I will then show that indeed today's mainstream methods of teaching and practicing cultural competency do more to promote an ethical relativism whereas the hermeneutical, narrative, dialogical approach that I espouse is more likely to promote

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[198] Michael Paasche-Orlow, "The Ethics of Cultural Competence," *Academic Medicine* 79, no. 4 (2004): 347.

[199] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001).

[200] Paasche-Orlow: 347.

more grounded ethical reflection and thus presumably better patient satisfaction and outcomes.

To answer the question of whether contemporary mainstream models of cultural competency endorse ethical relativity, I think it would behoove us to make explicit what is seldom questioned about cultural competency: What are its ethical underpinnings? Most cultural competency materials, when explaining the purpose of crosscultural understanding, use purely utilitarian justifications. Among the most popular are that we must be responsive to cultural differences to eliminate health disparities in the population, to meet legislative or regulatory guidelines, and to decrease the likelihood of medical malpractice claims.[201]

However, admitting of no other justifications for cultural competency education than instrumental ones belies what I think is the most important reason to be a culturally competent practitioner, namely that it is what a health-care professional *ought* to be. The moral good that is intrinsic and arises from having a moral commitment to patient-centered and responsive care is, quite astonishingly, hardly ever mentioned in these materials.

The ethics of cultural competency, whether stemming from the intrinsically good manner of doctoring it cultivates, or from the moral good that stems from an ethical commitment to patient autonomy and justice, seems to be consonant with Western notions of biomedical ethics. However, being reluctant to engage questions of clinical

[201] Ibid.

ethics, most cultural competency books and courses also seem to promote a sort of ethical relativism. This relativistic tendency is attributable to the implicit and explicit messages for doctors to respect and accommodate patient preferences in the name of autonomy. This tension in mainstream cultural competency materials is palpable, but many students remain confused since the tension remains not only unresolved but inchoate.

Table 2. Typology of Western Moral Theory

Typology of Western Moral Theory			
Absolutism	Fundamentalism (Principlism)	Relativism	Postmodern Subjectivism
Moral Truth is fixed and transcends cultural differences,	There exist basic, universal principles governing conduct,	Different ethical mores and norms are applicable to different cultures,	No objective reality or principles from which to deduce Truth and right conduct exist,

Table 2 depicts a simplified view of the major types of Western moral theory. Cultural competency education and materials including texts and field guides are typically unreflective about the ethical content of understanding and decision making. Which is to say that cultural competency materials usually do not explicitly engage in ethical reflection. These materials are, however, implicitly proposing an ethical stance appropriate for practitioners in clinical contexts. In promoting an uncritical respect for the patient's culture and its normative content, cultural competency education could be described as falling mainly within the relativism strain of moral theory.

Paasche-Orlow has shown how the current way cultural competency is taught, based on the three principles of (1) acknowledgment of the importance and prevalence of

culture in people's lives, (2) respect for cultural differences, and (3) minimization of the negative consequences arising from cultural differences,[202] resembles an absolutist claim of moral truth independent of culture or, at the very least a principlist claim of basic, shared moral goods. At the same time, the organizing framework of cultural competency remains the respect and accommodation of different cultures. If trainees believe this demands a relativist tack in clinical contexts, they may feel conflicted about the ethics of their actions or abandon the effort to render culturally sensitive care at all.

"Iatro"-Cultural Competence

I believe the way to resolve this tension in cultural competency education is to correct one of the main problems of its current methodology: a methodology based on nothing other than patient centeredness that usually ignores the culture and moral agency of the caregiver. For example, many cultural competency materials describe an optimal cultural competency as when a physician achieves a detached, objective, culture-less stance from which to fully identify and empathize with the patient. This notion of divesting oneself of one's cultural horizons and preconceptions and "going native" has been thoroughly discredited in the field of cultural anthropology and yet it continues to be one of the underlying assumptions of many popular cultural competency guides. A much healthier and realistic approach to the ethics of understanding in a crosscultural context is to admit that the patient (and often is family, community, religious heritage, and loved

[202] Ibid.: 347.

ones) is in a dialectical crossroads with a health-care professional (and the practitioner's community and culture) as well as the prevailing laws, mores, norms, and guidelines of the clinical context. This realization is not to say that the patient's preferences shouldn't be given special consideration and accommodation, only that they cannot be acquiesced to without taking competing interests and moral commitments into consideration.

Striving for Consensus

One attempt to find a workable middle way was proposed by H. Tristram Engelhardt in 1982 in an article entitled "Bioethics in Pluralist Societies", in which the author reasoned that since objective right and wrong were no longer moral terms that carried much weight in our multicultural and pluralistic society, what bioethical debate should strive for is *consensus*.[203] In order to reach this agreement, it was believed that very strict and structured methods of deliberation were needed.[204] Not only must these be rational and unemotional, but, it was commonly held, so must they be *culturally homogenizing*. Commentators like Engelhardt felt that this shift toward the rationalistic was a sign of how "[s]ecular ways of understanding … [are] … shaping our lives and our culture," and that bioethics had "evolved" to a point where it could "transcend the idiosyncrasies of our culture."[205]

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[203] H. Tristram Engelhardt Jr., "Bioethics in Pluralist Societies," *Perspectives in Biology and Medicine* 26, no. 1 (1982): 64-78.

[204] Ibid.: 66.

[205] Ibid.: 68.

This widely held perception paved the way for a transcendent, universal bioethical principlism.

At the same time, at the opposite apex of the pendulum's swing, postmodernity had become equally dogmatic. Postmodern thinkers warned that we live in a reality that is nothing more than our own pliable and biased perception, and that there is no solid rock outside of the mælstrom to which we can cling to get our bearings. This nihilism, as any observer might expect, had grave results for ethics. If there is no objective reality or principles from which to deduce Truth and right conduct, then some thought that "what is right for you is right for you, and what is right for me is right for me." This subjectivism will not do in a society where there are virtually as many different conceptions of the good and right as there are people. Subjectivism justifies any conduct on the grounds that no one but the actor can judge the action—an untenable notion in the face of the myriad atrocities that confront the viewer of nightly newscasts. The subjectivism that some postmodernists advocate contains the perfect ingredients for a Hobbesian life (short, nasty, and brutish).

So a more moderate position was carved out. Ethical relativism admits of certain mores and norms that dictate morality, but these are determined by the beliefs of particular cultures and subcultures. Any moral judgment from outside of these cultures is impossible and any attempt is bound to be disrespectful of the target population's culture

and worldview. In other words, cultural ethical relativism holds that being right is nothing more than that which is approved in one's culture.[206]

To be fair, relativism *has* served to chastise the major flaws of principlism—namely, the fact that haughty judgments that another culture's morality is wrong or primitive is surely a vestige of colonialism and imperialism. It is true that crosscultural ethical judgments, when done the principlist way, should evoke suspicion that someone is imposing their way of life upon someone else. But to say that no crosscultural ethics is possible is to risk standing idly by when a case of real injustice occurs.[207] As Martha Craven Nussbaum notes in *Sex and Social Justice*, relativists bring to mind the crowd of souls that are forced to mill about the vestibule of Dante's hell. The indifferent souls wave blank banners for they were never willing to stand for something in life—so contemptible, hell itself will not have them.[208]

The Attack upon Principlism

A whole cadre of thinkers, not all relativists, have mounted attacks upon the established reign of principlism. These take as their predicate an assumption that any universalist project (of which they see principlism a part) relies on ahistorical, atemporal

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[206] Loretta M. Kopelman, "Medicine's Challenge to Relativism: The Case of Female Genital Mutilation," in *Philosophy of Medicine and Bioethics: A Twenty-Year Retrospective and Critical Appraisal*, ed. Ronald A. Carson and Chester R. Burns, Philosophy and Medicine (Boston: Kluwer, 1997), 221-37.

[207] Martha Craven Nussbaum, *Sex & Social Justice* (New York: Oxford University Press, 1999), 30.

[208] Ibid.; Dante Alighieri, *The Divine Comedy: The Inferno, Purgatorio, and Paradiso*, trans. Lawrence Grant White (New York: Pantheon Books, 1958)., Inferno, canto 3, lines 16-57.

truths or principles from which can be deduced action guidance.[209] Since different cultures see these truths differently, and relativists may see them not at all, then any normative proclamation would invariably be biased toward the culture and beliefs of the proclaimer and *a fortiori* be disrespectful and imperialistic toward the subject matter.[210]

But, while these criticisms are persuasive for the type of blind principlism they caricature, there are other probably more common forms of principlism that in fact *are* respectful of time, place, and cultural difference. This principlism admits that principles exist, but that they are *derived from* history and context rather than prescriptive of it and prior to it. Nussbaum describes this "derivative principlism" in the following way:

> For universal ideas of the human do arise within history and from human experience, and they can ground themselves in experience. Indeed, those who take all human norms to be the result of human interpretation can hardly deny that universal conceptions of the human are prominent and pervasive among such interpretations, hardly to be relegated to the dustbin of metaphysical history … As Aristotle so simply puts it, "One may observe in one's travels to distant countries the feelings of recognition and affiliation that link every human being to every other human being."[211]

Thus, the strict form of "top-down" principlism (that which holds that all ethical deliberation, even that which happens between cultures, must be based first upon moral premises called principles that can be agreed upon by every rational person) indeed suffers from an acute unawareness of the impossibility of such an enterprise without

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[209] This is my probably over-simplified definition, but I think it captures the main points of the debate.

[210] Nussbaum, 37-38.

[211] Ibid., 38. Quoting Aristotle, 331.

ethnocentrism. However, a principlism that asserts the primacy of the "narrativity" and lived experience of humanity, and that the plurality of these narratives and lived experiences shows a "network of points of affinity,"[212] opens up a crosscultural common ground of tentative certainty upon which to base moral agreement or the hope thereof.[213] But this does not mean that they are contingent on or relative to culture or history. In a sublime sense, they become ahistorical by their deep and abiding historicity. The following is an example.

Most of America was transfixed to a television screen last April bearing witness to the massacre that transpired at Virginia Tech. Late on a Monday night, I switched on CNN and, like millions of others around the globe, teared up at the sight of teenagers, parents, teachers, and clergy standing in circles holding hands, hugging each other, crying, lighting candles, and praying. Some held signs with words like "peace" and "love," others were angry and pointing fingers. These emotions, signs, and actions are universally resonant and need no translation or interpretation to be understood. They reminded me of a book I read years ago by Michael Walzer entitled *Thick and Thin: Moral Argument at Home and Abroad*. In it, he remembers a television news clip of people marching in protest through the streets of Prague. Some of these demonstrators carry signs that simply say "Truth," others that say "Justice."

> When I saw the picture, I knew immediately what the signs meant—and so did everyone else who saw the same picture. Not only that: I also recognized and

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[212] Anthony Appiah, *In My Father's House: Africa in the Philosophy of Culture* (New York: Oxford University Press, 1992), vii-viii.

[213] Gillett, 241.

> acknowledged the values that the marchers were defending—and so did (almost) everyone else. … How could I penetrate so quickly and join so unreservedly in the language game or the power play of a distant demonstration? The marchers shared a culture with which I was largely unfamiliar; they were responding to an experience I had never had. And yet, I could have walked comfortably in their midst. I could carry the same signs.[214]

The immediate understanding that virtually any viewer has when confronted with some of the basic emotions of human life is a testament to the universality of what Walzer terms *minimalist principles*, and to the common humanity from which these emanate.

Minimal and Maximal Meaning

Without knowing the particulars of this story, Walzer claims that judgments as to what the people in Prague meant in their protestations make sense upon a cursory glance. If we are confident of the myriad ways that meaning can be misconstrued in crosscultural encounters, how is it that the moral principles of the Czechs could so easily and reliably be grasped, even if in a minimal way? If it cannot be that universal principles impose their truths on every place and time, must we then accept that every culture is radically incommensurate with our own?

According to Walzer, moral terms have both minimal and maximal meanings.[215] Maximal meanings are those where the full contextuality and particularity of the case

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[214] Michael Walzer, *Thick and Thin: Moral Argument at Home and Abroad* (Notre Dame: University of Notre Dame Press, 1994), 1.

