Spring 2020

Misdiagnosis: Race-Conscious Approaches to Medical Education

Sidney Saint-Hilaire
Yale College, New Haven Connecticut

Abstract:

Racial disparities in outcomes represent one of the most troubling issues in healthcare. The source of this problem lies not only in access to care, but the interactions and judgements that play out once patients are in the room. In response to these troubling issues, providers have turned towards the concept of "cultural competency" in the education of medical providers. The widespread adoption of these practices, however, has outpaced thorough research on its efficacy; much of the analyses of cultural competency education's ability to significantly reduce health disparities, or even bias more generally, remains inconclusive. More insidious are the historical vestiges of race-minded medicine, ideas of multiculturalism, normativity and, race essentialism, that constrain cultural competence's pedagogical usefulness. Engaging with primary sources and historical texts, literature reviews and contemporary medical pedagogy, this paper assesses how history informs the continued use of cultural competence concepts in medical practice. As such, this paper is situated at the intersection of American medical history, racial justice, and ethics and empathy education in medicine. Several core assumptions of cultural competence are identified; mainly cultural-racial conflation, cultural positivism, and lack of structural fluency. Ultimately, the findings of this paper conclude a systemic and pervasive insufficiency of cultural competence ideology and application. Further, it is proposed that we no longer rely solely on the concept of cultural competency and instead adopt pedagogies related to cultural humility, critical health studies and structural competency as addenda to cultural competence education for the medical profession.

Misdiagnosis: Race-Conscious Approaches to Medical Education
Sidney Saint-Hilaire
Yale University

Abstract

Racial disparities in outcomes represent one of the most troubling issues in healthcare. The source of this problem lies not only in access to care, but the interactions and judgements that play out once patients are in the room. In response to these troubling issues, providers have turned towards the concept of "cultural competency" in the education of medical providers. The widespread adoption of these practices, however, has outpaced thorough research on its efficacy; much of the analyses of cultural competency education's ability to significantly reduce health disparities, or even bias more generally, remains inconclusive. More insidious are the historical vestiges of race-minded medicine, ideas of multiculturalism, normativity and, race essentialism, that constrain cultural competence's pedagogical usefulness. Engaging with primary sources and historical texts, literature reviews and contemporary medical pedagogy, this paper assesses how history informs the continued use of cultural competence concepts in medical practice. As such, this paper is situated at the intersection of American medical history, racial justice, and ethics and empathy education in medicine. Several core assumptions of cultural competence are identified; mainly cultural-racial conflation, cultural positivism, and lack of structural fluency. Ultimately, the findings of this paper conclude a systemic and pervasive insufficiency of cultural competence ideology and application. Further, it is proposed that we no longer rely solely on the concept of cultural competency and instead adopt pedagogies related to cultural humility, critical health studies and structural competency as addenda to cultural competence education for the medical profession.

        Keywords: Cultural Competency, Structural Competency, Critical Health Studies,
        Cultural Humility, Social Justice in Medicine, Medical Education, Race and Medicine

The Many Faces of Racism in Health

   The effects of racism, readily clear in our educational,[1,2] governmental,[3,4] and economic[5] realities, also manifest equally as often within the very bodies of millions of individuals who are at the whim of these systems. Over the course of American history, and occurring painfully close to the present, exist the most egregious forms of medical racism—individual practitioners and medical societies alike have been found guilty of spreading the disease of racism; using Black people as instruments of experimentation and opting for torturous and dehumanizing methods of advancing the field of health as in the infamous case of the Tuskegee Experiments. In 1932, physicians from the United States Public Health Service allowed syphilis to progress untreated in hundreds of African American so that the course of the disease could be analyzed.[6] A horrifically similar fate befell thousands of Guatemalans in 1946 when sex workers, prisoners, mental patients, and soldiers and orphans were deliberately infected with syphilis, gonorrhea and other sexually transmitted infections by US doctors without consent, and for hundreds of victims, without any formal treatment.[7] Instances such as these represent the ugliest face of racism in health — one that is consciously prejudicial and predatory towards those already marginalized by a myriad of systems. There are, however, other facets of racial discrimination that are comparatively more subtle despite being equally hazardous. Even when individuals' health isn't being intentionally compromised by those in the medical community, the effects of living in a racist world, being subject to systemic discrimination through practices like segregation,

---

[1] Johnson-Ahorlu, Robin Nicole. "The academic opportunity gap: How racism and stereotypes disrupt the education of African American undergraduates." *Race Ethnicity and Education* 15, no. 5 (2012): 633-652.

[2] Carroll Massey, Grace, Mona Vaughn Scott, and Sanford M. Dornbusch. "Racism without racists: Institutional racism in urban schools." *The Black Scholar* 7, no. 3 (1975): 10-19.

[3] Wright, Gerald C. "Racism and welfare policy in America." *Social Science Quarterly* 57, no. 4 (1977): 718-730.

[4] Alexander, Michelle. *The new Jim Crow: Mass incarceration in the age of colorblindness.* The New Press, 2020.

[5] Lundberg, Shelly, and Richard Startz. "On the persistence of racial inequality." *Journal of Labor Economics* 16, no. 2 (1998): 292-323.

[6] Brandt, Allan M. "Racism and research: the case of the Tuskegee Syphilis Study." *Hastings center report* (1978): 21-29.

[7] Rodriguez, Michael A., and Robert García. "First, do no harm: the US sexually transmitted disease experiments in Guatemala." *American journal of public health* 103, no. 12 (2013): 2122-2126.

redlining, and exposure to lead and other pollutants[8], inevitably take their physical, biological toll.

A cursory analysis of health amongst different ethnic groups reveals this impact; in the United States, non-Hispanic Blacks and Native Americans are reported to have higher mortality rates than do non-Hispanic Whites.[9] A closer look in any category of health at any stage of life proves that the disparities are as ubiquitous as they are staggering; Black patients experience higher rates of infant *and* maternal mortality and lower birth rates than their white counterparts,[10,11] Black patients are more likely than any other group to receive worse care in the treatment of cancer, H.I.V., heart diseases and in the administration of prenatal care and preventive care.[12, 13] Black patients' response to these realities are also visible in the statistics; they are significantly more likely than white patients to opt for "full code," which is the most aggressive plan of treatment in the event of cardiac arrest, than white patients, and less likely to opt for "do not resuscitate," as their preferred medical protocol.[14] It seems as if patients in these situations are all too aware of the danger posed to their livelihood because of their race, taking every precaution to preserve their lives against, who they believe, are indifferent doctors. However, compared to examples of racism like those found in the Tuskegee experiments, there is

[8] Kraft, Michael E., and Denise Scheberle. "Environmental justice and the allocation of risk: the case of lead and public health." *Policy Studies Journal* 23, no. 1 (1995): 113-122.

[9] Nazroo, James Y. "The structuring of ethnic inequalities in health: economic position, racial discrimination, and racism." *American journal of public health* 93, no. 2 (2003): 277-284.

[10] Dominguez, Tyan Parker, Christine Dunkel-Schetter, Laura M. Glynn, Calvin Hobel, and Curt A. Sandman. "Racial differences in birth outcomes: the role of general, pregnancy, and racism stress." *Health psychology* 27, no. 2 (2008): 194.

[11] Petersen, Emily E., Nicole L. Davis, David Goodman, Shanna Cox, Nikki Mayes, Emily Johnston, Carla Syverson et al. "Vital signs: pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013–2017." *Morbidity and Mortality Weekly Report* 68, no. 18 (2019): 423.

[12] Ayanian, John Z., Joel S. Weissman, Scott Chasan-Taber, and Arnold M. Epstein. "Quality of care by race and gender for congestive heart failure and pneumonia." *Medical care* (1999): 1260-1269.

[13] Nelson, Alan. "Unequal treatment: confronting racial and ethnic disparities in health care." *Journal of the National Medical Association* 94, no. 8 (2002): 666.

[14] Johnson, Rebecca W., L. Kristin Newby, Christopher B. Granger, Wendy A. Cook, Eric D. Peterson, Melvin Echols, Wanda Bride, and Bradi B. Granger. "Differences in level of care at the end of life according to race." *American Journal of Critical Care* 19, no. 4 (2010): 335-343.

more ambiguity in terms of what forces are at play and who is responsible for these disparities. But the targets are as clear as ever; the precision with which people of marginalized races are put in harm's way and the severity of the dangers posed by the disparities make certain that this discrimination is as debilitating to their lives as any blatant human rights violation.

In thinking about what could be so common to the Black experience that leads to such pervasive health disparities, various research pinpoints the biological impact of experiencing racism as one of many culprits – the chronic stress it engenders, which in turn leads to prolonged exposure to stress hormones and oxidative stress on the cellular level and, eventually, long-term states of inflammation that leave patients susceptible to chronic disease and illness.[15,16] Down to the molecules that compose our bodies, racism sows difference where there once was none. Though people who are perceived as Black have similar outcomes in terms of health to each other, they often share more genetic information in common with individuals from *other* races.[17] In this way, it is almost as if racism and its manifestations force biological difference into existence, carving up discrete delineations between populations that were otherwise only separated by social construction.

When the concept of race is validated so consistently on an internal basis – through microscopic lens of biology, and physiology – as well as externally – not only via skin color but through a perceived difference in education & job attainment,[18,19] political and religious

---

[15] Ong, Anthony D., Thomas Fuller-Rowell, and Anthony L. Burrow. "Racial discrimination and the stress process." *Journal of personality and social psychology* 96, no. 6 (2009): 1259.

[16] DeSantis, Amy S., Emma K. Adam, Leah D. Doane, Susan Mineka, Richard E. Zinbarg, and Michelle G. Craske. "Racial/ethnic differences in cortisol diurnal rhythms in a community sample of adolescents." *Journal of Adolescent Health* 41, no. 1 (2007): 3-13.

[17] Ng, Pauline C., Q. Zhao, S. Levy, R. L. Strausberg, and J. C. Venter. "Individual genomes instead of race for personalized medicine." *Clinical Pharmacology & Therapeutics* 84, no. 3 (2008): 306-309.