[215] Ibid., 2.

comes forth in thick description. The richness and nuance of these meanings make them extremely difficult to perceive with anything but the painstaking work of narrative, dialogue, and careful interpretation, for morality is "thick from the beginning, culturally integrated, fully resonant."[216] And even then, of course, the original intent or meaning will never be experienced or known as the subject has experienced them and known them.[217]

"Minimal meanings," on the other hand, as described by Walzer,

> are embedded in the maximal morality, expressed in the same idiom, sharing the same (historical/cultural/religious/political) orientation. … Because (most of) the rest of us have some sense of what tyranny is and why it is wrong, the words used by the demonstrators shed whatever particularist meanings they may have in the Czech language; they become widely, perhaps universally accessible. Were there no common understanding of tyranny, access would fail.[218]

Thus, these minimalist understandings of morality are the only truly universal ethical principles there are. They are not the *a priori* principles of Kantian deontology or the transcendent Platonic forms; they are the universal principles derived from collective human stories. For this reason, these minimalist principles are anything but minor. As the aggregate and sediment of millenia of human experience and wisdom, they are the

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[216] Ibid., 4.

[217] This is one reason why the relativist will simply give up on crosscultural judgment, having bought into the positivist dogma of binary opposites: We either know "Truth" with a capital "T," or we know nothing.

[218] Walzer, 2-3.

substantive marrow of ethical human life. Walzer calls it "morality close to the bone."[219] Instead of being some kind of artificial moral Esperanto that all must agree to align themselves unto, ethical principles are the strangely harmonious story of billions of people. Instead of moral dissonance, chords of fundamental agreement can be heard throughout humanity's chorus.

Principles, in this less grandiose sense, have real utility for the health-care practitioner and medical ethicist in crosscultural settings. Not as *a priori* concepts to which they must bow when confronted with a dilemma, but rather as the familiar ghosts of stories handed down through generations and as the substantive distillation from the thickness of lived experience—their compendium of practical knowledge.[220] The practical wisdom to which this gives way (Aristotle's *phronesis*) is more reliable anyway. It is more reliable because of its organic provenance—the common ground that all humans share.

In *Love's Knowledge*, Nussbaum stresses that principles may still "play an important role in practical reason without being prior to particular perceptions."[221]

> For [principles] might be used not as normative for perception, the ultimate authorities against which the correctness of particular choices is assessed, but more as summaries or rules of thumb, highly useful for a variety of purposes, but valid only to the extent to which they correctly describe good concrete judgments,

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[219] Ibid., 6.

[220] This synthetic description of ethical "principles" owes much to Aristotelian notions of rationality as described in Martha Craven Nussbaum, *Love's Knowledge: Essays on Philosophy and Literature* (New York: Oxford University Press, 1990)., and "moral minimalism" as expounded generally in Walzer.

[221] Nussbaum, *Love's Knowledge: Essays on Philosophy and Literature*, 68.

and to be assessed, ultimately, against these.[222]

The owl of Minerva, as Hegel incisively aphorized, flies only by night.[223] That is, the goddess of ethical intellect can only begin her work after there is something to work on, like a moral sense that comes from experience.[224] It is only after we know what it is like to be human, that we know enough to start ethical reflection. And it is only after we have made efforts to engage another in dialogue that we can take humble and tentative steps toward making ethical judgments on how different cultures live. This should not feel like a restrictive situation for crosscultural understanding and bioethics. It is rather the nature of the case and one that is openly inviting.

Narrative Knowing as Ethical and Cultural Competency

The particularity of human experience makes narrative knowledge and practice an ideal way of knowing in medicine. Hilde Lindemann Nelson in her book *Stories and Their Limits* sees narrative approaches to health care based on two interrelated propositions:

> The first is that moral principles are not lawlike, universal, and unyielding, but modifiable in the light of the particulars of a given experience or situation. The

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[222] Ibid.

[223] Georg Wilhelm Friedrich Hegel, *Elements of the Philosophy of Right*, ed. Allen W. Wood and Hugh Barr Nisbet, Cambridge Texts in the History of Political Thought (New York: Cambridge University Press, 1991), i-iii.

[224] George Watson, "Socrates' Mistake," *American Scholar* 74, no. 2 (2005): 87.

> second is that these particulars either naturally take a narrative form or must be given a narrative structure if they are to have moral meaning.[225]

Thus, *narrative competence*, for Rita Charon, is "those modes of thought and action with which humans comprehend and respond to particularized human events to endow them with meaning."[226] Charon shows how narrative competence contributes to the trustworthiness of cultural competency and medical ethics by attending to the particulars and the context of each case, thereby yielding "the coherence, the resonance, and the singular meaning of particular human events."[227]

Anne Hudson Jones sees narrative approaches to health care as contributing something even more important for ethical deliberation—a developing of the capacity for empathy.[228] Since medical knowledge and practice is inherently narrative in its structure, Jones argues that this "bottom-up" way of ethical reflection might prove to be the bridge between the particularities of the individual case and general rules and principles.[229] If she is right, then at the end of the day, the best thing that a narrative approach to crosscultural health care might offer is to integrate and harmonize the moral space between universals and particulars—a golden mean between relativism and absolutism.

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[225] Hilde Lindemann Nelson, *Stories and Their Limits: Narrative Approaches to Bioethics*, *Reflective Bioethics* (New York: Routledge, 1997), ix.

[226] Rita Charon, "Narrative Contributions to Medical Ethics," 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), 260.

[227] Ibid., 261.

[228] Anne Hudson Jones, "Literature and Medicine: Narrative Ethics," *Lancet* 349, no. 9060 (1997): 1243.

[229] Ibid.

Viewed in this way, narrative ethics is a necessary but not a sufficient ethical theory. Yet it does not merely serve as a handmaiden to analytical ethics as some have proposed. Rather, the principles of ethical theory are and should be *derived from* a fuller, thicker, narrative-based ethics. Principles should be the reliable servants of storied ways of being.

Therefore, we cannot be content to splash about in the minimalist, shallow end of the pool. Sooner rather than later we must risk the deep end, knowing that we are giving up our foothold. And yet while we may be awash, we are not adrift. Human experience, even that across cultures, has a buoyancy of its own. We can be borne aloft on the stories of strangers because once we take a plunge beneath the surface of their experience, we find that our stories and theirs are all made of the same stuff. Their ripples and waves will be different, but not so different that we will not recognize the pain, suffering, elation, pride, happiness, worry, anger, and contentment that form the core of our own stories. It seems to me that principles are helpful in teaching others to swim toward the deep end of the pool, and also as a helpful orientation that helps define the space of moral reflection, but they cannot be the only place into which we dip our toes.

Diving Into The Deep End: A Case of Female Genital Mutilation (FGM)

It is a fair question to ask how, exactly, might a narrative-mediated, principle-using, crossculturally competent bioethic work in a real-life dilemma? In some parts of the world today, girls are ritually "circumcised." Without going into the graphic details of this practice, I will say that clitorectomy is extremely painful, dangerous, disfiguring,

inhibiting (or obliterating) of later sexual functioning, and can pose serious health risks immediately and later on in life. On the other hand, defenders will claim that it is purifying, community-building, God-pleasing, and gives women the opportunity for advancement by increasing their marriageability and chastity.[230]

It will be necessary to listen attentively to the stories told by the participants of this admittedly alien ritual, and in this case, it will be necessary to listen very carefully. Even if this practice did not sound barbaric to our Western ears, we would still be obliged to scrutinize this particular case strongly because as many commentators note, there is evidence of protesting minorities from within the target culture that are being silenced by those in power who might stand to gain from the dominant discourse.[231] It is these silenced voices for which we must listen the closest, and it is the people who stand to gain from this practice the most that we must scrutinize. Does this patriarchal society subject women to this practice in order to achieve legitimate ends? Or is it more accurate to say that women freely choose this way of life for their own and their society's benefit? Surely community cohesion is a legitimate end, but does FGM achieve this end? Are there less harmful ways to achieve this end? If we listen to the stories of many of those involved we find that women are beginning to rebel against this practice, and many of

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[230] For "thick descriptions" of FGM from both sides of the fence, see generally and variously Nussbaum, *Sex & Social Justice*., Anika Rahman and others, *Female Genital Mutilation: A Guide to Laws and Policies Worldwide* (New York: Zed Books, 2000); Schwartz: 431-41; Nahid Toubia and Susan Izett, *Female Genital Mutilation: An Overview* (Geneva: World Health Organization, 1998); and Alice Walker and Pratibha Parmar, *Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women* (San Diego, CA: Harcourt Brace, 1996).

[231] Nussbaum, *Sex & Social Justice*., and Gillett, 241.

those who will not yet openly oppose it admit that they would forgo the ritual if the ends could be achieved through different means.[232]

Along with our careful attention to the stories of the people affected, there should be a reciprocal story emerging from us. We should tell stories of the courageous women and men who fought for the equality of women while still honoring the singular roles women have played in our society. We should relate how America once actively participated in the subjugation of women but has grown into a healthier society without it (though we struggle with its vestiges still). The narratives will begin to give us a fairer understanding of each other—which should lead us to see fertile patches of common ground from which to mount either a critique or an agreement. Grant Gillett envisions these universal minimalist meanings as made up of the basics of human life:

> Consider, for instance, the person who falls and hurts her arm—our instant response is to soothe, to try to offer some balm or comfort. This works because her plight is so universal to the experience of being human that in the typical case we are not in doubt about what she needs. It is plausible that if we examine some of the things that are basic to human life—the actual experiences of nurturing, being welcomed, having one's hurts tended, having one's greeting snubbed, pain, loneliness, and so on—we can erect a common ground in lived experience for some of our moral intuitions.[233]

The experiences that are central or fundamental to being human are the ones that will resonate with everyone. And it is because of these that we can imagine a society where young girls are held down by five older women and submitted to a mutilation that

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[232] See, Walker and Parmar, and Nussbaum, *Sex & Social Justice*.

[233] Gillett, 241.

in addition to maiming them sexually, will achieve nothing that a change in social institutions will not accomplish even better. For instance, embarking on the long journey toward a women's liberation movement not unlike the one(s) that have been successful to varying degrees in virtually all Western societies. And thus not only are we able to protest the practice of female genital mutilation wherever it rears its ugly head, but we must do so lest we become the blank banner bearers forever damned to hell but denied entry therein.

CHAPTER EIGHT: THE CULTURALLY COMPETENT PHYSICIAN AS TRAVEL GUIDE

Long is the way, and hard, / that out of hell leads up to light.

—*John Milton,* Paradise Lost

Introduction

Though we have seen what a cultural competency educational program should not be, we now turn to the question of what *would* be an ideal approach to teaching and doing cultural competency in medical settings that would offer hopes for understanding?

Susan Sontag begins her book titled *Illness as Metaphor* with the oft-quoted description of illness as "emigrat[ion] to the kingdom of the ill."[234] Illness does seem to readily evoke the image of some foreign hinterland. Its topography and the length of the sojourner's stay are unknown, making sickness an isolative trek, to say nothing of the pain, both physical and emotional, that is the kingdom's currency. Recall that Arthur Frank likens serious illness to a "loss of the 'destination and map' that had previously guided the ill person's life."[235] Similarly, Oliver Sacks writes in *Awakenings* that in order to "reach out into the realm" inhabited by patients, the physician must become "a fellow traveler, a fellow explorer, continually moving *with* his patients, discovering with them."[236] Sacks sees himself as an explorer of "the furthest Arctics and Tropics of

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[234] Susan Sontag, *Illness as Metaphor* (New York: Vintage, 1978), 3.

[235] Frank, *The Wounded Storyteller*, 1. Quoting personal correspondence from Judith Zaruches.