[18] Margo, Robert A. "Race, educational attainment, and the 1940 census." *The Journal of Economic History* 46, no. 1 (1986): 189-198.

[19] Kim, Changhwan, and Christopher R. Tamborini. "The continuing significance of race in the occupational attainment of whites and blacks: A segmented labor market analysis." *Sociological Inquiry* 76, no. 1 (2006): 23-51.

behavior,[20,21] it is all too tempting for someone reading these facts to assume that race is inherently meaningful after all. This is all without considering the human mind's unique penchant for creating connections and categorizations that are seemingly meaningful. Essentialism, the belief that certain categories (racial groups, flowers, sandwiches, paintings) have immutable characteristics or true natures that cannot be directly observed, is a common theme of everyday cognition.[22] The means by which we psychologically differentiate between people, places, objects, and concepts is buoyed by essentialist thinking, often times without our conscious awareness.[23,24, 25]In the same way that a child may be certain that there are fundamental, essential differences between cats and dogs without knowing what those differences truly are, people are liable to believe that racial categories are essentially meaningful simply because they exist without further investigating their validity. This innate cognitive predisposition combined with an overwhelming amount of differences on a variety of scales is more than enough to make the perpetual existence and importance of race in our reality. How then should race — this thing that is simultaneously real and imaginary — be evaluated in medicine, a discipline that concerns itself with observable and objective truth? As evidenced from research cited below, the medical field has not properly reckoned with this nuanced relationship between race, biology and health. Rather than parse the complex web of factors that intertwine race and health outcomes, researchers and doctors have more often considered race itself to be the principal cause.

---

[20] Alex-Assensoh, Yvette. "Race, concentrated poverty, social isolation, and political behavior." *Urban Affairs Review* 33, no. 2 (1997): 209-227.

[21] Britt, Chester L. "Race, religion, and support for the death penalty: A research note." *Justice Quarterly* 15, no. 1 (1998): 175-191.

[22] Gelman, Susan A. "Essentialism in everyday thought." *Psychological Science Agenda* 19, no. 5 (2005): 1-6.

[23] Shweder, Richard A., Joseph B. Casagrande, Donald W. Fiske, J. David Greenstone, Paul Heelas, Laboratory of Comparative Human Cognition, and David F. Lancy. "Likeness and likelihood in everyday thought: magical thinking in judgments about personality [and comments and reply]." *Current anthropology* 18, no. 4 (1977): 637-658.

[24] Similer, Andrew P., and Susan A. Gelman. "Determinants of gender essentialism in college students." *Sex Roles* 58, no. 11-12 (2008): 864-874.

[25] Gelman, Susan A., John D. Coley, and Gail M. Gottfried. "13 Essentialist beliefs in children: The acquisition of concepts and theories." *Mapping the mind: Domain specificity in cognition and culture* (1994): 341-365.

The particular racial disparity in chronic pain treatment makes clear how medicine falls for the logic of racial essentialism, interchanging the effects of systemic racism and racist beliefs for genuine racial difference. Chronic pain is associated with chronic disease, psychological distress, Medicaid insurance, and lower education levels,[26] all factors that have higher incidence among Black Americans; 27 percent of Black patients who are over the age of 50 document experiencing severe pain most of the time, compared to 17 percent of non-Hispanic whites.[27] Despite these higher rates of incidence, Black patients are more likely to have their pain go untreated. Part of the reason for this disparity is due to systemic factors, like lack of access to medical insurance or capable medical facilities[28] as well as determinants that fall in a grey area between being systemically and historically influenced and personally upheld, like mistrust of doctors and the healthcare system.[29] However, this inequity in pain management also has its roots in misperceptions about race and health amongst medical staff as well. For example, nearly half of the 222 medical students who participated in a 2016 study were shown to harbor false beliefs about biological differences between blacks and whites (e.g. "black people's skin is thicker than white people's skin; black people's nerve endings are less sensitive than white people's nerve endings").[30] The same study reported that the strength of these beliefs are positively correlated with inaccurate diagnoses and treatment. Evidenced here are the ways in which interpersonal biases worsen, rather than mitigate, disparities in health amongst races that exist due to systemic forces. Similar oversights can be seen in the cases of diseases that are commonly known to fall along racial boundaries, like sickle cell anemia. Sickle cell anemia, a

---

[26] Meghani, Salimah H., Rosemary C. Polomano, Raymond C. Tait, April H. Vallerand, Karen O. Anderson, and Rollin M. Gallagher. "Advancing a national agenda to eliminate disparities in pain care: directions for health policy, education, practice, and research." *Pain Medicine* 13, no. 1 (2012): 5-28.

[27] Reyes-Gibby, Cielito C., Lu Ann Aday, Knox H. Todd, Charles S. Cleeland, and Karen O. Anderson. "Pain in aging community-dwelling adults in the United States: non-Hispanic whites, non-Hispanic blacks, and Hispanics." *The Journal of Pain* 8, no. 1 (2007): 75-84.

[28] Mueller, Keith J., Kashinath Patil, and Eugene Boilesen. "The role of uninsurance and race in healthcare utilization by rural minorities." *Health Services Research* 33, no. 3 Pt 1 (1998): 597.

[29] Alsan, Marcella, and Marianne Wanamaker. "Tuskegee and the health of black men." *The quarterly journal of economics* 133, no. 1 (2018): 407-455.

[30] Hoffman, Kelly M., Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver. "Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites." *Proceedings of the National Academy of Sciences* 113, no. 16 (2016): 4296-4301.

disorder characterized by misshapen red blood cells, is taught as a race-linked disease.[31] While there are populations from North and South Africa that carry the gene for the disease at higher rates than the average population, the same genes are present in populations in India, the Middle East, Southeast Asia, the Mediterranean, and Latin America.[32] In fact, the gene is found wherever malaria has been a historically pervasive disease. Researchers speculate that this gene is so common in these areas because the shape of the sickle cell red blood cells make individuals with the disorder less capable of developing malaria – it is essentially an evolutionary adaptation to a region specific disease.[33] Despite the universalness of the disease, it is routinely taught in medical schools as an ailment that is particular to the Black population.[34] Due to this false pattern recognition, a wide swath of the population that is susceptible to sickle cell anemia are assumed to not be capable of developing the disease.

While there has yet to be research that quantifies the scope of this problem, anecdotal evidence confirms the impact of race-central diagnosis from another angle. In a 2004 essay, emergency doctor Dr. Richard Garcia recounts how a Black friend who had cystic fibrosis was not formally diagnosed until age eight.[35] Typically, cystic fibrosis is diagnosed within the first six months of a child's life.[36] Moreover, when the patient was finally diagnosed, it was not thanks to a particularly pensive physician, but a radiologist who only saw the patient through the gray-scale X-ray film. Garcia ends the recount with the assertion, "if she had been a white child,

---

[31] Allison, Anthony Clifford. "Polymorphism and natural selection in human populations." In *Cold Spring Harbor symposia on quantitative biology*, vol. 29, pp. 137-149. Cold Spring Harbor Laboratory Press, 1964.

[32] Allison, Anthony C. "The distribution of the sickle-cell trait in East Africa and elsewhere, and its apparent relationship to the incidence of subtertian malaria." *Transactions of the Royal Society of Tropical Medicine and Hygiene* 48, no. 4 (1954): 312-318.

[33] Aidoo, Michael, Dianne J. Terlouw, Margarette S. Kolczak, Peter D. McElroy, Feiko O. ter Kuile, Simon Kariuki, Bernard L. Nahlen, Altaf A. Lal, and Venkatachalam Udhayakumar. "Protective effects of the sickle cell gene against malaria morbidity and mortality." *The Lancet* 359, no. 9314 (2002): 1311-1312.

[34] Tsai, Jennifer W. "You Can't Tell a Book by Its Cover - or a Disease by Drake's Race." STAT, July 10, 2018. https://www.statnews.com/2018/07/11/disease-race-associations-drake/.

[35] Garcia, Richard S. "The misuse of race in medical diagnosis." *Pediatrics* 113, no. 5 (2004): 1394-1395.

[36] Farrell, Philip M., Beryl J. Rosenstein, Terry B. White, Frank J. Accurso, Carlo Castellani, Garry R. Cutting, Peter R. Durie et al. "Guidelines for diagnosis of cystic fibrosis in newborns through older adults: Cystic Fibrosis Foundation consensus report." *The Journal of pediatrics* 153, no. 2 (2008): S4-S14.

she would probably have gotten the correct diagnosis and treatment much earlier." Perhaps all doctors might all aspire to be like that radiologist, unaffected by the illusions of race and attuned only to signs and symptoms presented by the ailing body. And yet, that kind of dogged, myopic focus on race as an inherent cause of ailment by so many in the medical profession is part of why the medical field seems to trail behind other fields of human study like anthropology, sociology, and psychology in understanding that racism is present in the body even if race is not. What is required is an approach treating health in marginalized communities that is race-conscious but not race-centered, a perspective that recognizes race not as an essential category, but as a social construction that is indicative of an unseen, but omnipresent constellation of systemic discrimination. However, mainstream medicine and medical education, so eager to make up for the sins of race-blindness, and the still graver sins of racist medical practices, have struggled to find language and terminology that capture the reality of human difference. A significant source of this difficulty lies in the legacy of race-conscious approaches to medicine

The Origins of Race-Conscious Approaches to Health

Race conscious approaches to health have existed as long as the concept of race itself. Though awareness of difference has been a hallmark of human society, race as the codified taxonomy as we recognize it today first took hold during the enlightenment period.[37] This was borne partly from the increasing amount of colonial exploration[38] leading to greater interaction with "new" people who looked different, the resulting need to rationalize slavery and colonialism as an exploitation of naturally inferior beings,[39] and a renewed cultural interest in quantifying and classifying the observable world.[40] Prior to its use to describe humans, the term race was used exclusively for domesticated animals, but French naturalist Louis Le Clerc brought the term

---

[37] Yudell, Michael. "A short history of the race concept." *Race and the Genetic Revolution: Science, Myth, and Culture* (2011): 13-30.

[38] Lafuente, Antonio. "Enlightenment in an imperial context: Local science in the late-eighteenth-century Hispanic world." *Osiris* 15 (2000): 155-173.