[236] Sacks, *Awakenings*, 225-26.

neurological disorder."[237] Indeed, Anne Hunsaker Hawkins reports that the metaphor of disease as another world appears again and again in illness narratives, serving as a trope by which fellow sufferers can organize their own pathographies.[238]

Sontag's "kingdom of the ill" metaphor, along with Sacks' "fellow traveler" allegory can be likened to many epic myths involving the common motifs of "journey" and "sage guide," but none may be so complementary and fruitful for our discussion as that of the medieval poet Dante Alighieri's *La Divina Commedia*. In the opening scene, Dante finds himself lost midway through life in a strange land.[239] Soon he realizes that he is expected to traverse hell and purgatory if he is to ascend into paradise and be reunited with his lost love and redemptrix Beatrice. But how can Dante cross the kingdom of the damned with any real hope of success? His only lodestone, Beatrice, is too far removed from the depths in which Dante now finds himself to be of any guidance; so she sends an emissary—the wise and benevolent poet Virgil—to be Dante's guide along the treacherous way. With Virgil's help, guidance, comfort, advice, and expert opinion, Dante successfully navigates the long and hard way "that out of hell leads up to light."[240]

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[237] Sacks, *A Leg to Stand On*, 110.

[238] Anne Hunsaker Hawkins, "Oliver Sacks's Awakenings: Reshaping Clinical Discourse," *Configurations* 1, no. 2 (1993): 232. For a thorough discussion of the concept of "organizing myth" and the journey metaphor, see Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography*, 2nd ed. (West Lafayette, IN: Purdue University Press, 1999).

[239] Dante Alighieri, *The Divine Comedy* (New York: Alfred A. Knopf, 1995).

[240] John Milton, *Paradise Lost*, trans. Robert A. Shepherd (New York: Seabury Press, 1983), 24.

"My ideal doctor," intimates Broyard, "would be my Virgil, leading me through my purgatory or inferno, pointing out the sights as we go."[241] Given the depths of despair that often accompany serious illnesses, it is no wonder that Broyard sees the epitome of the caring physician as a Virgilian guide. The implication is that the physician will have to invade the province in which the patient now finds herself, for only by "entering in" can one hope to comfort or "bring out." But modern medicine, with its organizing trope of disease-centered care has proven antithetical to the Virgilian pursuit.

Physician Narrative as Travelogue

The Purpose of Physician Narrative

Physician's stories of their patient's illnesses have always been an essential part of medical care in the Western tradition. Starting with the shamanistic practice of imparting knowledge of therapeutic modalities to descendent generations, narrative of illness, disease, and treatment has been the method of choice for perpetuating medical knowledge. Today, physician narratives of illness mainly take the form of "case histories"—documents whose main purpose is to aid in deciphering the patient's malady and gauge the effectiveness of the selected mode of treatment. Theoretically, the physician who writes a patient history then depends on her generalized knowledge of countless other case histories to reason by analogy and thereby shed insight into what treatment might help the patient in question. Because of the improbability of

[241] Broyard, "Doctor Talk to Me," 36.

remembering the many thousands of patient narratives that would be necessary to form a serviceable compendium of practical knowledge for the physician, it soon became standard pedagogical practice to synthesize large numbers of these case histories into typical but anonymous cases.

Arthur W. Frank, in his book *The Wounded Storyteller*, claims that this dehumanizing of the illness story became perceived as necessary because of the ascendancy of modern medicine which displaced the premodern popular experience of disease with "technical expertise, including complex organizations of treatment."[242] Clearly this reduction from the individual to the general in medicine as in all sciences allowed for real advances and discoveries, especially in the realm of public health where the prevention of disease and the care of large populations is the focus. At the same time that this technological progress was taking place however, the exile of the clinical story to hospital water-cooler gossip was marginalizing the intuition and care ethos at which the profession had once excelled.[243]

Oliver Sacks calls these knowledge gaps in medicine's care ethic "scotomas," the scientific term for blind spots.[244] To illustrate how some physicians have recognized the profession's disability and what some have prescribed as a cure, I will follow three physician-guides (Sigmund Freud, Aleksandr Luria, and Oliver Sacks) through their

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[242] Frank, *The Wounded Storyteller*, 5.

[243] For a discussion on this Kuhnian paradigm shift in medicine, see Ibid., ch. 1.

[244] Steve Silberman, *The Fully Immersive Mind of Oliver Sacks* [Website] (Wired Magazine Online, 2002, accessed March 8, 2003); available from http://www.wired.com/wired/archive/10.04/sacks_pr.html.

travelogues. All three made pointed efforts to regain the sight their profession had lost.

Perhaps their narratives can shed light on what it might mean to be a culturally competent health care practitioner.

Freud as Pioneer and Detective

The Purpose of Freud's Narrative Form

Sigmund Freud (1856-1939) blazed a trail through the kingdom of the ill. By the turn of the twentieth century, Freud was an established and respected neurologist who had begun to make extended forays into the mind of the patient. Freud's shift in emphasis from the physiological to the psychological underpinnings of illness were indicative of a more fundamental paradigm shift in Freud's conception of patient care.

Neurology was too concerned with the nomothetic for Freud. He saw in classical medicine the relegation of the idiographic to secondary status if not superfluous altogether. Freud saw evidence of this in the sterile case histories of his time, and in *Dora: An Analysis of a Case of Hysteria* he gave us an exemplar of a new genre, or rather, a revivification of a lost one: patient-centered narrative; the reemphasis of *illness* above *disease*.

Freud's Effectiveness as Pathographer

Freud was a relentless detective. Like Sherlock Holmes, Freud left no stone unturned, no patient word choice unscrutinized, no omission unprobed. In this, Freud

shows his own fallibility as guide through the kingdom of the ill. The fact that in *Dora*, the patient's voice is seldom heard unfiltered through Freud's heavy handed analysis makes one wonder whether Freud is guiding his patient as Virgil did or leading her as a captain would. Freud's thick and "tessellated"[245] description of Dora's hysteria is at once edifying the temple of the patient, but at the same time obscuring Dora within.

Freud's hubris seems characteristic of a pioneer in uncharted territory. Not unlike fame-seeking explorers risking life and limb to reach the unknown, Freud attempts to get to the bottom of Dora's hysteria—damn the costs—even if the toll is Dora's voice in the dialogue.

This is not to say that Freud's construction of Dora's illness isn't beautiful in its artistry, revelatory in its interconnectedness, and possibly even therapeutic. Freud's genius is in making his analyses ring true (and therefore offer therapeutic benefit) for the patient even when they may be more artifacts of Freud's neuroses than the patient's.

And yet as extraordinary and revolutionary as Freud's psychoanalysis of Dora may be, he does not provide Dora with the mythical Virgil to guide her through her illness. In fact, Freud takes the opposite tack in approaching patient care. Freud becomes an aggressor, an antagonist force fighting against the patient along her journey. For Freud, the patient must either relinquish the reigns of her vessel to allow for the heroic pioneer to lead her out of the abyss, or she must falter on her own. Freud lacks compassion.

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[245] Sigmund Freud, *Dora: An Analysis of a Case of Hysteria*, ed. Philip Rieff, 10 vols., The Collected Papers of Sigmund Freud (New York: Collier Books, 1963), xiii.

Philip Rieff, in his gushing introduction to *Dora,* concedes the antagonistic approach used by Freud.

> There is … a hint of intellectual combat in this case history. When the modern detective of the soul meets his client, he must, like Sherlock Holmes, immediately exercise his mind. "Now," says Freud to the girl, almost in the words Holmes often used in first reconnoitering a case, "I should like you to pay close attention to the exact words you used." The battle of wits then begins: Freud matched against every unconscious device that this intelligent young girl can muster.[246]

Using antagonism to get Dora to confront her repressed desires and feelings is something that Freud does well, but this overt paternalism cannot be confused with the type of respectful aid Virgil afforded Dante on their trek through *Inferno*, *Purgatorio*, and *Paradiso*. Though Virgil is heaven-sent to be a guide for him, the ultimate responsibility for salvation remains on Dante. Virgil proves an indispensable companion and sage, but he guides only through suggestion and appeal. Virgil never commandeers Dante's vessel or fights the sojourner for his own good.

As revolutionary as Freud's accounts of patients are, the main character in these is always Freud himself. And while his pathographies attempt to recenter the patient in narrative, they seem to me never to attempt to be sympathetic or empathic to the patients experience of illness. Freud's hegemony smudges the lens through which he sees Dora.

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[246] Ibid.

Luria as Observer

The Purpose of Luria's Narrative Form

Aleksandr Luria (1902-1977), a Russian neuropsychologist, was also disenchanted with what he termed "classical science" being used as the norm in therapeutic encounters. He believed that the medical treatment of disease was not amenable to the reductionist tendencies of the empirical sciences. Luria believed that only through a social view of the disease, or, in other words, the disease *as experienced* by the patient, could a physician truly inhabit the kingdom of the ill in order to best prove of any help

Illustration 2. "Luria with his patient Zasetsky (1950's)."

From University of California San Diego Luria archive. Luria is on the right. Used with permission.

to those in residence there. While Luria credits both his teacher Vygotsky and Freud with much of the idiographic tenor of his method,[247] Luria's approach is fresh, respectful, empathic, and unencumbered by anything like Freud's heavy hand.

In *The Man with a Shattered World*, Luria allows the patient to testify of his afflictions in an intensely personal and cathartic manner.[248] In this narrative, Luria treats a pseudonymous Zasetsky after he suffered a near-fatal gunshot wound to his parieto-occipital region of his brain. After a protracted coma, Zasetsky awoke to find that aside from losing his ability to read, write, and speak, he could now perceive only the left side of objects. This curious disability proved frightening to him, especially since he was unable to see even the right side of his own body. The disability left the young man terrified of having awoken in this quite alien place. But through long rehabilitation and therapy, and with Luria's guidance, Zasetsky was able to cobble an arresting narrative of his trip through the illness—no small task given his near total disconnection with all of the effective modes of communication.

There is no trace of contrivance or transference of a physician's agenda upon the patient in Luria's book. In fact he makes it quite clear that it is the patient, Zasetsky, who is the real author of this narrative.[249] Luria says this even though he must have spent countless hours shaping Zasetsky's three thousand pages of what must surely have been a

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[247] Aleksandr R. Luria, *The Man with a Shattered World: The History of a Brain Wound*, trans. Lynn Solotaroff (Cambridge, MA: Harvard University Press, 1987), viii.

[248] Ibid.

[249] "It is not false modesty on my part to wish no credit for this book. The real author is its hero." (Luria, xix). Accordingly, one of the forewords to *The Man with a Shattered World* entitled "From the Author" (xxi) is written not by Luria whose name appears on the book's byline, but by Zasetsky himself.

disjointed, rambling, and incurably interrupted text, into an illuminating window into neurological sickness. Of course, because of the fragmentary nature of Zasetsky's mind, the narrative itself exhibits fragmentation, repetition, and a certain "shatteredness." These are by no means impediments to the book's clarity and effectiveness—for through the shattered window that is Zasetsky's narrative, the reader gains a much truer perception of the illness as it must be experienced by Zasetsky.

Thus, we see that Luria's purpose as pathographer is mainly as observer and chronicler. Where *Dora* is Freudian manifesto, *The Man with a Shattered World* is travelogue. The quality of the narrative, which one might describe as reportage, could be due to the incurability of Zasetsky's illness, for unlike Freud, Luria is not attempting to cure his patient, but care for him. One gets the impression that Luria is never as concerned with cure as with empathic care and understanding. In correspondence with a young Oliver Sacks, Luria confesses that his writing can be compared to "unimagined portraits."[250] Working in the literary medium, Luria is the twentieth century's medical portraitist *par excellence*.

Luria's Effectiveness as Pathographer

While Freud's ultimate goal may have been more hegemonic than his patient-centered narratives ostensibly were, Luria's narrative is anything but. Luria never assumes Freud's mantle of swashbuckling detective hero. He conveys his humble

[250] Luria, xiii.

observations to the reader and elucidates points that he thinks need to be clarified but generally maintains a certain distance from his patient. And although Luria has indeed facilitated Zasetsky's rehabilitation (by teaching, for example, Zasetsky to write again by using the "kinetic melodies"[251] that his brain has forgotten but his muscles remember), at times it seems that Zasetsky has been left largely to fend on his own in the kingdom of the ill. This narrative abandonment seems strange for a writer as seemingly empathic as Luria. Considering the thirty-year relationship he has with Zasetsky, and the Herculean effort it must have required to edit Zasetsky's stream-of-thought journal, Luria seems oddly divested in Zasetsky's journey. While Freud's pathography is opaque with the physician's voice, Luria's is, by contrast, too "transparent." Luria maintains a properly scientific and detached tone as he describes the utter devastation of Zasetsky's world. Would a physician-guide through this world seem so aloof and uninvested? Luria describes with great precision what Zasetsky must be experiencing, but he is less than faithful at showing us what Zasetsky is *feeling*. The passages that do accomplish this are invariably written by Zasetsky himself. Perhaps Luria felt incompetent or presumptuous to describe what Zasetsky was already describing, but by not attempting to completely immerse the reader into the story of Zasetsky's sickness, Luria leaves us with the unsatisfying feeling that we are merely being shown a simulacrum of the real Zasetsky. Perhaps the portrait of Zasetsky is *realistic*, but it does not seem *real*—more a mugshot than a candid.