[39] Clark, William, Jan Golinski, and Simon Schaffer, eds. *The sciences in enlightened Europe*. University of Chicago Press, 1999.

[40] Tyson, Thomas N., and David Oldroyd. "Accounting for slavery during the Enlightenment: Contradictions and interpretations." *Accounting History* 24, no. 2 (2019): 212-235.

into common usage in his analysis of human difference that he deduced as being caused by climatic variety.[41] Carolus Linnaeus, the Swedish naturalist responsible for the taxonomic system of species we use currently, is responsible for cementing the scientific veneer of racial difference, with his classifications of the "natural system" being the prototype for today's racial groups; *Americanus, Asiaticus, Africanus*, and *Europeaeus*, groups that he distinguished using physical as well as behavioral and moral characteristics.[42] Johan Blumenbach then in the 18th century, massaged these terms into the more familiar *Caucasian*, *Mongolian*, *Ethiopian*, *American*, *and Malay*.[43] From then on, the racial taxonomies and accompanying hierarchies flourished throughout different societies across Europe and the rest of the world, some verging on the ornate, as in the sixteen different racial groupings of "*La Casta*" in the Spanish Colonies, [44]while others remained bluntly self-explanatory, as in the distinctions of white, black and coloured in 18th century South Africa.[45] What remained consistent amongst the classifications, however varied, was a faith in the meaningful, biological difference implied by racial categories. As the medical sciences became more capable of assessing the human body, their advances furthered the perpetuation of the myth of racial difference.

"And is this difference of no importance?"[46] Thomas Jefferson, on the topic of racial distinctions, pondered in "*Notes on the State of Virginia*." The work, often considered to be one of the most important published documents of the 18th century, was a veritable American almanac, offering insight on various geographic, political, economic, and social aspects of the then-young country. The text was the first American perspective on the character of the "Negro"

---

[41] Bindman, David. *Ape to Apollo: Aesthetics and the Idea of Race in the 18th Century*. Cornell University Press, 2002.

[42] Smedley, Audrey. *Race in North America: Origin and evolution of a worldview*. Routledge, 2018.

[43] Junker, Thomas. "Blumenbach's racial geometry." *Isis* 89, no. 3 (1998): 498-501.

[44] Bustamante, Adrian. "" The Matter Was Never Resolved": The" Casta" System in Colonial New Mexico, 1693-1823." *New Mexico Historical Review* 66, no. 2 (1991): 143.

[45] Deacon, Harriet. "Racism and medical science in South Africa's Cape Colony in the mid-to late nineteenth century." *Osiris* 15 (2000): 190-206.

[46] Jefferson, Thomas. *Notes on the State of Virginia ; Written in the Year 1781, Somewhat Corrected and Enlarged in the Winter of 1782, for the Use of a Foreigner of Distinction, in Answer to Certain Queries Proposed by Him ... 1782*. Paris, printed, 1784.

to be published, as well as the first to infer an innate inferiority of Black people. The writings

reveal Jefferson's staunchly abolitionist conclusions, convictions he held despite owning slaves

himself, as well as his rationalizations for why emancipated blacks could never remain in

America. Aside from the historic animosity, prejudice and injustice that existed between the two

groups, Jefferson also cited the "unfortunate difference of colour, and perhaps of faculty"[47] as

grounds in and of themselves. In *Notes*, the founding father recounts the myriad biological and

behavioral differences that conspire to divide the races perpetually; "they secrete less by the

kidneys and more by the glands of the skin…[which] renders them more tolerant of

heat…perhaps too a difference of structure in the pulmonary apparatus…they seem to require

less sleep…in general, their existence appears to participate more of sensation than reflection."[48]

These musings, however ungrounded, gained quick and permanent traction in American

medicine.

Fifty years after *Notes*' publishing, Samuel Cartwright, a Louisiana surgeon and

psychologist, provided some quantitative heft to Jefferson's passing suppositions on the

biological differences between races. Using a spirometer, a device that assesses lung capacity, he

recorded a "deficiency in the negro [lungs] of 20 per cent"[49], a deficiency that he inferenced was

responsible for the "debasement of the mind,"[50] as the impaired lungs prevented adequate blood

flow and development of the brain and higher faculties. In Cartwright's estimations, the smaller

lung capacity was "the true cause of their indolence and apathy,"[51] symptoms that were part of a

Black-specific disease that he dubbed *dysaesthesia aethiopica*. Thankfully, he had also

discovered a cure to the ailment; a slap with a "broad leather strap"[52] followed by forced labor in

the sunshine. As disturbing as the conclusions may seem, the influence that Cartwright and the

---

[47] Ibid.

[48] Ibid., 148-149

[49] Cartwright, Samuel A. "Report on the Diseases and Physical Peculiarities of theNegro Race." *Part II],
NOM&SJ* 8 (1851): 187-94.

[50] Ibid.

[51] Ibid.

[52] Ibid.

menagerie of pseudo-scientific findings he documented in the "Report on the Diseases and Physical Peculiarities of the Negro Race" had on American medicine was long-reaching. Strengthened by the findings of individuals like Cartwright, the concept of a racial difference in pulmonary biology was endorsed by Benjamin Apthorp Gould, who was commissioned by the US Sanitary Commission in 1864 to conduct a large-scale anthropomorphic survey of white and black Union soldiers following the civil war.[53] Using the same tool to measure lung capacity that Samuel Cartwright had popularized in the U.S., Gould had come to the same conclusion as the Louisiana physician. What distinguished Gould's work from Cartwright's, and what marks perhaps the first iteration of racism in medicine that is reminiscent of today's, is that Gould's conclusions are driven less by bigoted conjecture, and more by the appeal of quantitative methods. But an inspection of the influential study reveals that the paper is little more than a series of tables followed by an apparently unbiased assessment of the data; "this great difference…cannot fail to attract attention at first glance." It was these kinds of claims to objectivity that allowed racism and racial essentialism to rise through the ranks of the medical sciences and society.

Fredrick Hoffman, the chief statistician for the Prudential Life Insurance in 1891 and president of the American Statistical Association in 1911 wielded Gould's numbers in a justification for higher life insurance premiums for Black people citing it as proof of an "inferior physical organism."[54] Given the precedence of the idea, it is no wonder racial differences in lung capacity was listed a key finding in a 1925 educational text for pulmonologists published by JE Meyers.[55] As for Cartwright's pivotal tool, the spirometer, it is considered one of the standards of pulmonary assessment to this day. While the device has undergone several changes over the past two hundred years, one aspect that has remained the same is its sensitivity to racially-bound differences. Standard spirometers in the United States apply a "correction factor" of ten to fifteen

[53] Gould, Benjamin Apthorp. *Investigations in the military and anthropological statistics of American soldiers*. Vol. 2. US sanitary commission, 1869.

[54] Hoffman, Frederick Ludwig. *Race traits and tendencies of the American Negro*. Vol. 11, no. 1-3. American Economic Association, 1896.

[55] Myers, Jay Arthur. *Vital capacity of the lungs: A handbook for clinicians and others interested in the examination of the heart and lungs both in health and disease*. Williams & Wilkins, 1925.

percent for individuals identified as black and four to six percent for those identified as Asian.[56] This built-in bias implicates thousands of clinicians in the perpetuation of the same assumptions of racial inferiority that were conceived in the minds of slave owners and white supremacists. Indeed, both the Joint Working Party of the American Thoracic Society/European Respiratory Society and the National Institute for Occupational Safety and Health recommend the use of race- and ethnic-specific references values in their training and education guides.[57,58]

This consensus has persisted in spite of the fact that a majority of the 226 studies concerning racial differences published since 1922 don't offer definitions of race or ethnicity.[59] Ninety-four percent of the articles overlook the impact of socioeconomic status on lung capacity, and only roughly a quarter of the studies cite environmental or social factors.[60] An acceptance of a racial difference in lung capacity undermines efforts to understand and mitigate the true culprits of inequality; disparate access to quality health care,[61] unequal exposure toxins and pollutants,[62] and interpersonal biases.[63] While current misconceptions about race are significantly different from the kinds that were birthed in the 18th, 19th, and 20th centuries, they bear a few central resemblances in how they handle race. By making race a primary metric of health disparity analysis and education, physicians and educators have and continue to reaffirm race's legitimacy in the medical vocabulary, as standard and real as the bones and organs that they study and treat. Both old and new approaches to race in medicine consider race central to the

---

[56] Hankinson, John L., John R. Odencrantz, and Kathleen B. Fedan. "Spirometric reference values from a sample of the general US population." *American journal of respiratory and critical care medicine* 159, no. 1 (1999): 179-187.

[57] Pellegrino, Riccardo, G. Viegi, V. Brusasco, R. O. Crapo, F. Burgos, R. E. A. Casaburi, A. Coates et al. "Interpretative strategies for lung function tests." *European respiratory journal* 26, no. 5 (2005): 948-968.

[58] SPIROMETRY, NIOSH. "NIOSH Spirometry Training Guide." (2003).

[59] Braun, Lundy, Melanie Wolfgang, and Kay Dickersin. "Defining race/ethnicity and explaining difference in research studies on lung function." *European Respiratory Journal* 41, no. 6 (2013): 1362-1370.

[60] Ibid.

[61] Burney, P., D. Jarvis, and R. Perez-Padilla. "The global burden of chronic respiratory disease in adults." *The International Journal of Tuberculosis and Lung Disease* 19, no. 1 (2015): 10-20.

[62] Hegewald, Matthew J., and Robert O. Crapo. "Socioeconomic status and lung function." *Chest* 132, no. 5 (2007): 1608-1614.

[63] Van Sickle, David, Sheryl Magzamen, and John Mullahy. "Understanding socioeconomic and racial differences in adult lung function." *American journal of respiratory and critical care medicine* 184, no. 5 (2011): 521-527.

question of human difference and a credible principle of medical analysis and education that is corroborated, rather than complicated, by statistics and data. Just like Gould's set of tables, the medical field misplaces their trust in observable features and numbers, mistaking statistics for answers in and of themselves. In doing so, they biologize disparities that are often a function of environmental and social factors, repeating the myth of black inferiority amongst other noxious racist ideas.

Along with theologians, and politicians, medical practitioners were among the first professional groups in United States to make concerted efforts to make sense of the racial divide. However, the doctors in early America were endowed with the unique ability to take attitudes about race, whether motivated in political partisanship or religious decree, and shroud them in "objective" deduction. The racial inferiority of Black people as confirmed by physicians of the time was not a matter of racist prejudice or white supremacy, but of lung capacity, of mental ability, of "unfortunate, but undeniable" facts. The apparent neutrality of their findings brought racism and discrimination more into the realm of moral ambiguity, with the findings from these physicians used as arguments against abolition, integration and general equitable treatment. Therefore, as important as the history of race in medicine is for understanding the problems of contemporary race-conscious approaches to healthcare, physicians have played no small part in setting the foundation for beliefs about race that we hold as a society at large today. However, the medical community has not been idle in the face of these longstanding issues; they have engaged in decades long work to divorce themselves from the racism and discrimination that has composed so much of their history. Yet, due to a few key oversights, the mainstream approaches to combatting racism in medicine risk falling into the same faulty logic regarding race and culture that they have so earnestly fought.

Cultural Competency and the Persistence of Race Essentialism

In medicine, cultural competence has been proposed as the individual-level answer to treating health disparities; a pedagogical approach to medicine and healthcare that emphasizes the use of a patient's ethnic, racial, linguistic and religious backgrounds in diagnosis and health communication. This development is a momentous step towards equity in health and treatment. Prompting the medical field to recognize a patient's culture as relevant to perspectives on health

and patient-doctor relationships not only increases patient agency but reaffirms the ideals of humane, empathetic doctoring. Fundamental changes in medicine and clinician practice, like the use of medical interpreters for patients who don't speak English primarily, or the recognition of culturally specific interpretations of diseases like depression, high blood pressure, and anxiety, are in part thanks to doctors advocating for greater cultural competency in the field.[64] Any yet, for all the good that it has done for medicine, cultural competence is far from a sufficient framework for conceptualizing health disparity. Moreover, the flaws present in a purely culturally competent framework threaten to impede more substantive action to solve the issue of race in health.

Perhaps the most glaring problems facing cultural competence is the plurality of its meaning. Despite its prevalence in medical and social work discourse since the 1980's,[65] the term cultural competence itself still eludes a definitional consensus.[66] Though becoming more and more ubiquitous in medical education textbooks and training programs as beneficial approaches to improve physician care and decrease biases in health, what the models discretely entail vary widely from one to the other.[67,68,69] In fact, certain texts question whether cultural competence is a theory, framework or perspective – categories that are meaningfully different as they are bounded by different levels of measurability and accountability (theories must be

---

[64] Gregg, Jessica, 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): 542-547.

[65] Cross, Terry L. "Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed." (1989).

[66] Reitmanova, Sylvia. "Cross-cultural undergraduate medical education in North America: theoretical concepts and educational approaches." *Teaching and Learning in Medicine* 23, no. 2 (2011): 197-203.

[67]Campinha-Bacote, Josepha. "The quest for cultural competence in nursing care." In *Nursing Forum*, vol. 30, no. 4, pp. 19-25. Oxford, UK: Blackwell Publishing Ltd, 1995.

[68] Betancourt, Joseph R. "Cross-cultural medical education: conceptual approaches and frameworks for evaluation." *Academic Medicine* 78, no. 6 (2003): 560-569.

[69] Qureshi, A., F. Collazos, M. Ramos, and M. Casas. "Cultural competency training in psychiatry." *European psychiatry* 23 (2008): 49-58.

replicable and testable, frameworks are multidimensional, and scenario oriented whereas perspectives are stated pedagogical or intellectual approaches.)[70]

Regardless of the final determination, the ambiguity of cultural competence's true meaning across and within disciplines compromises its ability to faithfully adhere to those demands. Much like in the way that race is a socially and geographically malleable concept, making it inappropriate for objective rigors of medical diagnosis, cultural competence's ability to mean so much to so many makes it a pleasant, though relatively ineffective rallying cry amongst medical practitioners. The term is often mistaken for related, though fundamentally different, concepts like cultural sensitivity or cultural proficiency, which are terms that refer more to specific aspects of interpersonal interaction that might be encompassed in culturally competent engagement and relationships. Theorists in cultural competency define it as involving more than concepts like cultural sensitivity or proficiency alone because it involves not only the acquisition of knowledge related to individuals' cultural perspectives, but also the skills to be able to put that knowledge into action.[71] For the ease of dissecting the problems inherent in cultural competence, the definition offered by Larry Purnell, the originator of the Purnell Model for Cultural Competence, might be most applicable, especially its perception by many in medicine as a foundational text on the matter;[72] "*Cultural competence is the adaptation of care in a manner that is consistent with the culture of the client and is therefore a conscious process and nonlinear. A culturally competent health care provider develops an awareness of his or her existence, sensations, thoughts, and environment without letting these factors have an undue effect on those for whom care is provided.*"[73]

---

[70] Gallegos, Joseph S., Cherie Tindall, and Sheila A. Gallegos. "The need for advancement in the conceptualization of cultural competence." *Advances in Social Work* 9, no. 1 (2008): 51-62.

[71] Johnstone, Megan-Jane, and Olga Kanitsaki. "The politics of resistance to workplace cultural diversity education for health service providers: an Australian study." *Race Ethnicity and Education* 11, no. 2 (2008): 133-154.
[72] Hardy, Linda K. "Exploring the concept of race and its implications for health disparities research." *Journal of Theory Construction & Testing* 11, no. 2 (2007): 46.

[73] Purnell, Larry. "The Purnell model for cultural competence." *Journal of transcultural nursing* 13, no. 3 (2002): 193-196.

A review of the Purnell Model points us towards several more of cultural competence's oversights; a conflation of race, culture, and heredity as well as a detrimentally-hyper focus on patient culture in the medical process. The model is composed of 12 sub-domains of knowledge that are necessary for culturally competent care ranging from Communication Style to Family roles, from organizational attributes to differences in spirituality. One domain of particular interest and controversy is that of "bicultural ecology." This domain is comprised of "biological variations, skin color, heredity, genetics, ecology, and drug metabolism." Though this initial model makes careful note to avoid the use of the word race, the same can't be said for the myriad papers and practices that are informed by the work.[74,75,76] Part of this problem arises from the fact that missing from its "major assumptions," which are the practical guidelines that contextualize the model, is a statement clearly articulating how culture is distinct from both heredity and race. Race, being the socially constructed identity given to individuals, is different from heredity, which is the passage of biological and genetic traits from parent to offspring, which is different still from culture, which can be transmitted from parents to children but is often omnidirectional in its passage of information, giving any one within a culture the ability to pass on cultural information to anyone else. Despite the implicit perception that culture is something that is solely race or ethnicity-bound, cultures are present in every aspect of daily life; car-drivers are a culture, soda-drinkers are a culture and, as writer Anne Fadiman made clear in *A Spirit Catches You and You Fall Down*,[77] even doctors have their own culture. More importantly, each of these cultures are just as, if not more, meaningful for someone's health outcomes than

---

[74]Holland, Ann Elizabeth. "The place of race in cultural nursing education: The experience of white BSN nursing faculty." (2011).

[75] Nelson, Jennifer, and Teresa Macias. "Living with a white disease: Women of colour & their engagement with breast cancer information." (2008).

[76] Scott, Maegan. "Developing a racial equity stance: moving philanthropy beyond diversity statements." (2017).

[77] Fadiman, Anne. *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures*. Macmillan, 2012.

their race.[78,79,80] Two individuals who may be both identified as Black, may claim different heredities, such as Haitian or Kenyan. And even two individuals who share the same ethnicity may claim different cultures. The variability of each of the concepts individually is compounded through a conflation of the race, ethnicity and culture as seen in various approaches to culturally competent care. Though cultural competence is an equity minded concept, the idea that one can address disparities of *race* and *ethnicity* through training and education on *culture*, as Purnell and others argue, already reveals the implicit conflation of the three distinct facets. Not only does this narrow the circumstances within which doctors utilize culturally competent processes and perspectives, focusing applicability solely on racial minority populations, but the conflation of culture, race, and ethnicity invariably leads to more serious acts of racism.

In seeking to solve problems that are a function of racism with cultural competence, one risks categorizing issues that affect communities because of their race; issues like poverty, violence, and sickness, as being due to their culture. The mistake of not making clear and standard the differences between race and culture as they pertain to cultural competence not only leads to inaccurate presumptions of a patient's behavior, personal history and worldview, but also to a misunderstanding of what kind of work cultural competence is doing. Cultural competence in most of its definitions does not entail engaging critically with *systemic racism* – which is racism and discrimination that is not a result of one off interpersonal interactions, but instead the combined acts of companies, governments and laws that hinder minorities' abilities to engage in political, economic, health and social activities like voting, social mobility, accessing healthy food or high quality healthcare, and being considered part of the dominant culture – those issues require concerted and distinct efforts in their own right.

---

[78] Siren, Anu, Liisa Hakamies-Blomqvist, and Marjaana Lindeman. "Driving cessation and health in older women." *Journal of Applied Gerontology* 23, no. 1 (2004): 58-69.

[79] Rehm, Colin D., Thomas D. Matte, Gretchen Van Wye, Candace Young, and Thomas R. Frieden. "Demographic and behavioral factors associated with daily sugar-sweetened soda consumption in New York City adults." *Journal of Urban Health* 85, no. 3 (2008): 375-385.

[80] Davidson, Sandra K., and Peter L. Schattner. "Doctors' health-seeking behaviour: a questionnaire survey." *Medical Journal of Australia* 179, no. 6 (2003): 302-305.