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[251] Ibid., 72.

For example, shortly after his return to live at the family farm, Zasetsky is asked to repair a barn door. He unsurprisingly encounters much difficulty in the task and eventually injures himself. "At that point," Zasetsky writes, "my mother got angry with me, took the hammer, and fixed the door herself."[252] Similarly, ugly incidents with a callous oculist[253] and indecipherable stove assembly instructions[254] are told in an oddly stoic manner. By intricately describing Zasetsky's disability but not fully engaging his psyche, Luria leaves the reader with a clinically sterile picture that while immeasurably better than medical histories as they are done nowadays, remains less than lifelike. Luria is hitting all of the right notes, but his playing is curiously soulless.

Sacks as Virgilian Guide

The Purpose of Sacks's Narrative Form

After Anatole Broyard quipped that his "ideal doctor" would be his "Virgil," leading him through his purgatory or inferno, Broyard went on to say that his ideal doctor "would resemble Oliver Sacks, the neurologist who wrote *Awakenings* and *The Man Who Mistook His Wife for a Hat*."[255]

> I can imagine Dr. Sacks *entering* my condition, looking around at it from the inside like a benevolent landlord with a tenant, trying to see how he could make the premises more livable for me. He would see the genius of my illness. He

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[252] Ibid., 50.

[253] Ibid., 54-55.

[254] Ibid., 60.

[255] Broyard, "Doctor Talk to Me," 36.

would mingle his dæmon with mine: we would wrestle with my fate together.[256]

Considering what Hawkins, Frank, and Sontag have explained of its prevalence, it is not surprising that Broyard chose the metaphor of a journey through hell from *The Divine Comedy* to express how he perceived illness; and it should be even less surprising that Broyard chose Sacks to play the part of his Virgilian guide. For among the three great twentieth-century physicians discussed in this chapter, Sacks best embodies the qualities of empathic yet knowledgeable guide for whom Dante's Virgil is a symbol. Sacks models the kind of narratively competent, dialogical hermeneutics necessary for truly culturally competent care. This discursive method Sacks calls "trajective":

> [The doctor] must feel (or imagine) how his patient is feeling, without ever losing the sense of himself; he must inhabit, simultaneously, two frames of reference, and make it possible for the patient to do likewise.[257]

Here Sacks confesses that he is greatly influenced by both Freud, and more directly, Luria.

Luria appreciates the academic rigor of the classical approach to science, but not if it is achieved at the exclusion of the romantic approach.[258] These two methodologies roughly correspond to the nomothetic and the idiographic approaches to science—

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[256] Ibid.

[257] Sacks, *Awakenings*, 226. Emphases in the original

[258] Hawkins, "Reshaping Clinical Discourse," 230-31. Summarizing Aleksandr R. Luria, *The Making of Mind: A Personal Account of Soviet Psychology*, ed. Michael Cole and Sheila Cole (Cambridge, MA: Harvard University Press, 1979). For additional discussions on the synthesis of the nomothetic and idiographic in neurological pathographies, see Debra Journet, "Forms of Discourse and the Sciences of the Mind: Luria, Sacks, and the Role of Narrative in Neurological Case Histories," *Written Communications* 7,

reducing persons to disease in the former, and vaulting the patient as the "experiencer" of illness in the latter. The biographical style of *Awakenings* had in fact caught the eye of Luria as something that truly resonated with his own style of narrative. In a letter to Sacks after the 1972 publication of *Awakenings*, Luria both bemoans the loss of the art practiced by the nineteenth-century romantic scientists, and heralds the arrival of a bright new star in Oliver Sacks.[259]

But Sacks is doing more than "dusting off" the lost descriptive style that Freud and Luria had begun to unearth—a tradition Sacks calls Romantic to contrast with science's classical rationality—Sacks is "immersing" himself in the "world of the patient," he is assuming the mantle of the Virgilian guide. Not surprisingly, Sacks himself comments on Dante's odyssey in *A Leg to Stand On*. In this book, Sacks becomes the patient and is forced to undergo what he describes as a journey through hell, purgatory and heaven (under circumstances eerily reminiscent of Dante's in his *The Divine Comedy*), but without a Virgilian guide of his own.[260] Thus, he knows all too well the importance of a doctor willing to immerse himself in the patient's world.

Sacks's Effectiveness as Pathographer

Sacks's immersion in the patient's world, can best be seen through the trajective

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no. 2 (1990): 171-99; And Anne Hunsaker Hawkins, "A. R. Luria and the Art of Clinical Biography," *Literature and Medicine* 5 (1986): 1-15.

[259] Sacks, *Awakenings*, xxxv. Discussing Luria's letter of July 25, 1973.

[260] Sacks, *A Leg to Stand On*, 107.

discourse's "thick description" which Geertz sees as seeking to "grasp and render … a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another."[261] But Sacks's thick description is not as fantastical as Freud's or as sterile as Luria's. Sacks's rich and vibrant use of metaphor and literary allusion draws the reader into the kingdom of the ill as experienced (we imagine) by the patient.

In *Dora*, we are drawn into *Freud's* mind. In *The Man with a Shattered World*, we find ourselves compelled, but not fully immersed; Zasetsky's emotive mind is relatively inaccessible to us. In *Awakenings* on the other hand, Sacks' post-encephalitic patients' minds are so vividly described as to help us imagine the unimaginable.

Perhaps the chronological and incremental gains seen since Freudian narrative will continue unabated. Perhaps the tradition of Freud, Luria, and Sacks represents only the beginning of fundamental and refreshing paradigm shifts whose culminations are yet to come. Freud's genius, though perhaps equal to his hubris, has ushered in a new view of the mind as being ontologically different from the brain, effectively opening the door to the kingdom of the ill. Luria's recentering of the patient in physician narrative has gone a long way toward the rehumanization of medicine, while Sacks's empathic care and literary skills come the closest we've seen to the Virgilian aspirational goal.

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[261] Geertz, 10.

CHAPTER NINE: THE PROPOSED APPROACH

The Perfect interlocutor, the friend, is he not the one who constructs around you the greatest possible resonance? Cannot friendship be defined as a space with sonority?
—*Roland Barthes,* A Lover's Discourse*, 'mutisme/silence'*

A faithful friend is the medicine of life.
—The Bible, Apocrypha*,* Ecclesiasticus 6:16

Interpretive, Narrative Competence: A Route to Someplace in Between

On the crosscultural road to understanding and ethical decision-making between patient and health care giver are many epistemological obstacles. In order to navigate this treacherous road with a minimum of harm to both parties, health care professionals and their cultural brokers or interpreters should be able to facilitate the dialogue with an eye toward a syncretic agreement—not merely a compromise of two conflicting viewpoints into one that bears little resemblance to either (such as Englehardt's consensus), but an agreement where both viewpoints are dynamically altered toward a third more harmonious understanding of the two original positions. Ronald Carson, in an entry for the *Encyclopedia of Bioethics*, sees this as being possible by "approach[ing the lived experience of illness] in this way, as a text requiring reading—ideally, by a patient and a caregiver comparing notes."[262] Thus defined, true understanding becomes a collaborative convergence—not a discovery of 'the matter' but a co-constructed narrative

[262] Carson, 1287.

that makes sense for both interlocutors. "Thus construed," Carson goes on to say, "the patient-caregiver relationship is collaborative, and the work of healing commences not when the caregiver makes the diagnosis but when text and readers converge in a common narrative."[263]

But how exactly can two (or more) irreducibly different interlocutors converge in this way? The failure even to address this question is, I think, one of cultural competency's major flaws. What is needed (and usually overlooked in cultural competency education) to achieve a syncretic agreement is an awareness of what is known as the "hermeneutic circle." Carson defines this as

> [c]onsisting of an oscillating movement—conjecturing…, then comparing this conjecture with similar previous experiences, conjecturing, comparing, and so on—talking with the text of experience until an understanding is reached. "The hermeneutical principle…is that just as the whole is understood from its parts, so the parts can be understood only from the whole."[264]

Notice that this conception of the hermeneutic circle depends upon analogical abstraction ("comparing … with similar previous experiences")—a diagnostic maxim well known to medical practitioners. This analogical abstraction is constantly being tested and compared to our perception of *this particular patient*. This is how understanding in the crosscultural clinical encounter should be arrived at. Not by some hyperrational stratagem that reduces particular cases to instantiations of paradigm cases in cultural competency guidebooks, but by the analogical reason and emotion of an interlocutor

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[263] Ibid.

[264] Ibid., 1284. Quoting Schleiermacher, 75.

awash in the narratives of the case. In the former, the clinician is only ever engaging the already-settled paradigm case. She is forever clipping the protruding borders and smoothing out the rough edges, never engaging the particularities at hand.

While abstraction is an essential tool for time-pressed diagnosticians, it is always dangerous to reduce a patient's individual beliefs and/or attitudes to a straw-person of the culture we putatively believe him to be a member of. Oliver Sacks bemoans this reductionism prevalent in biomedicine. "Our health, diseases, and reactions cannot be understood *in vitro*, in themselves; they can only be understood with reference to *us*, as expressions of our nature, our living, our being-here (*da-sein*) in the world."[265] Clifford Geertz says that understanding of another's culture should "expose their normalness without reducing their particularity."[266] All-too-often we stereotype the other as approaching what we have been told or what our finite experience tells us is his culture's paradigmatic specimen, thus forming a convenient reduction for scientific treatment while ignoring the person. This is the cultural equivalence to the objectification for which modern medicine has become notorious. This lamentable trend of modern medicine supplants the once-central subject of medical practice and narrative (the patient) with the object of her symptomata, malaise, diagnosis, prognosis, or diseased organ. So while it may be helpful to approach patients with a few abstractions to guide our

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[265] Sacks, *Awakenings*, 228.

[266] Geertz, 14.

conversation, these preconceptions must always remain pliable, provisional, and amenable to change.[267]

And so it is that the interpretive oscillation that occurs in the hermeneutic circle, demanding, as it were, a tentativeness in our judgments until the back-and-forth solidifies or repudiates our prejudices, proves a befitting corrective to the modern trend of abstraction. An illuminating example of this as it happens in the health care setting is given by Carson:

> [I]n the therapeutic encounter the caregiver turns a trained ear to a particular patient's account of misfortune or malaise, places it in the company of similar accounts he or she has heard before, and then attends not only to what is said but also to what is unspoken and to what is unspeakable, all the while conversing with the patient to test the fit of the patient's experience with similar experiences. This requires a capacity to imagine illness or injury from the patient's perspective and an awareness of the impossibility of identifying with the patient's experience: a kind of listening with the third ear—an awareness of setting and significance and an alertness to narrative possibility.[268]

This "listening with the third ear" leads, in the best of circumstances, to understanding and thereby the possibility of healing. For while cures and remedies may come cheaper, understanding is the threshold of healing. Of course, as evidenced by Anne Fadiman's *The Spirit Catches You and You Fall Down*, sometimes reality is not so tidy.

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[267] For further discussion on his concept of "the spirit of abstraction" and its concomitant dangers, see Gabriel Marcel, *Man against Mass Society* (Lanham, MD: University Press of America, 1985).

[268] Carson, 1285.