Georgetown University's National Center for Cultural Competence recommends a commitment to contending with racism and problems that affect marginalized identities for groups who are interested in engaging in culturally competent medical education.[81] While it is true that the problems and biases that occur as a result of cultural incompetence worsen the effects of discrimination and marginalization, it is a fundamentally separate problem. Culturally competent care alone will not rectify issues of water and food access or segregation. When culture is conflated for race, and therefore cultural competence with undoing racial inequality, the work of dismantling systemic and social influences of health is lumped in with that of cultural competence. Cultural competence's original framework was designed with explicit attention towards improving the interactions between medical staff and patients. Therefore, the implementation of cultural competence as a remedy for the unequal economic, social and political structures that perpetuate racial disparities implies a fundamental misunderstanding of the aims and limitations of the paradigm. The work of undoing systems-level issues of discrimination and health inequity can be approached, but never truly carried out by cultural competence in the same way that a scalpel can never effectively accomplish the tasks of a bone saw. This central misuse transforms cultural competence from an arguably legitimate treatment for the particular issue of cultural bias to a panacea for every race-related problem in health, obscuring the other necessary forms of work that must take place.

Another predication of cultural competence is the idea that culture is a bounded, finite concept. Even the phrasing of "competence" conveys the idea of a potential mastery of the subject. It is true that the term culture refers to a set of behaviors and perspectives that communities use to make sense of the world, however it is rarely the case that the behaviors are discrete enough to faithfully apply on individual bases. Describing culture as a fixed, knowable entity risks overlooking the fluidity of culture. A growing consensus of anthropologists confirms that within the United States, there does not exist any discrete ethnic, linguistic, or other cultural group that does not grow and change as a result of interactions with other cultures – ranging

---

[81] Gregg, Jessica, 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): 542-547.

from sexual to religious, gender, or socioeconomic dimensions.[82,83] This sentiment clashes with

the assumption of the numerous cultural competence tests, assessments, and training programs

present in the medical field – that cultural competence is something that one can "ace" let alone

test.[84] Even though culture is a social object that is coherent from a community level view – we

can accurately list holidays that Italians celebrate, or the death rituals that may be particular to

Argentineans – on the personal level, culture nears infinite context dependency, being influenced

by factors like age, geography and years in the United States to name a few. As frustrating as the

conclusion that one may never fully comprehend the culture of others may be, it is imperative

that the healthcare field face the messy complexity of culture at face value, as opposed to

collapsing it into a quantifiable, and learnable metric. Witling culture down to a "useful" metric

in diagnostic contexts sacrifices the reality of our social world for analytic utility. This issue is

most on display in observing cultural competence's perspective on one of the most fundamental,

yet inaccurate traditions of diagnosis in medicine; physical examination.

Mosby's Guide to Physical Examination is one of the most well-known educational texts

concerning the initial steps of patient interaction – assessment and diagnosis.[85,86,87] However, it is

not unique in its first instructions — all doctors are taught to record a patient's "age, sex, race

[and] general appearance"[88] at the beginning of any physical examination. Over the course of

---

[82] Knauft, Bruce M. *Genealogies for the present in cultural anthropology*. Psychology Press, 1996.

[83] Gregg, Jessica L. *Virtually virgins: sexual strategies and cervical cancer in Recife, Brazil*. Stanford University Press, 2003.

[84] Kumas-Tan, Zofia, Brenda Beagan, Charlotte Loppie, Anna MacLeod, and Blye Frank. "Measures of cultural competence: examining hidden assumptions." *Academic Medicine* 82, no. 6 (2007): 548-557.

[85] Verghese, Abraham, Blake Charlton, Brooke Cotter, and John Kugler. "A history of physical examination texts and the conception of bedside diagnosis." *Transactions of the American Clinical and Climatological Association* 122 (2011): 290.

[86] Gregg, Jessica, and Somnath Saha., 2006

[87] Seidel, Henry M., Jane W. Ball, Joyce E. Dains, and G. William Benedict. *Mosby's guide to physical examination*. St Louis: Mosby, 2006.

[88] Ibid., pg 865

medical history, these attributes have gained the highest priority in their relevancy to treatment.[89] And while cogent arguments can be made for how a patient's age or sex may entail vital information that instructs any following procedures, race's place amongst those set of features remains fast, regardless of its inutility in the diagnostic process.

For reasons described earlier, race is extremely limited in the information it reliably provides about a patient's health – keep in mind that it does not overlap cleanly with ideas of culture or ethnicity. And yet, its proximity to important and relevant factors and its primacy in the diagnostic process implicitly recapitulate the idea that race is an essential factor of an individual's health. More often than not, the role of race identification falls onto the doctor,[90] who, bound by the categories set by the Office of Management and Budget for federal data collection uses, must choose between "American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or White"[91] for race and "Hispanic or Latino; Not Hispanic or Latino"[92] for ethnicity. Previous medical studies have already pointed out the inappropriateness of labelling Hispanic to be a coherent ethnicity (it is the equivalent of grouping every English-speaking country together as an ethnicity).[93] Furthermore, requesting doctors to intuit a patient's race from physical features further legitimizes the legacy of race essentialism in medicine. If race is such a critically important tool of the diagnostic process, why is it left to the subjective interpretation of the physician, who's racial experience and history color who they see as any given race? Put concisely by Acquaviva and Mintz in their 2010 paper, "*how you perceive a patient's race or ethnicity is not a piece of clinical data about the patient but rather a piece of data about your own assumptions about what*

---

[89] Caldwell, Stephen H., and Rebecca Popenoe. "Perceptions and misperceptions of skin color." *Annals of internal medicine* 122, no. 8 (1995): 614-61

[90] Acquaviva, Kimberly D., and Matthew Mintz. "Perspective: are we teaching racial profiling? The dangers of subjective determinations of race and ethnicity in case presentations." *Academic Medicine* 85, no. 4 (2010): 702-705.

[91] Tabulation Working Group. "Interagency Committee for the Review of Standards for Data on Race and Ethnicity. Provisional Guidance on the Implementation of the 1997 Standards for Federal Data on Race and Ethnicity. December 15, 2000."

[92] Ibid.

[93] Kaplan, Judith B., and Trude Bennett. "Use of race and ethnicity in biomedical publication." *Jama* 289, no. 20 (2003): 2709-2716.

a white, black, Hispanic, or Asian individual 'looks' like." Even if we were to entertain the idea

that race is accurate in its indications about an individual's health, visual assessments of race

conducted by physicians often times conflict with patients' self-reported races.[94,95] However,

instead of being a meaningful act of health contextualization, highlighting an individual's race in

their treatment can lead to greater disparities in care, as is the case in individuals who are

identified as Black being more likely to be treated with higher doses of antipsychotics or those

who are identified as Black being more often denied life-improving medication for chronic

pain.[96,97] While thought to be beneficial in shedding light on race-bounded illnesses, using race

as an introductory and elementary component of diagnosis is not only inaccurate and unhelpful

to that end, but makes the patient susceptible to a host of explicit and implicit biases by making

their race salient to practitioners.

Each of the faults of cultural competence are made plainer when they are situated in the

history of race and health. Culture and ethnicity are conflated with race due to the medical field's

history of masking the reality of human difference under pseudo-scientific taxonomies. Cultural

competency is seen as a quantifiable metric because of medicine's historical predisposition

towards over-relying on quantifiable and observable information. Moreover, cultural competence

training is seen as a salve not only for biases that exist between doctors and patients, but for

systemic level discrimination in part because of the culture-ethnicity-race conflation but also

because of a hyper-focus on the body that was already present in medicine and was reiterated by

cultural competency's person-focused pedagogies. Taking these considerations into account, it

becomes clear that cultural competence, while useful as a framework in limited ways, is

therefore an insufficient solution to racial disparities in health and medical practice. Treating the

[94] Jones, Camara Phyllis. "Invited commentary:"race," racism, and the practice of epidemiology." *American journal of epidemiology* 154, no. 4 (2001): 299-304.

[95] Kressin, Nancy R., Bei-Hung Chang, Ann Hendricks, and Lewis E. Kazis. "Agreement between administrative data and patients' self-reports of race/ethnicity." *American journal of public health* 93, no. 10 (2003): 1734-1739.

[96] Walkup, James T., Donna D. McAlpine, Mark Olfson, Larissa E. Labay, Carol Boyer, and Stephen Hansell. "Patients with schizphrenia at risk for excessive antipsychotic dosing." *The Journal of clinical psychiatry* (2000).

[97] Burgess, Diana Jill, Megan Crowley-Matoka, Sean Phelan, John F. Dovidio, Robert Kerns, Craig Roth, Somnath Saha, and Michelle van Ryn. "Patient race and physicians' decisions to prescribe opioids for chronic low back pain." *Social science & medicine* 67, no. 11 (2008): 1852-1860.

stubborn illness of racism requires further work. Such necessary developments in the field of health disparity education are the concepts known as cultural humility, critical health studies, and structural competency.

Cultural Humility, Critical Health Studies and Structural Competency

Cultural Humility

One of cultural competence's strongest attributes is its stated focus on the cultural distance that exists between practitioners and their patients. However, one of the initial missteps in its approach lies in the assumption that this distance could be overcome by acquiring a finite body of knowledge. It seems intuitive that a field that is hallmarked by assessment in traditional formats (from the Medical College Admissions Test to the United States Medical Licensing Examinations) would treat cultural competence as yet another set of competences that can and should be assessed. The reasoning behind such an approach is clear; it is useful to give individuals an objective measure of their skills, knowledge and progress in the process of learning a set of skills, and even more helpful to indicate to them when they've achieved a level of mastery. Yet, when truly put to the test, the effect of cultural competence trainings is called into question. In a review by Lie et al. that examined two hundred and fifty one studies between 1990 and 2010 that reported cultural competence educational interventions for those in the medical field, and also measured the impact of the programs on patient outcomes and healthcare utilization, only two studies confirmed a positive effect.[98] According to Butler et al., out of 37,000 citations concerning cultural competence trainings with respect to LGBTQ populations, no study measured the effect of cultural competence interventions on health care disparities outside of psychometric evaluations such as satisfaction with care and other attitudinal changes. A 2014 review by Zuwang Shen of cultural competence models and assessment instruments published by nurse researchers since 1982. corroborated those findings, concluding that few models were empirically tested, and event fewer utilized model-specific instruments.[99]

---

[98]Butler, Mary, Ellen McCreedy, Natalie Schwer, Diana Burgess, Kathleen Call, Julia Przedworski, Simon Rosser et al. "Improving cultural competence to reduce health disparities." (2016).