Talking Past Each Other

In Fadiman's insightful investigation of "the collision of two cultures,"[269] Lia—a Hmong child suffering from epilepsy, her parents, and her American doctors all struggle to come to terms alternately with an illness, with foreign cultures, and with each other. But the Hmong, despite having a sizeable presence in Merced County, California, where the story takes place, remain utterly alien to the Western doctors, and seemingly unamenable to Western medical techniques. The Hmong are also ill-prepared to make sense of the strangeness of their new habitat, and reluctant to acquiesce to the hegemony that is modern, Western biomedicine. The result is that the misunderstandings that occur on the borders between the doctors and the parents compromise the quality of health care of which Lia is the unfortunate recipient.[270] She falls through the faultlines of cultural clashes and seems to be more a victim of the failure of communication between two cultures than of the neurological disease. Despite the efforts of well-meaning medical caregivers, it proved difficult to 'expose Lia's normalness without reducing her particularity.'[271]

It took a discerning journalist approaching the quarrel as an interloping ethnographic mediator to shed light on both sides of the conversation. Anne Fadiman,

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[269] Anne Fadiman, *The Spirit Catches You and You Fall Down* (New York: Farrar, Straus, and Giroux, 1997), Jacket front.

[270] Admittedly and reflexively, I gauge the "quality" of Lia's healthcare from my own inescapable situatedness within a thoroughly Westernized perspective as can be attested by my readiness to accept the American doctor's diagnosis of epilepsy instead of the mystical Hmong diagnosis of *Dab Nyeg* or evil spirits. Differing opinions exist that should be given charitable consideration.

[271] Geertz, 14.

through the ability to engage the Other in conversation, plumbs the murky depths of the culture clashes, helping to create an empathic narrative.[272] It is quite a feat to be able to make clear the irreducibly complex structures of meaning using modes of interpretation that are reciprocally complex. It is the mark of an ideal interpreter to have the capacity for introspection, and sagacity for narrative surrender, which enables an empathic relationship with the Other; thus rendering simultaneously an illuminated and illuminating translation.

For this, the interlocutors in health care settings must develop a dialogical community with patients in which understanding (syncretic agreement) is the goal, receptivity the catalyst and discernment the modality.

Transformative Engagement

In the film adaptation of revolutionary Ernesto "Che" Guevara's travelogue *The Motorcycle Diaries*,[273] Ernesto and his travel companion Alberto Granado, take a once-in-a-lifetime trek around the South America they have only read about in books. Both affluent young men from Buenos Aires, they want to "sow their wild oats" before settling

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[272] There are those, however, who take Fadiman to task for what they perceive to be over-generalizations and stereotyping of the Hmong culture in Merced County. To be sure, the story does focus it's attention primarily on a particular family and the travails of similarly-situated families in California, but her book includes plenty of instances of Hmong with varied levels of English proficiency, health literacy, education, socioeconomic level, and degree of "assimilation" into the mainstream Californian culture. For an interesting critique of Fadiman's book, see Janelle S. Taylor, "The Story Catches You and You Fall Down: Tragedy, Ethnography, And "Cultural Competence"," *Medical Anthropology Quarterly* 17, no. 2 (2003).

[273] Ernesto "Che" Guevara, *The Motorcycle Diaries: Notes on a Latin American Journey* (New York, NY: Ocean Press, 2004).

down to live the upper-middle class lives they always knew they would live. But something transformative happens on their 8,000 mile journey. These doctors-in-training encounter the people of South America.

They were unprepared to be so transformed by the people they encountered on their trip. They met the poor and the disenfranchised. They met proud indigenous peoples whose ancestors had once created the most spectacular cities and civilizations in the world—but were now forced to work dangerous and humiliating jobs for the pittance that the American-owned companies felt was commensurate with their station in life. The young *motociclistas* were changed forever by their encounters along the way, though one scene in particular symbolizes this more than the others.

Ernesto and Alberto take summer positions as interns in a leper colony on the shores of the Amazon river. On the right bank are the clean white buildings of the doctor's living quarters, offices, and the rectory of the nuns that run the colony. On the left bank are the shacks of the lepers. The doctors and nurses make their daily trip to the leper side and return home in the evening. Ernesto hates this artificial separation that has no clinical relevance. The lepers "are not contagious or unclean," he tells the nuns who make him wear gloves and attend mass. But this is the way that the colony has been run for decades, and this is what is best for the patients.

Toward the end of the young interns' stay in the colony, the doctors and nuns throw Ernesto and Alberto a night-time farewell party on Ernesto's birthday (on the "clean" side of the river). Che, deciding that he'd rather celebrate his birthday on the other side of the river, slips into the piranha-infested water to swim across. The Amazon

is dark and wide. A small light can be seen in the blackness—his only guide to the village. He will swim to them tonight and enjoy their company on his birthday.

Interestingly, throughout what seems an interminable swim, the film is noticeably quiet. No music can be heard playing—only the slapping of water, the asthmatic wheezes of Ernesto, and the receding shouts of the doctors imploring him to turn back. How could he do something so stupid!? No one has ever swum across the river; and to attempt it at night is suicide.

After a few minutes, the lepers notice the faint commotion coming from the right bank. They congregate on the riverbank and make out the figure of a young man swimming across the Amazon. It could only be Ernesto, no one else would brave these waters at night to be with them. The patients begin to cheer him on, for if anyone can bridge the river that stands between them and the rest of the world, it is Ernesto, their doctor and friend.

Ways of Knowing in Medicine

Here it is appropriate and beneficial to note that what I am asking for is nothing out-of-the-ordinary or alien to what good, seasoned clinicians already do. Some physicians, like the ones staffing the Amazonian leper colony in *The Motorcycle Diaries*, keep their patients at a distance—and not just a physical one as was the case in the film. Doctors, due at least in part to the positivist, scientific gaze taught them by modern biomedicine, objectify and reduce their patients to organ systems and symptoms. In short, they dehumanize them, supposedly in service to "medical science."

Physicians today continue to conflate medicine and science. Instead of regarding medicine as what Kathryn Montgomery Hunter describes as "a science-using, … interpretive activity undertaken for the care of a sick person",[274] Western biomedicine continues to push a definition of medicine as a form of science.[275] Any shortcomings as a "hard" science are chalked up to a temporary wrinkle that has yet to be ironed-out—a gap in current knowledge that awaits filling by a future discovery. This evolutionary model of medical knowledge wherein there is a continual and inexorable reduction of indeterminacy also presupposes something more pernicious in current medical practice—that everything is potentially knowable, predictable and quantifiable.[276]

The reason that this latent surety is dangerous to the doctor-patient relationship is that it tends to gloss over or marginalize any datum that doesn't squarely fit into the physician's (pre)conception of the problem at hand. As scientists are sometimes prone to do in their quantitative research, outlying data are seen more as evidence of the immediate and temporary imperfection of the technology than as potentially meaningful markers of processes that are as yet undetected or overlooked.[277] This tendency to smooth any rough edges allows for gross misunderstandings due to inattention to the nuance of the particular case. After all, it is not merely (or in some cases, even primarily)

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[274] Hunter, 25.

[275] Carl Mitcham, "Technology: Philosophy of Technology," in *Encyclopedia of Bioethics*, ed. Warren T. Reich (New York: Simon & Schuster Macmillan, 1995), 2479.

[276] Kathryn Montgomery Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," *Journal of Medicine and Philosophy* 21, no. 3 (1996): 304.

[277] John Dunagan and Santosh Vempala, "Optimal Outlier Removal in High-Dimensional Space," (MIT Laboratory for Computer Science, 2003), http://www.csail.mit.edu/research/abstracts/abstracts03/theory/17dunagan.pdf

the disease that defines the patient's illness, but rather it is what Arthur Kleinman describes as "the innately human experience of symptoms and suffering, … it is how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability."[278] When only the broad outlines of a case are used in finding a fit within medicine's nosology of disease, then much of what makes this an *illness* for this patient will be lost in the reduction. This is where I believe a narrative competence proves helpful in cultural competency.

Narrative Competence

Narrative is how humans make sense of their lives and their world. Over the past half-century, the human sciences have been revolutionized by the realization that human beings "live within and embody socially constructed narratives from which they cannot be extricated."[279] In this way, the terms "socially constructed narrative" or "cultural narrative"[280] can be said to be redundant. For, as Clifford Geertz noticed, "there is no such thing as a human nature independent of culture"—that narrative "system of significant symbols" that tell our story.[281]

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[278] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, & the Human Condition* (New York: Basic Books, 1988), 3.

[279] Anna Donald, "The Words We Live In," in *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, ed. Trisha Greenhalgh and Brian Hurwitz (London, UK: BMJ Books, 1998).

[280] Mattingly and Garro.

[281] Geertz, 49.

Narrative provides context, perspective, and, most importantly, meaning in a patient's lifeworld.[282] Thus, Rita Charon describes narrative competence as "those modes of thought and action with which humans comprehend and respond to particularized human events to endow them with meaning."[283] This in turn yields "the coherence, the resonance, and the singular meaning of particular human events" that can be lacking in a more principlist approach to ethics and care in a crosscultural clinical context.[284] It offers, according to Trisha Greenhalgh and Brian Hurwitz, "a possibility of *understanding* which cannot be arrived at by any other means."[285]

Narrative cultural competence is closely allied with hermeneutics in the obvious way that the "reading" metaphor is pertinent to all of these ways of knowing. However, a much more interesting point is that humans use narrative as the main organizing principle of their lived world.[286] Rita Charon says that

> [n]arrative studies suggest that individuals achieve identity and intimacy by telling and following stories, as cultures define their values and membership through the narrating of myth and epic. […] Through such narratives as fiction, journalism, history, and autobiography, human beings seek the meaning of their experiences, subscribe to causality, and represent and configure the world so that it makes sense enough to act in it.[287]

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[282] Trisha Greenhalgh and Brian Hurwitz, eds., *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice* (London: BMJ Publishing Group, 1998), 6.

[283] Charon, "Narrative Contributions to Medical Ethics," 260.

[284] Ibid., 261.

[285] Greenhalgh and Hurwitz, eds., 6. Emphasis in original.

[286] Charon, "Narrative Contributions to Medical Ethics."

[287] Ibid., 261.

This epistemic gap between the useful abstractions which are seen to provide universal relevance and clarity in clinical practice, and the entreating call that comes from this particular patient and her situation is yet another contributor to what the theologian Martin Buber called the gap "between man and man."[288] Bridging these gaps, with narrative competence and open dialogue, taking advantage of interpreters or cultural brokers whenever necessary, will enable health care professionals to foster a "renewed sense of community"[289] that can be so conspicuously lacking in between health care professionals and patients today.

It makes sense that we should look to this fundament for our "common ground." The experiences and ways of knowing that are central or fundamental to being human are the ones that will resonate with anyone and everyone.

What Is Narrative Competence?

Psychoanalyst Donald Spence believes that what he calls "empathic witnessing" suggests that the same sensibilities required of reading literature offer models of how best to listen to patients.[290] Immersion in the lifeworld of the patient, Spence says, is when we

> listen to the patient and become accustomed to his manner of speaking. [We] learn to hear his store of private meanings reflected in the words he uses. …

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[288] Martin Buber, *Between Man and Man*, trans. Ronald Gregor Smith (New York: Routledge, 2002).

[289] Bernstein, *Beyond Objectivism and Relativism: Science, Hermeneutics, and Praxis*, 203.

[290] Martha Montello, "Narrative Competence," in *Stories and Their Limits: Narrative Approaches to Bioethics*, ed. Hilde Lindemann Nelson (New York: Routledge, 1997), 191-92.

> Listening in this manner is similar to making a close reading of a poem; it attempts to get 'behind' the surface structure of the sentence and to identify with the patient as he is expressing the thought.[291]

This is what narrative competence means—the refinement of the sometimes innate, sometimes cultivated ability to engage the narrated world of the speaker, surrender to its call for recognition and meaning-making, and thereby be changed by it. Rita Charon, one of the first to use the term, suggests that without narrative competence health caregivers cannot deliver empathic care.[292]

With roots in Martin Heidegger's notions of "*dasein*" or "being in the world," the interpretive theory or practice of hermeneutics sees the importance of becoming aware of our "situatedness." Unlike empirical science's tendency to "bracket" or marginalize the subjectivity of the observer, philosophical hermeneutics is aware of the perspective of the observer and aware of the futility of trying to bracket it. In fact, this situatedness is to be acknowledged as the only possible lens through which we can inspect the world, and, as such, it becomes the means by which we comprehend the *Lebenswelt*, the lifeworld of others.

The advantage of this kind of medical knowledge is a better understanding of the patient and his story.[293] However, this narrative way of understanding each other requires that each interlocutor place her beliefs and understandings at risk. Carson shows

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[291] Ibid., 191-92. Quoting Donald P. Spence, *Narrative Truth and Historical Truth: Meaning and Interpretation in Psychoanalysis* (New York: W.W. Norton, 1982), 8.

[292] Rita Charon, "The Narrative Road to Empathy," in *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*, ed. Howard M. Spiro et al. (Hew Haven: Yale University Press, 1993).

that this kind of surrender takes place *between* the two interlocutors.[294] This "liminal space" is where new meanings can be co-constructed by the communicators—meanings not belonging wholly to one or the other, but to both as a pair. This results in a new plateau wherefrom a new understanding is shaped, but also a place unmoored from the comforts of our unreflective day-to-day lives:

> Liminal space is a place of ambiguity and anxiety, of no-longer and not-yet. To enter such a space is to slip one's moorings and be carried by currents toward one knows not where, to be in limbo. … I want both to have my "otherness" acknowledged and to be recognized as still belonging to the tribe of the living. I want to understand what is happening to me, and for this I need to be understood.[295]

Understanding how it is that people make sense of their lives and of illness makes possible a greater capacity for empathy that is the hallmark of better care.

Yet, like hermeneutics, narrative competence does not consider itself a "method." Like hermeneutics it asserts that it is a more accurate reflection or awareness of how life *is*. "[I]nternational, transhistorical, transcultural, narrative is *there*, like life."[296]

> One reads of people "doing ethics" or "doing casuistry." But one does not "do narrative," a phrase that seems to suggest that one can choose *not* to. Rather, narrative forms of knowing, telling, and reflecting are inborn parts of being human and are central aspects of making difficult choices in troubling human

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[293] See e.g.: Ronald A. Carson, "Interpretive Bioethics: The Way of Discernment," *Theoretical Medicine*, no. 11 (1990): 51-59.; and Carson, "Interpretation."

[294] Ronald A. Carson, "The Hyphenated Space: Liminality in the Doctor-Patient Relationship," in *Stories Matter: The Role of Narrative in Medical Ethics*, ed. Rita Charon and Martha Montello, *Reflective Bioethics Series* (New York: Routledge, 2002), 171-82.

[295] Ibid., 180.

[296] Roland Barthes quoted in Charon, "Narrative Contributions to Medical Ethics," 261.

> situations, no more elective than the systole and diastole of that baffling heartbeat.[297]

Aristotle understood the narrative character of life and about the different kind of knowledge that is required of medicine. This mode of knowing differs from science because it invariably depends on the discernment of qualitative differences in what is being said or done. Science is not amenable to this kind of reasoning. Medical knowing is, according to Aristotle, a narrative, interpretive, and practical reasoning—what he called *phronesis*.[298] He distinguishes this local, particular knowing with the knowledge most appropriate for science: *episteme*.[299] *Episteme* is formal knowledge that is either inductive or deductive in nature and whose objects are of necessity and eternal.[300] *Phronesis*, on the other hand, is particular and practical. Kathryn Montgomery feels that

> in realms where knowledge is necessarily particular and rules arise from individual instances of practice (rather than being deduced from a general law) … a different kind of knowing is called for. It is not that abstractions – scientific truths, legislation, moral or religious principles – are irrelevant to practical reason, but that they cannot go the whole way alone. They must be applied, put into action, in varied, changing, or incompletely specified circumstances; these abstractions sometimes fit well and sometimes poorly, but never in detail. Indeed, to decide that a principle or law is applicable to the here-and-now, the reasoner begins by recognizing the situation as one to which it may apply. Is this a case of physician-assisted suicide? Or is it rather a withdrawal of treatment at the patient's request? The circular, hermeneutic procedure that ensues is equally familiar to lawyers, physicians, and moral reasoners, all of whom are required to

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[297] Ibid., 278.

[298] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 304.

[299] Aristotle, 207.

[300] Ibid.

> fit the overarching laws of their disciplinary world view to the particular circumstances – called in each instance a "case."[301]

The induction and deduction that are the hallmarks of Aristotle's notion of *episteme* and of our modern "bench" sciences are not the mainstay of *phronesis*. Instead, what expert physicians do in discerning the particular contours of the case is again what Sacks called a *trajective* approach:

> Neither seeing the patient as an impersonal object nor subjecting him to identifications and projections of himself, the physician must proceed by sympathy or empathy, proceeding in company with the patient, *sharing* his experiences and feelings and thoughts, the inner conceptions which shape his behaviour. He must feel (or imagine) how his patient is feeling, without ever losing the sense of himself; he must inhabit, simultaneously, two frames of reference, and make it possible for the patient to do likewise.[302]

In this "thick" way of knowing, the physician does not resemble so much a diagnostician as she does an anthropologist. The "immersion" of which Sacks speaks is like Geertz's "thick description" which seeks to "grasp and render […] a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another."[303]

These similarities between medical practice and anthropology should not surprise us, for good anthropological narratives, just like good medical narratives, are fictions in

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[301] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 305.

[302] Sacks, *Awakenings*, 226. Emphases in the original.

[303] Geertz, 10.

the most charitable sense of the word. "In short," Geertz contends, "anthropological writings are themselves interpretations,"

> [t]hey are, thus, fictions; fictions, in the sense that they are "something made," "something fashioned"—the original meaning of *fictio*—not that they are false, unfactual, or merely "as if" thought experiments. To construct actor-oriented descriptions … is clearly an imaginative act."[304]

All of this should begin to build a notion in the reader's mind of the "narrative competence" or sensibility needed of physicians in order to be empathic, understanding, guides through the "kingdom of the ill."[305] Narratives give structure and meaning to our lives as humans. They are what give us access to our thoughts and emotions. Narrative is the primordial way of being human and a central aspect of decision making—"no more elective than the systole and diastole of that baffling heartbeat."[306] It should therefore be no surprise that expert physicians, even those who would readily align themselves with the logico-scientific lot, already engage in narrative ways of knowledge that are dialogical, interpretive, and particular.[307]

Narrative Competence in Clinical Practice

As Kathryn Montgomery notes in *Doctors' Stories: The Narrative Structure of Medical Knowledge*, medicine is inherently narrative in its structure, whether we are

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[304] Ibid., 15.

[305] Sontag, 3.

[306] Charon, "Narrative Contributions to Medical Ethics," 278.

[307] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 305.

talking about how medical knowledge is gained or how this knowledge is applied to clinical situations. As we have already seen, narratives of illness have been the method of choice for perpetuating medical knowledge throughout history. Today, medical narratives of illness mainly take the form of "medical case histories" which physicians now write to make the salient contours of this case more visibly "match up" with paradigmatic cases. Because of the improbability of accurately remembering the many thousands of patient narratives that would be necessary to form a serviceable compendium of practical knowledge, it became necessary to reduce the mountain of case histories into typical and anonymous cases from which to reason by analogy. And while these paradigmatic cases may definitely be helpful for beginning students, Patricia Benner and Hubert Dreyfus have found that decisions are more reliably arrived at when large numbers of particular cases have been experienced first-hand by the practitioner.[308]

Montgomery also understands this knowledge database as providing not only ways of knowing, but also ways of discerning between culturally sensitive and insensitive, appropriate and inappropriate, and right and wrong courses of action:

> What expert physicians possess, with or without the facts from the latest journal article, is an immense and well stored stock of clinical cases. Many of these cases are their own; others they have acquired through observation, reading, and reflection. This store of clinical narrative is various and extensive enough so that the general rules which the cases collectively embody are hedged and qualified, layered in memory with skepticism about their applicability to any particular patient.[309]

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[308] Patricia Benner, "The Role of Experience, Narrative, and Community in Skilled Ethical Comportment," *Advances in Nursing Science* 14, no. 2 (1991): 1-21; Patricia E. Benner, "From Novice to Expert," *American Journal of Nursing* 82, no. 3 (1982): 402-07; Hubert L. Dreyfus, *Being-in-the-World: A Commentary on Heidegger's Being and Time, Division I* (Cambridge, MA: MIT Press, 1991).

[309] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 308.

It seems that the human mind, being, after all, a narrative organ, is well-suited to making decisions this way. Rules and principles may have never been articulated or even consciously known for our minds to take vast amounts of experience and cull them into serviceable and reliable guides to action for particular cases.[310]

It should then seem obvious that educational curricula for clinical practice should teach this basic principle of knowledge and help begin amassing this compendium of stories in the student. Through richly-textured case histories, the clinical student, presumably short on clinical experience, can begin to gain a vicarious knowledge of the interpretive, dialogical process that makes up a narrative competency. This awareness of how medical knowledge is collected can teach students that the empirical science associated with medicine is not the only way to know in medicine—and not even the primary path to knowledge. That title is rightly reserved for narrative.

While the important thing is for students to be exposed to the lifeworlds of characters in stories and patients in hospital units, the teaching of a narrative competence should ideally be led by someone who is aware of the work that narrative is doing to transform ways of knowledge. This will usually mean that medical curricula should include medical humanists and literature faculty in their teaching so that students will be better equipped to engage the patient and cases in dialogical understanding rather than reducing them to the "rule of the case." This broadening and deepening of the medical

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[310] Patricia E. Benner and Carolyn Tanner, "Clinical Judgment: How Expert Nurses Use Intuition," *American Journal of Nursing* 87, no. 1 (1987): 23-31.

curriculum has already been done by many prescient and progressive academic medical centers.[311] Employing the tools of their trade—texts and theory—"literary scholars have been teaching medical students and clinicians to comprehend patient's experiences of illness, to form effective therapeutic alliances with patients and their families, to reach accurate diagnoses, and to discern appropriate treatment goals."[312] Others have employed medical sociologists and medical anthropologists who are aware of the narrative character of knowledge and use a narrative competence to temper the social-scientific push to lay foreign cultures bare and de-mystified.

It should also be clear by now that clinical students should be assigned lots of literary reading. At this stage in their education, most students have turned to reading books filled with statistics, evidence-based treatment modalities, and lab test normals. These are all necessary in the treatment of disease, but they should be considered adjunctive to the real work of doctoring, which rightly should be treatment of the *illness*. What is best for this work is fiction and literary nonfiction. "Literature is unmatched for the access it gives to the experience of others," Montgomery remarks, "especially to the inner lives of patients and the meaning of circumstances physicians cannot (or do not yet) share."[313]

If time and resources were no obstacle, and I had my druthers, health care students would routinely submerge themselves in stories and poems from physician

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[311] Rita Charon, "To Render the Lives of Patients," *Literature and Medicine* 5 (1986).

[312] Montello, 185.

[313] Hunter, "Narrative, Literature, and the Clinical Exercise of Practical Reason," 312.

writers like Richard Selzer, Rafael Campo, Anton Checkhov, Walker Percy, Abraham Verghese, William Carlos Williams, Jerome Groopman, Atul Gawande, and Oliver Sacks. These would give students an "insider's view" of medicine and expose them to fine examples of empathic practice as well as some good examples of how *not* to practice medicine. Many non-physician writers have also provided lots of absorbing stories of medicine including good ways of doctoring and plenty of frighteningly good examples of how not to be. Add to these other great stories that serve as both exemplary and cautionary tales for clinical practice in addition to exemplifying both the narrativity of knowledge and the interpretive nature of understanding.