[99] Shen, Zuwang. "Cultural competence models and cultural competence assessment instruments in nursing: a literature review." *Journal of Transcultural Nursing* 26, no. 3 (2015): 308-321.

These findings do not suggest that the aims of cultural competence are unachievable, but instead that defining the process of learning about the influence of culture on people's lives, thoughts, and perspectives on health encompasses much more than could be contained within any singular training or study. Knowing this, operating under the belief that cultural competence can be totally achieved at all can undermine the very ideals that it sets out. Take the example described in Melanie Tervalon Jann Murray-García's critique of cultural competence in 1998; "*An African American nurse is caring for a middle-aged Latina woman several hours after the patient had undergone surgery. A Latino physician on a consult service approached the bedside and, noting the moaning patient, commented to the nurse that the patient appeared to be in a great deal of postoperative pain. The nurse summarily dismissed his perception, informing him that she took a course in nursing school in cross-cultural medicine and "knew" that Hispanic patients over- express "the pain they are feeling*."[100] The nurse, under the assumption that she was sufficiently empowered and informed by a single cultural competence class, allowed the perceptions of her own competence to overrule the signals of patient distress that were obvious to the passing practitioners. As soon as a finish line is set on the road to cultural competence, clinicians will naturally assume that their journey is done. Clearly, what is called for is something more akin to cultural humility.

Cultural humility, as an alternative approach to bridging the patient-doctor divide, sets itself apart from cultural competence by establishing itself as a lifelong pursuit, punctuated by vigilant and continuous self-reflection and self-critique. Cultural humility retains the same pathos as cultural competence, but it differentiates itself from the mainstream paradigm by refusing to equate culture to other bodies of knowledge in the medical field out of a recognition of the sheer multiplicity of experience that culture entails. Once something that is as fluid, dynamic, and varied as culture is defined as a "master-able" body of knowledge, it can lead to a false sense of security that causes medical staff to not only over-estimate their understanding of a patient's particular circumstances, but apply harmful and incorrect stereotypes in the process. One of the

---

[100] Tervalon, Melanie, and Jann Murray-Garcia. "Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education." *Journal of health care for the poor and underserved* 9, no. 2 (1998): 117-125.

first admissions of cultural humility is that it is "impossible to be adequately knowledgeable about cultures [that are not your own]"[101]

Instead of seeking mastery on the subject, cultural humility advises clinicians to look to *patients* as valuable sources of information about their own experience with their culture and their illness. In fact, despite patients having this wealth of knowledge, their expertise are often times underutilized by doctors. In a study that analyzed dialogue between physicians and patients, it was found that over ninety percent of the questions were physician-initiated.[102,103] The assumption embedded in this disparity is that physicians' analyses of a patient's illness are paramount to the process of treatment and healing, more important even than patients' own interpretations of their ailments. A shift from a culturally competent approach to one of cultural humility not only serves to reduce the burden on physicians to be experts on the intricacies of other's cultures, but also asserts a more equitable dynamic between doctor and patient in which both have legitimate claims to knowledge that are vital to successful, mindful patient care. Given that cultural humility is a career-long pursuit, an ideal education in cultural humility wouldn't concern itself so much with teaching clinicians about the cultures that they may encounter in their careers, but rather equipping them with the tools that would allow them build earnest, clear and meaningful rapport with their patients. When thinking about how to teach doctors to upend the power dynamics that they are complicit in, the same techniques from critical pedagogies in education at large are endorsed. A review of alternative pedagogies in Medicine by Tsevat et al., suggests first engaging students not from the perspective of an educator or didact, but a "co-learner" in the suggestion of education philosophers like Paulo Friere.[104,105] Pedagogical

---

[101] Levi, Amy. "The ethics of nursing student international clinical experiences." *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 38, no. 1 (2009): 94-99.

[102] Beckman, Howard B., and Richard M. Frankel. "The effect of physician behavior on the collection of data." *Annals of Internal medicine* 101, no. 5 (1984): 692-696.

[103] Platt, Frederic W., and Jonathan C. McMath. "Clinical hypocompetence: the interview." *Annals of Internal Medicine* 91, no. 6 (1979): 898-902.

[104] Tsevat, Rebecca K., Anoushka A. Sinha, Kevin J. Gutierrez, and Sayantani DasGupta. "Bringing home the health humanities: narrative humility, structural competency, and engaged pedagogy." *Academic Medicine* 90, no. 11 (2015): 1462-1465.

[105] Freire, Paulo. *Pedagogy of the oppressed*. Bloomsbury publishing USA, 2018.

approaches like co-creation of curricula, establishing class values and personal agency help to mirror the kind of hierarchy-eroding behavior that students should bring to the examination rooms.[106] Outside of the classroom, E-shien Chang, Melissa Simon, XinQi Dong endorse the "QIAN curriculum," which highlight the importance of self-Questioning and critique, bi-directional cultural Immersion, mutually Active-listening, and flexibility of Negotiation as core[107] behaviors in interacting with patients and communities. Such pedagogies are already being readily applied in programs like Columbia University's Master of Science in Narrative Medicine[108] and the Medical Humanities and Narrative Medicine Program at Temple University's Lewis Katz School of Medicine,[109] and can provide a robust model for more formal integration of concepts of cultural humility into mainstream medical education.

Critical health studies

Similar to cultural humility, critical health studies (CHS) is distilled from the best aspects of cultural competence education. Frameworks like the Purnell Model, for all of their misperceptions, fundamentally desire to engage learners in thoughtful reflection of the dynamics that they take part in. Where these models fall short is in their scope; not only of the social and societal factors that are involved in patient health, but the pedagogical strategies that are used in their deployment. In "A Silent Curriculum," Katherine Brooks illustrates the problem well: "*It wasn't that I didn't receive any education on race. In fact, there have been many well-intentioned curricular attempts to understand the intersections between race and medicine. Since first year, I've been inundated with lecture PowerPoint slides that list dis- eases with higher rates among minorities. But few of them delved into an explanation as to why these dis- parities*

---

[106] Angoff, Nancy R., Laura Duncan, Nichole Roxas, and Helena Hansen. "Power day: addressing the use and abuse of power in medical training." *Journal of bioethical inquiry* 13, no. 2 (2016): 203-213.

[107] Chang, E-shien, Melissa Simon, and XinQi Dong. "Integrating cultural humility into health care professional education and training." *Advances in health sciences education* 17, no. 2 (2012): 269-278.

[108] Miller, Eliza, Dorene Balmer, Ms Nellie Hermann, Ms Gillian Graham, and Rita Charon. "Sounding narrative medicine: Studying students' professional identity development at Columbia University College of Physicians and Surgeons." *Academic medicine: journal of the Association of American Medical Colleges* 89, no. 2 (2014): 335.

[109] Cole, Thomas R., Nathan S. Carlin, and Ronald A. Carson. *Medical humanities: an introduction*. Cambridge University Press, 2014.

exist."[110] Brooks' account is one that is unfortunately all too common. A review of cultural competency programs offered for healthcare providers by Beach et al. revealed a broad range of activities that were considered applicable to cultural competence education, ranging from medical translation to international study and practice. Yet, only two of the thirty-four studies reviewed involved discussions of racism at all.[111] A related 2016 study searching throughout across all of PubMed, one of the largest search engines for medical and health related studies, yielded just thirty-five entries with two of them relating directly to medical education.[112] For comparison, a cursory search of an extremely rare connective tissue disease known *as Fibrodysplasia Ossificans Progressiva* receives a modest count of 2,554 as of March 2020.

The paucity of teaching about race in these important ways begs the question; how can an educational endeavor succeed in its aim of mitigating the impact of racism in health if it does not at first go as far as to name racism and its most basic mechanisms? These curricula are often not based on the true tenants of cultural competence but rather multiculturalism, which is understood as the tolerance and accommodation of nondominant colors. While multiculturalism is a helpful component, a cultural competence pedagogy that is anything less than anti-racist—made with an explicit and concerted attention to identifying the ways that racism affects every aspect of medicine from how doctors interact with patients to where hospitals are located—is doomed to be insufficient. Understanding this necessity, recent researchers have looked towards other fields for wisdom, drawing upon Critical Race Theory (CRT) in particular.

Critical Race Theory has its origins in legal studies during the 1980's, but is considered an interdisciplinary venture of sociological, ethnic, cultural and education studies to make legible

---

[110] Brooks, Katherine C. "A silent curriculum." *Jama* 313, no. 19 (2015): 1909-1910.

[111] Beach, Mary Catherine, Eboni G. Price, Tiffany L. Gary, Karen A. Robinson, Aysegul Gozu, Ana Palacio, Carole Smarth et al. "Cultural competency: A systematic review of health care provider educational interventions." *Medical care* 43, no. 4 (2005): 356

[112] Wear, Delese, Joseph Zarconi, Julie M. Aultman, Michelle R. Chyatte, and Arno K. Kumagai. "Remembering Freddie Gray: medical education for social justice." *Academic Medicine* 92, no. 3 (2017): 312-317.

the dominant ideologies of race and culture that perpetuate inequality.[113] In the words of Daniel Solorzano, a renowned critical race theorist, the goal of CRT is to "identify, analyze, and transform those structural and cultural aspects of society that maintain the subordination and marginalization of People of Color."[114] One of the theory's most fundamental arguments is that the presumption of race-neutrality in society's economic, legal and social structures is a gross, and dangerous misconception.[115] As it has been able to do for researchers and scholars in countless other fields, CRT can endow healthcare providers with a meaningful appreciation for the ways that race-based inequality affects the health and lives of patients and peers. Most appropriately for medical education, CRT can help elucidate the assumptions and biases of medical curricula themselves, offering another site of anti-racist intervention. Western medicine and medical education is often assumed to be value neutral by virtue of its objectivity, what some theorists have referred to as having "a culture of no culture."[116] However, if confrontations with manifestations of racism end at the classroom doors, this presumed neutral culture often recapitulates the societal and cultural (which are to say white and racist) norms of medical education.[117] Problematic concepts like race essentialism, "race correcting factors," and race-linked diseases become mainstays in medical education because their sociological and biological implications have not been critically exposed and dissected. A true integration of CRT into medical education, under the name of Critical health studies (CHS) would allow training physicians to break the cycles of racism that have continued in the field since the dawn of health education in the United States.