Narrative Competence in Cultural Competency

One of the main reasons that what I have termed herein "mainstream" cultural competency initiatives in health care lack the generative capacity for dialogical understanding between patient and health caregiver is the lack of depth with which the materials deal with their subject matter. In this, I do not mean that they simply treat it cursorily—this is largely due to the perceived time limitations for cultural competency instruction—but rather that the curricula fail to show the complexity of others. Cultural competency materials will most often commit the unforgivable sin of caricaturing the patient from another culture/nationality/ethnicity (often conflating all three) and never adding the disclaimer that everyone is, in fact, an unruly conglomerate of multiple, competing and often contradictory values, attitudes, and perspectives. The careful

attention to the fundamentally polyglot nature of human being is ably discussed by the Russian literary theorist Mikhail Bakhtin in his study of Dostoevsky.[314]

Bakhtin terms Dostoevsky's sensitivity to the complexity of speakers' voices and identities as "dialogism" which infuses not only the cultural interplay between two interlocutors, but also, and this more fundamentally, composes the multivalence of each person's inner dialogue. [315]

> In every voice [Dostoevsky] could hear two contending voices, in every expression a crack, and the readiness to go over immediately to another contradictory expression; in every gesture he detected confidence and lack of confidence simultaneously; he perceived the profound ambiguity, even multiple ambiguity, of every phenomenon.[316]

It is this basic awareness of the irreducible complexity and (multiple) ambiguity of each person that is most lamentably and conspicuously lacking from health care giver/patient communication education and cultural competency training today. The positivist drive towards de-personalized and objective analysis of the most personal and intersubjective of encounters may be blinding students to the reality of interpersonal communication. As Viv Martin notes, "The intersubjective nature of reality is such that meanings are continually shifting, continually negotiated, in the moment and within the context of a particular set of relationships."[317]

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[314] Mikhail Mikhailovich Bakhtin, *The Dialogic Imagination: Four Essays*, trans. Michael Holquist (Austin: University of Texas Press, 1981), 349; Mikhail Mikhailovich Bakhtin and Caryl Emerson, *Problems of Dostoevsky's Poetics* (Minneapolis: University of Minnesota Press, 1984).

[315] Bakhtin and Emerson, *Problems of Dostoevsky's Poetics*, 30.

[316] Ibid.

[317] Martin: 54.

When patient's cultural identities are shorn of their stories, their contradictions, and their context, they become hollow caricatures that hinder more than help the practitioner charged with the patient's health. This is precisely when the use of fiction and literary nonfiction in health care education can help rehumanize cultural competency

The Medical Humanities in Cultural Competency Education

As many curricula are now incorporating cultural competency modules into their undergraduate and graduate medical training, I propose that cultural competency education and training should attempt to instill an awareness of the deeply interpretive, narrative structure of crosscultural encounters. Instead of the reductivist cultural competency "fieldguides" on the market today whose aim is to make physicians more knowledgeable about their patients, I would propose reading books like Anne Fadiman's *The Spirit Catches You and You Fall Down*.[318] This book is greatly instructive as a cautionary text of how the doctor/patient relationship can falter, especially across cultures, while the story also opens up the lifeworld of a patient and her family to understanding and empathy. A physician reading this book will have been exposed to the kind of trajective rendition of a patient's story that should be the definition of cultural competency. However, if taught without instilling in the student a hermeneutic where judgment is reserved, even books such as this can be misread so as to teach that all Hmong believe and act the way that Lia's parents did. This is why a good adjunct to this

[318] Fadiman.

book would be another nonfiction book that tackles the complexity of the Hmong culture in a respectful and "thick" way such as the ground-breaking book *Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers* edited by Culhane-Pera *et al*. In this "casebook," many different writers from different cultures, professions, and perspectives, take a close look at the often-conflictual encounters between the Hmong community and health care practitioners in Western settings.[319] The 368-page tome eschews facile, reductive, and homogenizing descriptions of the Hmong (for the most part). And attempts to bridge the gap between the literary genres of anthropological studies of a target culture, and the cultural competency guides to foreign cultures aimed at busy health care practitioners who have neither the time or the inclination to engage in thorough anthropological research and analysis. The book is divided into discrete chapters that can be read by themselves and which give perspicuous and easily digested essays for clinicians.

In many cases, however, the kind of ethnographic and anthropological literature that can offer us a thick description of a target culture falls prey to the epistemological gap that there is "between man and man." We are often offered what someone from our own culture or one very much like it has to say in regard to the remote and exotic foreign culture. This 'hearsay' can be quite illuminating and speak to us in an idiom far easier to understand, but as is always the case, the narrator can only ever be a spectator of that culture and not a native. Some would argue that works originally written from within the

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[319] Kathie Culhane-Pera, *Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers* (Nashville: Vanderbilt University Press, 2003).

foreign culture and then translated are less mediated than when an ethnographer or anthropologist is creating the narrative from his admittedly outsider perspective. Fortunately, there are thousands of works in translation from around the world, each of which can be a gateway to understanding (if only minimally and provisionally) another culture or person. International novels and films may be the best way to experience another culture short of an extended visit. There are films like *Talk to Her* from Spain that deals with caregiver/patient communication and health care professionalism and propriety; *The Sea Inside*, also from Spain, that centers on end-of-life care and the right to die. *Festa da Moca* from Brazil about a girl's puberty ritual; *Horse Thief* from China (still banned there) which shows a sympathetic portrait of Tibetan indigenous life, and *The Motorcycle Diaries* from Latin America that deals with the transformative power of empathic understanding.

Kleinman's Ethnographic Approach

What we've seen thus far should argue for the centrality of the humanities to a well-rounded medical curriculum, even though courses in narrative, literature, or other medical humanities in medical and health care professions schools are scarce and when they are found, usually considered merely as enriching electives for upper-class students. So how, in this environment currently hostile to the medical humanities, can harried and hurried health care practitioners learn and apply these pearls of clinical wisdom to everyday crosscultural contexts? If a doctor does not have the benefit of ethnographic study and a literary education, can he still learn some minimal skills that can help cut

through the static sometimes brought about by racial, ethnical, cultural, and/or socioeconomical distance?

In *The Illness Narratives*, Kleinman, agrees that an approach of "empathic listening, translation, and interpretation" is the best way to care for patients.[320] In this fascinating book, Kleinman makes the somewhat counter-intuitive observation that beginning medical students' efforts at patient interviewing are often instructive for seasoned clinicians when it comes to understanding of patients and empathic care. Students "often bring a sense of awe to their auditing of the accounts of their first few patients, which encourages them to resonate genuinely with the illness narrative."[321] According to Kleinman, this receptivity, expectation of surprise, and empathic listening are the prerequisites for cultural competency.[322] What should happen next is what he terms the "mini-ethnography."[323]

An ethnography is the interpretation of the lifeworld of a person for which anthropologists are well known. Anthropologists observe a culture in all of its situatedness and, after careful dialogical and hermeneutical study (ideally), offer a thick description of the culture. "[E]thnography," Says Geertz, "is dialogical. … We are seeking, in the widened sense of the term in which it encompasses very much more than talk, to converse with them."[324] Obviously, modern health care practitioners cannot

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[320] Kleinman, *The Illness Narratives*, 228.

[321] Ibid., 233.

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

[323] Kleinman, *The Illness Narratives*, 227-51.

[324] Geertz, 13.

afford all of the luxuries that this methodology demands. That is why Kleinman hopes that a stripped-down yet still robust version of an ethnography—a "mini-ethnography"—will help doctors do the job.

What Kleinman first suggests is that the physician elicit the patient's illness narrative. Careful attention to this will then enrich the physician's notion of what the problem may be. For this it is necessary for health care professionals to learn to allow the patient time to tell their story. Studies show that on average, physicians interrupt their patients 12 seconds after the patient begins to talk.[325] Next comes a list of the current psychosocial problems associated with not only the illness, but with its treatment thus far.[326] The psychological and social ramifications of disease are responsible for further shaping the course of the illness in such a marked way that to ignore these should be considered culturally unresponsive and perhaps even negligent.

After this narrative, the patient should be asked for a brief life history.[327] One of the boons of a brief biography is that not only will the physician be better equipped to diagnose the ailment and better be able to tailor the care to the particular situation of this patient, but also that dehumanization of the patient (something for which modern medicine is notorious) will be much more difficult once the patient becomes a fully-realized, complex *person* in the medical narrative through a biography instead of the disembodied disease that figures so prominently in medical parlance today.

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[325] Donna R. Rhoades and others, "Speaking and Interruptions During Primary Care Office Visits," *Family Medicine* 33, no. 7 (2001): 531.

[326] Kleinman, *The Illness Narratives*, 235.

[327] Ibid., 236-38.

Next, Kleinman recommends eliciting the patient's (and if pertinent and convenient, the patient's family's) explanatory models of the illness.[328] This is not only to help the physician better understand the cultural and religious context of the patient's understanding of the disease and hint at what treatment modalities this patient might be open to, but also because doing so is therapeutic for the patient as often these explanatory models are inchoate and thus conceptually frustrated until a patient attempts to articulate them.[329] This is where the temptation to judge a patient's sophistication and disregard the patient's notions as quaint or archaic when they don't align themselves to the doctor's reasoning is most prevalent. Granted, it is inadvisable for the health care professional to accept the patient's explanatory model at the expense of models that the caregiver knows (or reasonably expects) will give greater relief, but it remains necessary in most cases to give the patient a charitable reading of her story. This is true not only in order to better understand her (the cogency and coherence that a charitable reading provides a story is essential in understanding the story, even if one disagrees with it) but also because having a true grasp of the patient's understanding of her illness will help insure that the education, care and treatment provided better interfaces with the patient and addresses her expectations directly.

Kleinman suggests eight questions to help elicit a patient's explanatory models:

1. What do you call the problem?

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[328] Ibid., 239.

[329] Ibid., 239-40.

2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a short or long course?
6. What kind of treatment do you think the patient should receive? What are the most important results you hope he/she receives from this treatment?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?

After these data are compiled, the physician carefully interprets the findings with a hermeneutical oscillation between the whole picture and the particulars. Nonverbal cues and intuitions should be given fair hearings in the doctor's mind as well as the ways the patient answered or chose to deflect questions. After a fair amount of sleuthing, the doctor returns to the patient to collaborate with her on a plan of care that will help achieve what both patient and physician (and sometimes others) would like out of the therapeutic relationship.

Obviously this approach collaborates with other, more scientific medical diagnostic methodologies—and cultural competency guides can play a role as well—but nothing can substitute for the work of dialogue, interpretation, and narrative competence. Therefore, in my opinion, what should be taught in cultural competency programs and educational materials is an interpretive, dialogic approach that focuses on understanding through the co-construction of a coherent and consonant narrative between patient and

health care provider. This, in turn, should serve as a platform by which a culturally appropriate care becomes *de rigueur*.

Conclusion

Foremost, the narratively based, dialogical hermeneutic that forms the basis of this approach to cultural competency (in both training and practice) is a surrender to encounter. In this surrender we open ourselves to the possibility of being changed by our fellow interlocutor through receptivity and reciprocity.[330] This surrender connotes an intimate bond with our dialogic partner.

"All actual life is encounter",[331] said the theologian Martin Buber. "Relation is reciprocity. [My partner] acts on me as I act on [him]. Our students teach us, our works form us."[332] For health care professionals, this means a shift from thinking *about* a patient's story to one of thinking *with* narrative—a complete immersion in the patient's story, becoming a dialogic partner with the patient instead of buying into the reductivist illusion of being a detached and objective observer of the drama.

In *The Motorcycle Diaries*, as Che Guevara emerges from the water after crossing the dark Amazon to be closer to his patients, he is borne aloft by their cheers while a

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[330] Bloom, 1.

[331] Buber, *I and Thou*, 62.

[332] Ibid., 67.

voice-over of Che plays in the background. "This isn't a tale of heroic feats," says the future revolutionary:

It's about two lives running parallel for a while, with common aspirations and similar dreams.

Was our view too narrow, too biased, too hasty? Were our conclusions too rigid? Maybe. But that wandering around our America with a capital "A" has changed me more than I thought. I am not me anymore, at least I am not the same me I was before.[333]

[333] Walter Salles, "Diarios De Motocicleta (the Motorcycle Diaries)," (Argentina: Focus Features (USA), 2004).

CHAPTER TEN: AN EXAMPLE COMPARING THE DOMINANT MODEL OF CULTURAL COMPETENCY AND A NARRATIVE HERMENEUTIC APPROACH

> *Even moral concepts are never given as a whole or determined in a normatively univocal way. Rather, the ordering of life by the rules of law and morality is incomplete and needs productive supplementation. Judgment is necessary in order to make a correct evaluation of the concrete instance.*
>
> –Gadamer, *Truth and Method*

Introduction

In this chapter I will explore how a narrative, hermeneutic, dialogical approach as derived from Gadamer can increase the sensitivity to the individual case by including cultural factors that may complicate the reading and help the interlocutors open and cultivate a liminal space wherein the patient and the health-care practitioner can more adequately collaborate in plans of action. These aforementioned sensitivities or competencies are the hallmarks of what I take to be culturally competent health care. I will attempt to show the relevance to this approach through an everyday example encountered by most health-care practitioners, patients, and research participants—that of the informed consent process.

The Informed Consent Process in Contemporary North American Health Care

Informed consent has become a culturally defined, historically mediated, metaphoric shorthand term whose cultural, linguistic, legal, ethical, historical,

philosophical, and procedural patina serves to obscure the myriad ways in which people consent to having things done to them and the varied and sometimes contradictory views people have of the process. The term has become a pillar of both medical practice and law, and of the ethical codes that govern these two professions in America. Jan Marta has called it the "enshrinement of the dominance of the principle of autonomy in contemporary North American bioethics";[334] and despite its nearly universal dominance (in the West, anyway), it is attended by a "great dissatisfaction."[335] These dissatisfactions are well known to anyone who has studied the subject. For example, there is a widespread skepticism that genuine informed consent can ever be obtained.[336] This skepticism is not without basis or merit. There are numerous ineradicable factors such as power imbalances, knowledge and expertise differentials, language barriers, practitioner lack of communication skills, and the insurmountable "emotional distress and urgency which often cloud the situation"[337] that contribute to the difficulty (if not the outright impossibility) of a truly informed consent. These are, in fact, many of the same difficulties attending crosscultural clinical encounters in general.

Could it be that this is yet another example of the dominant, reductive, logicoscientific culture imposing a well-intentioned, but ultimately misleading and restrictive template on what should be a narratively mediated, dialogical engagement

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[334] Jan Marta, "Toward a Bioethics for the Twenty-First Century: A Ricoeurian Poststructuralist Narrative Hermeneutic Approach to Informed Consent," in *Stories and Their Limits: Narrative Approaches to Bioethics*, ed. Hilde Lindemann Nelson, Reflective Bioethics (New York: Routledge, 1997), 198.

[335] Ibid.

[336] Eugene G. Laforet, "The Fiction of Informed Consent," *JAMA* 235, no. 15 (1976): 1579-84.

[337] Marta, 198.

between the cared-for and caregiver? I believe not only in the truth of this statement, but also in the kind of narrative hermeneutic approach espoused by Gadamer as a necessary corrective.

The Dominant Model of Informed Consent

The elements of informed consent in the North American medicolegal system are standard and, in fact, codified by both case law[338] and statute.[339] There commonly should be a *disclosure* of information that a fictionalized standard patient would want to know of the proposed intervention or its forbearance. There should then be a concomitant *comprehension* of these details by a legally defined *competent* patient. After this often unascertainable comprehension has been achieved, a *voluntary consent* or *refusal* to allow the intervention follows.

While this definition of the informed-consent process is unquestioningly and widely accepted in North American contexts, it is an example of a gross distillation of the actual process of decision making undertaken by real people in particular circumstances. For one, this enshrined model of informed consent is often thought to be the *only* way to ethically go about settling on a course of action in health care. Practitioners tend not to realize that this model is ripe with the cultural meanings and valorizations of North American rugged individualism from which spring contemporary atomistic notions of

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[338] *See e.g. Schloendorff v. Society of New York Hospital*, 211 N.Y. 125 (1914); and *Canterbury v. Spence*, 150 U.S. App. D.C. 263 (1972).

[339] CODE OF FEDERAL REGULATIONS, Title 45, Part 46 PROTECTION OF HUMAN SUBJECTS, § 116 GENERAL REQUIREMENTS FOR INFORMED CONSENT. (45 CFR 46.116)

independence and autonomy. Other cultures (including many cultures outside of the mainstream culture in North American but comprising what in some parts of the United States are now the majority populations) have very different beliefs and conceptual frameworks for how we should go about making treatment decisions. For example, many people emphasize relationship and trust in these situations and complain that the dominant model is shorn of all context and regard for the particular case—ineradicable elements that must be taken into consideration.[340]

The Narrative, Hermeneutic Approach

In the situations in which informed consent becomes problematic, the rigid, procedurally based conception of informed consent can lead to paternalism on the one hand (when, for example, patients are pressured into signing a document without having been truly informed), and something close to abandonment on the other (when, for example, the doctor perceives her duty to be fulfilled by cataloging the interventions available, listing the pros and cons of each one along with the statistically probable outcomes of each possible course of action, and then summarily dumping all of this often decontextualized information in the lap of the patient for her to sort through).

The dialogical model that I am espousing recaptures the essence of the informed-consent process—conversation. It is easy for health care practitioners to rattle off the bald requirements of informed consent, but nowhere in this short list can one point to the

[340] See generally, Alan W. Cross and Larry R. Churchill, "Ethical and Cultural Dimensions of Informed Consent. A Case Study and Analysis," *Annals of Internal Medicine* 96, no. 1 (1982): 110-13.

inherently discursive nature of the process. The comprehension bullet point on the informed-consent flowchart comes closest to intimating the true nature of the process, but, not surprisingly, it is the step most likely to be skipped or given short shrift (one supposes it is because of the interpretive work involved in assessing comprehension in patients).[341] Ideally, the health-care professional would be satisfying this "step" in the process along the way. As we have already seen, the hermeneutic circle—whereby we understand the whole from its parts and *vice-versa*,[342]--is an excellent model for the kind of to-and-fro that helps bring two interlocutors out of their respective entrenched positions toward a collaborative understanding and comprehension of the matter. In this way, it can be said that a narrative, dialogical hermeneutical ethic of encounter will better enable the informed consent of not only the patient, but also, curiously, of the health-care provider. This is true because when done correctly, the informed-consent process will better "inform" or educate the physician as to the possible ramifications and consequences of the proposed intervention to the patient that a rote recitation of pharmacokinetics can never convey. Careful attention to the patient's mini-ethnography will make the physician better informed and better situated to convey the risks and benefits in a way that is sensitive to what matters to this patient. Patients will weigh risks and benefits differently according to numerous indicia that have less to do with the raw statistics and much more to do with their lifeworld including their culture, occupation,

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[341] Joseph R. Betancourt, Alexander R. Green, and J. Emilio Carrillo, "The Challenges of Cross-Cultural Healthcare--Diversity, Ethics, and the Medical Encounter," *Bioethics Forum* 16, no. 3 (2000): 27-32.

[342] Carson, "Interpretation," 1284. Quoting Schleiermacher, 75.

desires. Knowing more about the patient and her lifeworld makes tailoring and assisting the patient in her decision making possible and optimal.

CONCLUSION

> *It is precisely in losing the certainty of truth and the unanimous agreement of others that man becomes an individual. The novel is the imaginary paradise of individuals. It is the territory where no one possesses the truth, neither Anna nor Karenin, but where everyone has the right to be understood, both Anna and Karenin.*
>
> *– Milan Kundera,* The Art of the Novel*, 159.*

In an age when much discussion in health disparities, medical ethics, and health care in general arises from misunderstandings on the borderlands of medicine, there needs to develop a heightened sense of duty to foster and engage in dialogical communion across borders to come to understandings. These borders are not merely geographic boundaries between countries, nor differences in gender, race, or ideologies (all of these blur more and more with every passing day anyway), but more precisely, they are the chasm "between man and man," as Buber put it.[343] Bridging these gaps, through open dialogue and through mediator/interpreters when needed, will enable physicians and other health-care providers to better serve their patients by fostering a "renewed sense of community" [344] that Richard J. Bernstein, quoting in part Richard Rorty, envisions as:

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[343] Martin Buber, *Between Man and Man*, trans. Ronald Smith Gregor, Routledge Classics (New York: Routledge, 2002).

[344] Bernstein, *Beyond Objectivism and Relativism: Science, Hermeneutics, and Praxis*, 203.

> "the willingness to talk, to listen to other people, to weigh the consequences of our actions upon other people." It means taking conversation seriously (and playfully), without thinking that the only type of conversation that is important is the type that aspires to put an end to conversation by reaching some sort of "rational consensus," or that all conversation is to be construed as a disguised form of inquiry about the "truth." It means not being fooled into thinking that there is or must be something more fundamental than the contingent social practices that have been worked out in the course of history, that we can find some sort of foundation or metaphysical comfort for our human projects. It means resisting the "urge to substitute *theoria* for *phronesis*," and realizing that there are no constraints on inquiry save conversational ones, and even these "cannot be anticipated." It means turning away from obsession "to get things right" and turning our attention to coping with the contingencies of human life.[345]

And while this dialogical hermeneutic is by no means a simple or reducible axiom by which we can understand each other, the work invested into its accomplishment will be enriching for everyone involved; it will further enable physicians to hear with the third ear and become those whom patients need: Virgilian guides through the hinterlands and borderlands of illness.

What I hope to achieve in this dissertation is to remind us of the simple truths we are so unfortunately prone to forget nowadays. I could have proposed a complete restructuring of the cognitive apparatus by which modern health-care practitioners apperceive patients. I could have demanded a transformation of physicians and other health-care professionals and prescribed what I saw as the right vision or attitude by which we could identify ethical and culturally competent professionals. But apart from being haughty and élitist, these demands are unnecessary. As people who have dedicated

[345] Ibid.

their lives to health care, health-care practitioners are not in need of retooling their commitment to others, but rather simply in rekindling the sensitivities to those for whom they care, and which have been painstakingly beaten out of them by the dominant discourse in medicoscientific education on the late twentieth and early twenty-first centuries. What strict typologies of cultures and peoples achieve is not something of much use to the caregiver of a person. For people resist being subsumed under moral, psychological, and social typologies. This reduction is the regrettable and inevitable product of the logicoscientific enterprise that, far from being content to limit its descriptive powers to the natural world, has overrun its banks and flooded the realm of humanity.

And so I propose the reclaiming of this territory for ways of knowing that are sensitive to the myriad ways in which one is different from everyone else but not alien—ways that can help us to "expos[e others'] normalness without reducing their particularity."[346] Which is why I wish that we took as our lights the great novelists of our Western tradition more than the great philosophers and social scientists. Novelists (the good ones anyway) are detail-oriented. They linger on the human and the quotidian and offer no clear-cut encapsulations of people for the reader's easy digestion. Novelists show us the unruliness of human existence and in so doing have much more fruitful things to say about human nature than do the philosophers for whom human nature is one more process to be determined with mathematical exactitude.

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[346] Geertz, 14.

Milan Kundera, the noted novelist and literary (anti)theorist, in his beautiful treatise *Art of the Novel*, makes a bold claim for the supremacy of Dickens to modern philosophers on the question of understanding of our fellow man. While philosophers will attempt to transform people into something foreign to humanity in order to achieve a more "humane" society (e.g., a two-dimensional person for whom the maximization of happiness is his only motive and reason his only vehicle), Dickens made a much more modest and ultimately more powerful demand of his readers—that we notice and understand those who populate our lives. This demand is why Dickens's characters are so fully formed and "human." Just like you and me, Mr. Pickwick, Gradgrind, and Oliver Twist resist so simplistic and reductive a move as categorization. In a world to Kundera's liking, the "wisdom of the novel" would mean that we would eschew the brusque, domineering, and misleading nomenclature of principles and categories when speaking of moral and cultural comparisons. Instead, these judgments would be aided by proper names in the Kunderian utopia. Instead of using convenient placeholders that only reflect small portions of the multiple facets of a person (Jehovah's Witness, Chinese, single mom), Kundera would use nondescriptive proper names. These would tell one virtually nothing about the person, instead, they would require one to engage, ask questions, test our presuppositions, and construct a fuller portrait of the person.

In praising Kundera's vision of a moral universe, Rorty describes this society as one

> which took its moral vocabulary from novels rather than from ontotheological or ontico-moral treatises … Rather, it would ask itself what we can do so as to get along with each other, how we can arrange things so as to be comfortable with

one another, how institutions can be changed so that everyone's right to be understood has a better chance of being gratified.[347]

[347] Rorty, 15.

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