Fortunately, several schools have begun to engage in curricula that serve as robust models for how CHS could take shape in standard medical education. In 2016, medical students

---

[113] Crenshaw, Kimberlé, Neil Gotanda, Gary Peller, and Kendall Thomas. "Critical race theory." *The Key Writings that formed the Movement. New York* (1995).

[114] Solorzano, Daniel G. "Images and words that wound: Critical race theory, racial stereotyping, and teacher education." *Teacher education quarterly* (1997): 5-19.

[115] Delgado, Richard, and Jean Stefancic. *Critical race theory: An introduction*. Vol. 20. NYU Press, 2017.

[116] Taylor, Janelle S. "Confronting "culture" in medicine's "culture of no culture"." *Academic Medicine* 78, no. 6 (2003): 555-559.

[117] Kuper, Ayelet. "When I say… cultural knowledge." *Med Educ* 48, no. 12 (2014): 1148-9.

at the Icahn School of Medicine at Mount Sinai have created an elective course that specifically focuses on critical theory and activism's role in medicine.[118] Similarly, a student-supported elective in structural inequality at Brown University Schools has been running, open to all years, since 2013.[119] The Social Justice Vertical Integration Group at the Geisel School of Medicine at Dartmouth have been convened to define and incorporate core matters of social justice education into the school's curriculum as a part of its larger curricular redesign, which saw its first students this past year.[120] The University of Carolina School of Medicine houses full departments dedicated to social medicine, with space preserved in the first two years of curriculum.[121]

The University of Michigan Medical School has perhaps the most rigorous in their integration and breadth of CHS in their curriculum.[122] Topics of racism, cultural competence and are incorporated by way of lectures and group discussions over the first two years of medical student's education; taking place mainly in a clinical foundations skills course, a longitudinal case studies course, and an experiential learning program concerning patient-centered care. The fact that these are courses central to mainstream medical education, as opposed to elective or alternative classes, is indicative of the program's recognition of racism's centrality to understanding unequal care. In the longitudinal case studies course and clinical foundations skills course in particular, students are encouraged to interrogate issues of health equity and race in small groups of ten to twelve that are led by the same clinician facilitator for the duration of the first two years. The designed intimacy and familiarity of the discussion groups is intended to ease the expected discomfort that talking about difficult, and often messy realities. Prior to

---

[118] Garvey, Amy, Denzel R. Woode, Charlotte S. Austin, and White Coats for Black Lives National Working Group. "Reclaiming the white coat for Black lives." (2016): 1749-1751.

[119] Braun, Lundy. "Theorizing race and racism: preliminary reflections on the medical curriculum." *American journal of law & medicine* 43, no. 2-3 (2017): 239-256.

[120] Coria, Alexandra, T. Greg McKelvey, Paul Charlton, Michael Woodworth, and Timothy Lahey. "The design of a medical school social justice curriculum." *Academic Medicine* 88, no. 10 (2013): 1442-1449.

[121] Austin, Charlotte, A. Crawford-Roberts, M. Kahn, G. Lynch, C. Mirand, and L. Ostrer. "Beyond implicit bias: a medical student course of race and racism in medicine." In *144th Annual Meeting of the American Public Health Association*. 2016.

[122] Kumagai, Arno K., and Monica L. Lypson. "Beyond cultural competence: critical consciousness, social justice, and multicultural education." *Academic medicine* 84, no. 6 (2009): 782-787.

leading the discussions, clinical facilitators and instructors themselves also engage in comprehensive faculty development in order to "facilitate exchanges rather than lecture, to stimulate critical reflection and critical analysis of personal assumptions, biases, values, and perspectives."[123] The meticulousness and integrative nature of the University of Michigan's approach highlights the universality and intentionality with which critical health studies might be best approached in order to ensure progress amongst students and the field of medicine as a whole.

Critical health studies is a powerful tool of internal analysis, reflection and critique. Primarily, CHS teaches physicians how to "read the world" which was Paolo Freire's description of recognizing the difference in power, privilege and inequity that are present in interpersonal and structural dynamics alike.[124] Like a stethoscope, CHS is designed to make apparent the otherwise invisible pedagogies and assumptions of the classroom, the hospital, and other institutions that are symbolic of mainstream medical culture. But neither critical health studies nor the quest for a fulsome cultural competence is sufficient. What is also needed is a framework that prompts doctors to engage in intervention and action on much larger, "structural" scales than the individual patient.

Structural Competency
The notion of structural competency, developed by Johnathon Metzl and Helena Hanson in 2014, is a theory of health composed of five main tenants: 1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure (i.e fluency with describing the social hierarchies that sustain systemic racism); 3) rearticulating "cultural" categorizations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility.[125] These components not only center the real-yet-fabricated natures of race and culture in health through framing an understanding of disparities and

---

[123] Ibid. pg 784

[124] Freire, Paulo. Ibid.

[125] Metzl, Jonathan M., and Helena Hansen. "Structural competency: Theorizing a new medical engagement with stigma and inequality." *Social science & medicine* 103 (2014): 126-133.

healthcare in a discussion of structural influences, but also call upon physicians to recognize themselves and their positions within that structure. By translating race disparities into a series of social dimensions—social, economic, and legal, structural competency makes these inequities more capable of being intervened upon by healthcare providers. Take the following vignette from a 2006 study for example:

> A medical anthropologist is asked by a pediatrician in California to consult in the care of a Mexican man who is HIV positive. The man's wife had died of AIDS one year ago. He has a four-year-old son who is HIV positive, but he has not been bringing the child in regularly for care. The explanation given by the clinicians assumed that the problem turned on a radically different cultural understanding. What the anthropologist found, though, was to the contrary. This man had a near complete understanding of HIV/AIDS and its treatment—largely through the support of a local nonprofit organization aimed at supporting Mexican-American patients with HIV. However, he was a very-low-paid bus driver, often working late-night shifts, and he had no time to take his son to the clinic to receive care for him as regularly as his doctors requested. His failure to attend was not because of cultural differences, but rather his practical, socioeconomic situation. Talking with him and taking into account his "local world" were more useful than positing radically different Mexican health beliefs.[126]

Structural competency recognizes that purely cultural approaches to understanding disparities obscure the discrete and intervenable mechanisms that underlie inequities in health. What was initially the opaque quandary of "Mexican culture" that stumped doctors who were eager to provide quality care was realized to be distinct socioeconomic circumstances that, while are not easily resolvable, give healthcare providers accessible points of advocacy. It begins with acts as simple as integrating structurally relevant questions normally absent from routine medical discharge: "*can you support your basic needs like food, shelter, and clothing? Do you have a primary care provider, and if so, what are the factors that prevent you from visiting (.e., work transportation, money, etc.)? Can you afford your medications?*"[127] From here, physicians can lobby their hospitals to engage in structurally competent interventions like creating healthcare

---

[126] Kleinman, Arthur, and Peter Benson. "Anthropology in the clinic: the problem of cultural competency and how to fix it." *PLoS medicine* 3, no. 10 (2006): e294.

[127] Wang, Ernest E. "Structural Competency: What is it, why do we need it, and what does the structurally competent emergency physician look like?." *AEM Education and Training*.

sites *within* low income communities to increase accessibility,[128,129] developing health-pertinent facilities and resources for communities like childcare,[130.131] or contributing to political campaigns for an increase in the minimum wage through citations of its benefits on qualities of life.[132] In bringing these kinds of actions within the purview of healthcare, structural competency urges an active disruption of the systems of racism, homophobia, and classism that cultural competency does not implicitly demand. Though the name was only coined relatively recently, the necessity of structurally competent perspectives in medicine has been championed for centuries. Following the typhus epidemic in 1848, German physician and politician Rudolf Virchow reasoned "If Medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?"[133] Yet, for some reason, whether it be the pervasive influence of American individualism and bodily autonomy,[134] or a concerted focus on biomedical advancements and frameworks that have defined medical education since America's founding,[135] the connection between society and body became obfuscated to the U.S. physician. It is therefore the responsibility of the medical educators of today to renew that mantle of health as a political and social tool.

---

[128] Pearce, Jamie, Karen Witten, and Phil Bartie. "Neighbourhoods and health: a GIS approach to measuring community resource accessibility." *Journal of Epidemiology & Community Health* 60, no. 5 (2006): 389-395.

[129] Brindis, Claire D., Jonathan Klein, John Schlitt, John Santelli, Linda Juszczak, and Robert J. Nystrom. "School-based health centers: Accessibility and accountability." *Journal of Adolescent Health* 32, no. 6 (2003): 98-107.

[130] Creel, Theresa. "Benefits of hospital-based child care." *SSM* 8, no. 4 (2002): 58.

[131] Powell, Rhea E., Amanda MB Doty, Kristin L. Rising, David N. Karp, Avi Baehr, and Brendan G. Carr. "A content analysis of nonprofit hospital community health needs assessments and community benefit implementation strategies in Philadelphia." *Journal of Public Health Management and Practice* 24, no. 4 (2018): 326-334.

[132] Bhatia, Rajiv, and Mitchell Katz. "Estimation of health benefits from a local living wage ordinance." *American Journal of Public Health* 91, no. 9 (2001): 1398-1402.

[133] Kopelovich, Jonathan C. "Reflections on social activism in otolaryngology." *Otolaryngology–Head and Neck Surgery* 150, no. 3 (2014): 348-349.

[134] Wear, Delese, and Mark G. Kuczewski. "Perspective: medical students' perceptions of the poor: what impact can medical education have?." *Academic Medicine* 83, no. 7 (2008): 639-64

[135] Hewa, Soma, and Robert W. Hetherington. "Specialists without spirit: Limitations of the mechanistic biomedical model." *Theoretical Medicine* 16, no. 2 (1995): 129-139.

In practical applications, the impact of structural competence is difficult to comprehensively capture using current standard frameworks of health. Only recently do mainstream medical studies track the impact of physician intervention on the prevalence of factors like food deserts, voting accessibility, or internet access in a given community. We are, however, able to catch glimpses of medicine's culturally competent future by peering into the practices of classrooms around the country today. A student-run, elective course at the Oregon Health & Science University School of Medicine in structural competency, through group facilitation and discussion on topics from unconscious bias to urban structures and homelessness, reported significant increases in knowledge concerning structural competency, increased comfort in making structurally informed treatment plans for individual patients more than six months following the program.[136] The California family medicine residency program had developed a structural competency training with the goal of increasing resident physician's fluency in the language of structures and patient health.[137] While this three-hour training found qualitative evidence of a deepening of understanding of structural forces, ideally, structural competency would take a more central role in medical education. Though as some theorists have argued, structural competence education cannot merely be a replication of traditional classroom dynamics with new material, but rather reflect the crucial transformation in perspectives on pedagogy and treatment that it calls for.[138] As such, it should bring students out of the classroom and into the communities and narratives of those they hope to serve, in the process giving community members the capacity to be teachers and mentors. The Psychiatry Department at New York University Medical school employs structural competency rotations bringing students to public mental health facilities in underserved areas where individuals with lived experiences with a severe mental illness provide mentorship regarding building relationships between clinics

---

[136] Rabinowitz, Molly R., Melanie Prestidge, Glenn Kautz, Mary Clare Bohnett, Mariah JA Racicot, Michelle Beam, Brianna M. Muller, and Atif Zaman. "Assessment of a peer-taught structural competency course for medical students using a novel survey tool." *Medical Science Educator* 27, no. 4 (2017): 735-744.

[137] Neff, Joshua, Kelly R. Knight, Shannon Satterwhite, Nick Nelson, Jenifer Matthews, and Seth M. Holmes. "Teaching structure: a qualitative evaluation of a structural competency training for resident physicians." *Journal of general internal medicine* 32, no. 4 (2017): 430-433.

[138] Colón, Edgar Rivera. "This Ain't No Tool, This Ain't No Toolbox." In *Structural Competency in Mental Health and Medicine*, pp. 27-33. Springer, Cham, 2019.

and communities and community resource mapping that can inform treatment plans.[139] Clinical ethnography programs, like that at the University of California, Los Angeles, engage residents in documenting the impact of gentrification, homelessness and incarceration on the experience of mental illnesses in populations as a part of community treatment teams.[140] At Yale Medical School, students have the opportunity to take part in the Yale Department of Psychiatry Structural Competency Community Initiative, which familiarizes second-year residents to the everyday lives of New Haven locals through the perspectives of community leaders, including the structural barriers to health that are present in their communities.[141] Psychiatry residents can also take part in a policy advocacy program in that has been able to draft and successfully lobby for two bills concerning improving access to mental health services in Connecticut.[142] Vanderbilt University has been able to introduce themes of structural competency even earlier than medical school, introducing the interdisciplinary pre-health major of "Medicine, Health and Society."[143] The curriculum, with course options ranging from "Theories of the Body," to "Medicine, Humanities and the Arts," has become the fastest growing and third most popular major amongst the University's seven thousand undergraduates. Among the major's core structural competencies was the ability to demonstrate an understanding of the mechanisms through which structural factors shape health outcomes, which has had significant outcomes on student comprehension at the end of their curriculum; approximately half of students listed socioeconomic status and environmental or social factors as major influences on patient health

---

[139] Hansen, Helena, Joel Braslow, and Robert M. Rohrbaugh. "From cultural to structural competency—training psychiatry residents to act on social determinants of health and institutional racism." *JAMA psychiatry* 75, no. 2 (2018): 117-1

[140] Bourgois, Philippe, Seth M. Holmes, Kim Sue, and James Quesada. "Structural vulnerability: operationalizing the concept to address health disparities in clinical care." *Academic medicine: journal of the Association of American Medical Colleges* 92, no. 3 (2017): 299.

[141] Rohrbaugh, Robert M., Billy Bromage, John A. Encandela, Virginia T. Spell, Bridgett Williamson, and Walter S. Mathis. "Allying with Our Neighbors to Teach Structural Competence: The Yale Department of Psychiatry Structural Competency Community Initiative (YSCCI)." In *Structural Competency in Mental Health and Medicine*, pp. 159-166. Springer, Cham, 2019.

[142] Hansen, Helena, Joel Braslow, and Robert M. Rohrbaugh, 2018, pg. 118

[143] Metzl, Jonathan M., and JuLeigh Petty. "Integrating and assessing structural competency in an innovative prehealth curriculum at Vanderbilt University." *Academic Medicine* 92, no. 3 (2017): 354.

when unprompted,[144] significantly more than the general population of respondents when assessed by the Robert Wood Johnson Foundation in "A New Way to Talk About the Social Determinants of Health."[145]

The effects of such education early on in medical education can be foreseen in the development of programs like the Cincinnati Child Health-Law Partnership (Child HeLP), which is a coordinated effort between the Cincinnati Children's Hospital Medical Center and the Legal Aid Society of Greater Cincinnati that began in 2008.[146] The program dovetails with the work of legal advocates with medical providers and social workers to resolve the social and legal sources of patient illness and disease like public benefit denials, availability of transportation and housing conditions. The Boston Medical-Legal Partnership is one of the earliest examples of this kind of work, having been conceived in 1998, and now serving more than one thousand patients annually at Boston Medical Center and several community health centers.[147] The partnership is involved in the required 4 week course known as the Leadership in Advocacy Block (LAB) at Boston University, in which they train fourth year medical students concerning medical's involvement in the legislative process, media advocacy, clinical experiences of marginalized populations, as well as have them engage in project work to address a chosen structural health disparity.[148] The Peninsula Family Advocacy Program (FAP), another partnership between the Lucille Packard Children's Hospital at Stanford, Ravenswood Family Health Center, and Legal Aid Society of San Mateo County, came together in 2004 with similar goals of alleviating

---

[144] Metzl, Jonathan M., and JuLeigh Petty., 2017, pg. 356

[145] Carger, E., and D. Westen. "A new way to talk about the social determinants of health." *Princeton (NJ): Robert Wood Johnson Foundation* (2010).

[146] Beck, Andrew F., Mallory Curran, Adrienne W. Henize, Melissa D. Klein, Donita S. Parrish, Edward G. Paul, and Elizabeth Tobin-Tyler. "Is Poverty Making Me Sick? An Example of the Impact of Medical-Legal Partnership on Keeping Children Healthy." In *Structural Competency in Mental Health and Medicine*, pp. 121-134. Springer, Cham, 2019.

[147] Paul, Edward, Danya Fortess Fullerton, Ellen Cohen, Ellen Lawton, Anne Ryan, and Megan Sandel. "Medical-legal partnerships: addressing competency needs through lawyers." *Journal of Graduate Medical Education* 1, no. 2 (2009): 304-309.

[148] Cohen, Ellen, Danya Fortess Fullerton, Randye Retkin, Dana Weintraub, Pamela Tames, Julie Brandfield, and Megan Sandel. "Medical-legal partnership: collaborating with lawyers to identify and address health disparities." *Journal of general internal medicine* 25, no. 2 (2010): 136-139.

systemic causes of health inequalities through providing close cooperation between social

workers, legal services and physicians. In a pilot study researching the partnership's

effectiveness, over two thirds of the social and legal services that patients brought to the clinic

were fully or partially resolved.[149] FAP has also integrated a cross-disciplinary curriculum

between Stanford Medical School and Stanford Law School, instantiating the kind of

cooperation across fields that is necessary for the aims of structural competency to be realized. It

is in examples like these that we witness the transformative power of health to be used as a tool

of social and structural change.

Conclusion

The most memorable, but apocryphal, excerpt from the Hippocratic oath is; "above all, do no harm."[150] It is a promise to use the privilege and power of doctorship only to a patient's benefit. This ethical vow repeated by physicians-in-training upon their entrance into medical school, is widely considered synonymous with the medical profession itself.[151] As we grow as a society in our recognition of the long arms of racism and discrimination, ones that reach into the bodies of those that doctors have sworn to heal, so must physicians grow in their appreciation of the harms they can and should heal. Cultural competence, being so tethered to a history of medical practice that didn't consider so many to be worthy of care, is limited in its ability to rectify both that past as well the issues of harm that face us today. Cultural humility, critical health studies, and structural competence represent essential extensions of cultural competence that build upon its strongest attributes while not falling victim to the same biases and assumptions that have hindered it thus far in the fight against racism and health. These are strategies that are necessary to integrate at every pedagogical stage of medical practice in order to fully reckon with, and rectify, the reality of racism in health and in society at large. Donald Berwick captures the spirit of the need for such change in his address for the 2012 Harvard Medical School commencement ceremony.

> *If Isaiah needs a bone marrow transplant, then, by the oath you swear, you will get it for him. But Isaiah needs more. He needs the compassion of a nation, the generosity of a commonwealth. He needs justice. He needs a nation to recall that, no matter what the polls say, and no matter what happens to be temporarily convenient at a time of political combat and economic stress, that the moral test transcends convenience. Isaiah, in his legions, needs those in power—you—to say to others in power that a nation that fails to*

---

[149] Weintraub, Dana, Melissa A. Rodgers, Luba Botcheva, Anna Loeb, Rachael Knight, Karina Ortega, Brooke Heymach, Megan Sandel, and Lynne Huffman. "Pilot study of medical-legal partnership to address social and legal needs of patients." *Journal of Health Care for the Poor and Underserved* 21, no. 2 (2010): 157-168.

[150] Greener, Mark. "First do no harm." *EMBO reports* 9, no. 3 (2008): 221-224.

[151] Miles, Steven H. *The Hippocratic Oath and the ethics of medicine*. Oxford University Press, 20

> *attend to the needs of those less fortunate among us risks its soul. That is your duty*
> *too.*[152]

This kind of fundamental, revolutionary shift in the field is one that strikes at the heart of healthcare. With the kind of pedagogical rethinking offered in this paper, and in the voices that it builds upon, doctors can begin to strive to heal not only their patients, but the systems that they exist in.

---

[152] Berwick, Donald M. "To isaiah." *JAMA* 307, no. 24 (2012): 2597-2599.